PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

Mental Health and Suicide Prevention - Final Report

House of Representatives Select Committee on Mental Health and Suicide Prevention

October 2021
CANBERRA

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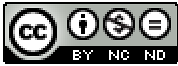

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Chair's foreword

Today, Australia is navigating a mental health, suicidality, and social and emotional wellbeing crisis. Exacerbated by successive natural disasters and the COVID-19 pandemic, this crisis has amplified social disadvantage, increased service demand and presentations of mental illness, and exposed the limitations of our mental health and suicide prevention and aftercare service systems.

There is growing evidence linking mental health and climate change. The compounding trauma of living through extreme weather events – bushfires, floods, droughts – along with increasing levels of anxiety about the future cannot be ignored. It is past time for a whole-of-government, whole-of-parliament approach to mental health and suicide prevention that takes into account wider environmental considerations.

The Productivity Commission Inquiry Report on Mental Health (Productivity Commission Report) quantified the significant annual cost of mental ill health and suicide – approximately $70 billion per year, based on 2018-19 estimates. If the Australian Government wishes to improve services and minimise future costs, it must act decisively on the recommendations raised in this and across other relevant reports and shift the focus to implementation.

The 2021-22 Budget responding to the findings of the Productivity Commission Report and a range of other major reports, along with initiating the National Mental Health and Suicide Prevention Agreement and the National Mental Health Workforce Strategy, were positive steps towards improving services and outcomes for individuals.

Over the course of the last year, the Committee conducted its inquiry into mental health and suicide prevention to assess the current landscape, review the recommendations already before the Australian Government, and examine the gaps that are resulting in far too many people still unable to access the right care at the right time and place.

The Committee found several barriers and identified priority reforms across the mental health and suicide prevention sectors that must be addressed. Workforce shortages and inadequate training are underpinning service gaps, especially for our most vulnerable populations. Many of these issues stem from governance and funding structures that, once reformed, would enable improvements across workforce management, multi-jurisdictional collaboration, and referral processes.

This inquiry highlighted that a broad definition of the mental health workforce is required to provide a person-centred, stepped care approach that incorporates the physical and social determinants of health. There is also an urgent need to further embed training around culture, suicide prevention and lived experience across public, private and non-government services and agencies, to ensure the safe provision of services. This will be crucial for delivering the efficient, consumer-oriented, and accessible mental health and suicide prevention services and systems of the future.

The Committee was pleased to hear the success of some of the federally funded initiatives, such as telehealth as a part of virtual mental health care, which is helping to mitigate barriers to access as a result of distance, stigma or lack of specialist workforces. An increased focus and funding for digital health service systems, service evaluation, and research are now required to rapidly increase access to assessment, service coordination and to track outcomes of care and data collection.

Evidence was clear that the key points for intervention are early in life and early in illness – supporting parents through pregnancy, providing scaffolding for children throughout school, and helping adults transition through life stages with ready access to reliable information and clear pathways to appropriate services. Underpinning this is ensuring that there is a common mental health language shared across the community and a diverse, coordinated workforce that incorporates lived experience and a wide range of specialist skills.

The Committee's recommendations support the safety, quality, and evidence-based delivery of mental health care by improving our regulation systems of health professionals to recognise both the value and risks associated with the full range of mental health-interacting professions.

The Committee recommended further work for the Australian Government, to advance the cultural competencies of workforces, the commissioning pathways for culture, and the funding available for community infrastructure. These investments are critical for building community connectedness and the social and emotional wellbeing of all Australians across-the-lifespan, noting specifically the

needs of Aboriginal and Torres Strait Islander, culturally and linguistically diverse, LGBTIQ+, and rural and remote populations.

The recommendations of the Committee have focussed on consolidating the evidence base for reform and ensuring that the Australian Government is responsive to the current demands of the mental health and suicide prevention sectors. Looking forward, the Committee would like to see mental health and suicide prevention given the same recognition as physical health both within the health sector and by policy makers. On this basis, the Committee has recommended the appointment of a Standing Committee on Mental Health, Suicide Prevention, and Social and Emotional Wellbeing in the next Parliament.

The Committee would like to express its appreciation to all who have contributed their time, knowledge and lived experience throughout the course of the inquiry.

Dr Fiona Martin MP

Chair

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Membership of the Committee

Chair

Dr Fiona Martin MP

Deputy Chair

Ms Emma McBride MP

Members

Mr Vince Connelly MP

Mr Llew O'Brien MP

Mr Tony Pasin MP

Mr Julian Simmonds MP

Ms Anne Stanley MP

Ms Susan Templeman MP

Committee Secretariat

Greg Ward, Committee Secretary

Vikki Darrough, Inquiry Secretary

James Peters, Researcher

Cathy Rouland, Office Manager

Terms of reference

On 10 December 2020, the House of Representatives resolved to establish a Select Committee on Mental Health and Suicide Prevention to inquire into:

- the findings of the Productivity Commission Inquiry Report into Mental Health, the Report of the National Suicide Prevention Officer, the Victorian Royal Commission, the National Mental Health Workforce Strategy and other recent strategic reviews of the current mental health system in light of events such as the 2019 bushfires and COVID-19 pandemic, including the capacity of the mental health workforce to respond to such events; and
- other matters not addressed by these recent reviews, including:
  - emerging evidence-based approaches to effective early detection, diagnosis, treatment and recovery across the general population and at-risk groups, including drawing on international experience and directions;
  - effective system-wide strategies for encouraging emotional resilience building, improving mental health literacy and capacity across the community, reducing stigma, increasing consumer understanding of the mental health services, and improving community engagement with mental health services;
  - building on the work of the Mental Health Workforce Taskforce and forthcoming National Medical Workforce Strategy, the roles, training and standards for all health and allied health professionals who contribute to mental health care, including peer workers, that are required to deliver quality care at different levels of severity and complexity, and across the spectrum of prevention, early intervention, treatment and recovery support;

- the funding arrangements for all mental health services, including through the MBS and PHNs, and whether they are structured in a way that supports safe, high quality and effective care in line with the qualifications of practitioners and needs of consumers across whole of population;
- the use, standards, safety and regulation of telehealth services and the role and regulation of domestic and international digital and online mental health service providers in delivering safe and high quality care in Australia; and
- any related matters.

Abbreviations

AAPi	Australian Association of Psychologists Inc
AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
ACA	Australian Counselling Association
ACCHO	Aboriginal Community Controlled Health Organisation
ACPA	Australian Clinical Psychology Association
ACSQHC	Australian Commission on Safety and Quality in Health Care
ACSSO	Australian Council of State School Organisations
ACT	Australian Capital Territory
ADF	Australian Defence Force
AHMRC	Aboriginal Health and Medical Research Council of NSW
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
ALIVE	Academy of Lived Experience
AMA	Australian Medical Association
ANU	Australian National University
APACS	Australian Psychologists and Counsellors in Schools
APS	Australian Psychological Society
ARHEN	Australian Rural Health Education Network
ASIST	Applied Suicide Intervention Skills Training

AV	Audio visual
CALD	Culturally and linguistically diverse
CMO	Community Managed Organisation
CMY	Centre for Multicultural Youth
COVID-19	Coronavirus Disease of 2019
CPD	Continuing professional development
DBT	Dialectical behaviour therapy
DVA	Department of Veterans' Affairs
ED	Emergency department
EP	Exercise physiologist
ESSA	Exercise and Sports Science Australia
FPS	Focussed psychological strategies
FTE	Full-time equivalent
GCMHSS	Gold Coast Mental Health and Specialist Services
GP	General practitioner
GPMHSC	General Practice Mental Health Standards Collaboration
GROW	Guiding Rural Outback Wellbeing
HHS	Hospital and Health Service
IP	Internet Protocol
IT	Information technology
KALACC	Kimberley Aboriginal Law and Cultural Centre
KPI	Key performance indicator
LEA	Lived Experience Australia
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and queer
LHN	Local Health Network
MBBS	Bachelor of Medicine/Bachelor of Surgery
MBS	Medicare Benefits Schedule
MHA	Mental Health Australia
MHFA	Mental Health First Aid International

MHNIP	Mental Health Nurse Incentive Program
MSAMHS	Metro South Addictions and Mental Health Services
MYST	Mountains Youth Services Team
NACCHO	National Aboriginal Community Controlled Health Organisation
NAPLAN	National Assessment Program – Literacy and Numeracy
NBN	National Broadband Network
NBRF	National Bushfire Recovery Fund
NDIS	National Disability Insurance Scheme
NFRC	National Federation Reform Council
NGO	Non-government organisation
NMBA	Nursing and Midwifery Board of Australia
NMHC	National Mental Health Commission
NMHCCF	National Mental Health Consumer and Carer Forum
NSCP	National School Chaplaincy Program
NSQDMH Standards	National Safety and Quality Digital Mental Health Standards
NSW	New South Wales
PACFA	Psychotherapy and Counselling Federation of Australia
PANDA	Perinatal Anxiety and Depression Australia
PC	Personal computer
PC Report	Productivity Commission Report
PHN	Primary Health Network
PPE	Personal protective equipment
PTSD	Post-traumatic stress disorder
QAIHC	Queensland Aboriginal and Islander Health Council
QNMU	Queensland Nurses and Midwives' Union
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCA	Regional commissioning authority

RFDS	Royal Flying Doctor Service
SAGE Australia	Sex and Gender Education Australia
SGD	Sex and/or gender diverse
SPA	Speech Pathology Australia
SPLA Committee	House Standing Committee on Social Policy and Legal Affairs
TAE	Training and Education
TV	Television
UK	United Kingdom
UTS	University of Technology Sydney
WA	Western Australia
WAAMH	Western Australian Association for Mental Health

List of recommendations

Recommendation 1

1.37 The Committee recommends that the Australian Government propose the appointment of a House Standing Committee on Mental Health, Suicide Prevention, and Social and Emotional Wellbeing, at the commencement of the next parliamentary cycle.

Recommendation 2

2.108 The Committee recommends that the Australian Government invest in research to determine the longitudinal impacts of compounding trauma and successive disasters including extreme weather events caused by climate change on the mental health, suicidality, and the social and emotional wellbeing of individuals and communities.

Recommendation 3

2.112 The Committee recommends that the Australian Government ensure that the Deputy Chief Medical Officer for Mental Health is present to provide advice and actively participate at all crisis meetings, and encourage states and territories to adopt an equivalent position, if they have not yet done so.

Recommendation 4

3.127 The Committee recommends that the Australian Government ensure the principle of accessibility is at the forefront of all policy and funding programs for the mental health and suicide prevention sector, with a focus on:

- increased funding for specialist services, such as forensic, perinatal and autism services, to innovate, expand and meet demand
- frameworks that include consumer co-design and community partnership requirements to ensure equitable access for priority populations
- Indigenous-led and culturally appropriate models improving Aboriginal and Torres Strait Islander experiences with mental health and suicide prevention services.

Recommendation 5

4.77 The Committee recommends that the Australian Government review available digital technologies to identify and promote best practice options for mental health and suicide prevention professionals to:

- increase access to rapid assessment for self-harm
- coordinate with other service providers to reduce administrative pressures on professionals and improve the user experience
- track outcomes of care to ensure that the right care is being offered.

Recommendation 6

4.80 The Committee recommends that the Australian Government make compliance with the National Safety and Quality Digital Mental Health Standards mandatory for all digital mental health service providers who receive Commonwealth funding.

Recommendation 7

4.100 The Committee recommends that the Australian Government ensure the next National Digital Health Strategy (2022-27) explicitly addresses barriers to digital access, and includes specific actions for reducing the ‘digital divide’.

Recommendation 8

4.114 The Committee recommends that the Australian Government commit ongoing funding for digital mental health research, considering the

increased prevalence of mental health problems and rapid expansion of virtual mental health care.

Recommendation 9

4.117 The Committee recommends that the Australian Government embed and expand virtual mental health care in the next National Digital Health Strategy (2022-27).

Recommendation 10

5.35 The Committee has found that a workforce strategy is key to improving the mental health of all Australians and on this basis recommends that the Australian Government provide funding and other supports needed for the immediate development of a national workforce institute for mental health. The institute must:

- include Aboriginal and Torres Strait Islander peoples and lived experience expertise
- incorporate professional stigma and burnout reduction strategies
- develop avenues for mental health supervision and debriefing for all participants in the mental health workforce.

Recommendation 11

5.51 The Committee recommends that the Australian Government leverage the existing Australian Rural Health Education Network by providing funding for clinical placements in regional, rural and remote university clinics, and using these clinics to trial multidisciplinary, hybrid mental health hubs that integrate digital services and face-to-face services.

Recommendation 12

5.69 The Committee recommends that the Australian Government led by Aboriginal and Torres Strait Islander representatives, engage with state and territory governments, education authorities, schools and tertiary institutions to increase visibility and promote careers in mental health and suicide prevention for Aboriginal and Torres Strait Islander peoples, including students at high school and tertiary institutions.

Recommendation 13

5.89 The Committee recommends that the Department of Health and the National Mental Health Workforce Strategy Taskforce include in the National Mental Health Workforce Strategy:

- suicide prevention training standards for all health and allied health professionals and other professionals that form the suicide prevention workforce
- national standardisation of suicide training in risk assessments and safety plans, to ensure consistency and evidence-based training delivery
- specific references to the workforce development requirements for suicide aftercare and postvention.

Recommendation 14

5.115 The Committee recommends that the Australian Government work with the Medical Board of Australia and the Royal Australian College of General Practitioners to:

- review the core competencies required in mental health and suicide prevention for all medical students
- identify pathways for general practitioners in training to complete mental health and suicide prevention clinical placements that will expose them to the types of mental health presentations likely to be seen in practice
- develop incentives for general practitioners to access General Practice Mental Health Standards Collaboration approved training and continuing professional development.

Recommendation 15

5.132 The Committee recommends that the Department of Health and the National Mental Health Workforce Strategy Taskforce engage with psychiatry peak bodies to develop a workforce strategy that maximises access to the expert skills of psychiatrists for those with complex and serious mental illness, including through:

- increasing support for mental health nurses to provide pre- and post-appointment services
- a multidisciplinary team or consultancy function, where other health professionals can quickly access psychiatry expertise.

Recommendation 16

5.155 The Committee recommends that the Australian Government appoint a chief mental health nurse to work alongside the Deputy Chief Medical Officer for Mental Health, and encourage states and territories to adopt an equivalent position, if they have not yet done so.

Recommendation 17

5.186 The Committee recommends that the Australian Government support the growth and diversity of psychology specialties by:

- funding ongoing Australian research to compare outcomes across the nine areas of practice endorsement in the psychology profession, and using this research to inform future policy and funding decisions
- increasing university master's level programs to improve distribution across the nine areas of endorsement, with at least one educational and developmental psychology program in every state and territory
- dedicating a percentage of Commonwealth funded scholarships to psychology specialisations outside of the primary clinical psychology pathway
- providing funding or tax incentives to registered psychologists:
  - to increase their capacity to offer placements to psychologists in training and ongoing clinical supervision
  - for continuing professional development.

Recommendation 18

5.202 The Committee recommends that the Australian Government consider continuing and expanding the Continued Dispensing arrangements, which have enhanced access to vital medicines and improved patient outcomes

during the COVID-19 pandemic including for those living with mental ill health, especially in regional, rural and remote areas.

Recommendation 19

5.203 The Committee recommends that the Australian Government evaluate the efficacy of pharmacy mental health training programs and strengthen funding to support an expansion of best practice training in mental health and suicide prevention for all pharmacists and pharmacy staff.

Recommendation 20

5.219 The Committee recommends that the Australian Government review the existing self-regulated standards being used by the counsellor and psychotherapist peak bodies and use the results to determine appropriate terminology, national minimum standards for education, supervision, continuing professional development and oversight requirements.

Recommendation 21

5.274 The Committee recommends that the Australian Government strengthen the frameworks for allied health professions to be fully integrated into the mental health workforce, including by:

- reviewing the regulation and oversight of allied health professions that contribute to the mental health workforce, and specifically the need to establish national boards supported by the Australian Health Practitioner Regulation Agency where they do not currently exist
- providing funding or incentives to increase the availability of discipline-specific supervision to expand the number of places for allied health professionals wanting to specialise in mental health
- recognising the full spectrum of allied health professionals, including physiotherapists, exercise physiologists and Dietitians, and their contribution to the mental health workforce as allied health professionals in the final National Mental Health Workforce Strategy and subsequent implementation plans
- developing and implementing a strategy to promote the mental health related interventions that allied health professionals can offer. This

should include information targeted at both consumers and other health professionals.

Recommendation 22

5.287 The Committee recommends that the Australian Government formally acknowledge the value of the volunteer mental health workforce, with consideration of its role, training, and standards included in the final National Mental Health Workforce Strategy and subsequent implementation plans.

Recommendation 23

5.323 The Committee recommends that the Australian Government support the development of the lived experience (peer) mental health and suicide prevention workforce by:

- establishing a lived experience office within the Department of Health portfolio to support the growth of a safe and effective lived experience (peer) workforce, led by a National Lived Experience Officer
- providing seed funding for the establishment of a national professional association for lived experience (peer) workers, with additional guaranteed funding for the first five years of operations.

Recommendation 24

5.352 The Committee recommends that the Department of Social Services, in consultation with the Department of Health, National Mental Health Commission and National Suicide Prevention Office, develop a national carer strategy that includes:

- details on how and when unpaid carers are to be integrated into care teams
- access to national standardised training for suicide awareness, risk and prevention for all carers
- a clear pathway for engagement with carer representative bodies.

Recommendation 25

5.353 The Committee recommends that the Department of Social Services implement a fit-for-purpose respite care program that is flexible and includes access to educational components, counselling services and other supports to boost resilience.

Recommendation 26

6.73 The Committee recommends that the Australian Government provide legislative authority to strengthen the independence of the National Mental Health Commission, with a designated task being to monitor and report on compliance by Primary Health Networks and Local Health Networks against their commitments.

Recommendation 27

6.77 The Committee recommends that the Australian Government review the commissioning constraints on Primary Health Networks to ensure that the implementation of regional plans providing for regional mental health and suicide prevention services can reasonably be delivered.

Recommendation 28

6.80 The Committee recommends that, in line with stakeholder and the Productivity Commission Report recommendations, the Australian Government:

- fund Primary Health Networks (PHNs) for mental health and suicide prevention services on five year cycles
- transition mental health and suicide prevention services provided by non-government organisations to five year funding contracts
- require PHNs to commission mental health and suicide prevention services on five year contracts
- strengthen long- and short-term outcome reporting requirements to enable continuous service evaluation in response to increasing the length of contracts and funding cycles.

Recommendation 29

6.84 The Committee recommends that the Australian Government review the types of mental health and suicide prevention services that would be better delivered nationally, noting the importance of having strong national standards of care, quality, and evidence-based practice in service delivery, as well as reducing the burdens of unnecessary commissioning complexity.

Recommendation 30

6.146 The Committee recommends that the Australian Government's evaluation of Better Access, and reform of the system, focus specifically on:

- the viability of bulk-billing incentives available to general practitioners (GPs) being similarly made available to mental health practitioners for the treatment of mental illness, where there are patient affordability constraints
- the two-tier system impacts on treatment access, appropriateness and affordability of psychological care
- including psychologists with other areas of endorsement (non-clinical endorsement) on the higher rebate tier, noting that this will increase access to specialists, address non-clinical endorsement disincentives and support the diversity of the psychological workforce
- the value of extending the annual cap on psychologist sessions, to ensure evidence-based delivery of care for complex presentations to increase affordability for people experiencing serious and/or complex mental illness
- the GP referral system for psychological services, including a valid 12 month referral:
  - utilising digital services for treatment to track patient outcomes
  - with a limit of two GP review sessions – an initial Better Access assessment/ referral and another after session 10 (to assess if another 10 sessions with the current provider is appropriate).

Recommendation 31

6.148 The Committee recommends that the Australian Government reform the Medicare Benefits Schedule to ensure that the completion of mental health treatment plans and consultations by general practitioners for the management of mental illnesses have the same rebate value as chronic disease management plans and physical health consultations.

Recommendation 32

6.151 The Committee recommends that the Australian Government add Medicare Benefits Schedule items to support case conferencing in the treatment of mental illness for:

- allied health professional attendance, for example psychologists, pharmacists, social workers, occupational therapists, exercise physiologists, and speech pathologists
- health professional attendance, for example general practitioners, mental health nurses, and psychiatrists
- mental health professionals to support the attendance of carers and families.

Recommendation 33

6.189 The Committee recommends that the Australian Government direct specific funding for LGBTIQ+ and sex and/or gender diverse community-controlled health services, community groups and programs to provide mental health and suicide prevention services that meet community needs.

Recommendation 34

6.193 The Committee recommends that the Australian Government formalise commissioning pathways for Aboriginal cultural programs, noting the significant relationship between cultural connectedness and Aboriginal mental health, suicide prevention, and social and emotional wellbeing.

Recommendation 35

6.200 The Committee recommends that the Australian Government:

- consolidate its funding portfolios to Aboriginal Community Controlled Health Organisations (ACCHOs) within the Department of Health for Aboriginal mental health, suicide prevention, and social and emotional wellbeing
- ensure that Commonwealth funding for Aboriginal services is redirected from Primary Health Networks to ACCHOs, where available
- ensure funding is sufficient for the full and rapid implementation of the Gayaa Dhuwi (Proud Spirit) Declaration.

Recommendation 36

6.214 The Committee recommends that the Australian Government ensure:

- under the Commonwealth Procurement Rules it is a condition for participation that any potential supplier demonstrate minimum standards of mental health support and care in their workplace
- mental health and suicide prevention service commissioning activity requires services to reasonably demonstrate the inclusion of lived experience in service design and delivery.

Recommendation 37

7.42 The Committee recommends that the Australian Bureau of Statistics *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020* be embedded into all health and social services minimum datasets, including coroners' data and Census data.

Recommendation 38

7.49 The Committee recommends that the Australian Institute of Health and Welfare convene a cross-jurisdictional working group, including Commonwealth, state and territory authorities, researchers, clinicians, and service delivery organisations, to establish a national collection framework for data on mental health and suicide prevention. The national collection framework must include:

- a central repository of current, harmonised and comparable data from all jurisdictions which is broadly available for research and service delivery planning

- harmonised data reporting requirements for inclusion in service delivery contracts.

Recommendation 39

7.67 The Committee recommends that the Australian Government develop enabling legislation to make the National Mental Health Commissioner an independent officer of the Parliament with responsibility under the legislation for monitoring and reporting on outcomes of mental health and suicide prevention initiatives.

Recommendation 40

8.30 The Committee recommends that the Australian Government ensure the sixth National Mental Health and Suicide Prevention Plan acknowledges and addresses the social determinants of health and psychosocial supports needed in the treatment of mental illness and suicide prevention.

Recommendation 41

8.91 The Committee recommends that the Australian Government work with state and territory governments to:

- conduct an independent evaluation on the effectiveness of existing programs that support wellbeing in schools, including the National School Chaplaincy Program, with a focus on the outcomes of children participating

- implement an agreement to increase the ratio of school psychologists to a minimum of one full time equivalent on-site for every 500 students across all levels of school.

Recommendation 42

8.96 The Committee recommends that the Australian Government prioritise the needs of young people by implementing a national prevention and wellbeing strategy through the Australian curriculum, which includes upskilling staff and students.

Recommendation 43

8.113 The Committee recommends that the Department of Health and the National Mental Health Commission develop, define and promote a common mental health language that can be shared across the community, and especially vulnerable groups including Aboriginal and Torres Strait Islander peoples, other culturally and linguistically diverse communities, elderly, youth, and LGBTIQ+ people.

Recommendation 44

8.114 The Committee recommends that the Australian Government fund the development of training resources for the mental health workforce in the provision of culturally appropriate and sensitive services to Aboriginal and Torres Strait Islander peoples, other culturally and linguistically diverse communities, and LGBTIQ+ and sex and/or gender diverse individuals. Such training should be mandated through Australian Government funding agreements.

1. Introduction

Overview

1.1 Approximately one in five Australians and nearly half of all adults will experience a mental or behavioural condition in their lifetime.[1] Mental illness such as schizophrenia, eating disorders, anxiety and depression, bipolar mood disorder, personality disorders, and trauma may be episodic, acute or chronic and can significantly affect how a person feels, thinks and behaves, and impacts on relationships with family, friends, colleagues and the wider community.

1.2 People living with mental health problems may also experience times of homelessness, poverty, isolation, poor physical health and unemployment.

1.3 Often people who have a mental or behavioural condition are stigmatised and defined by their illness leading to discrimination, making their mental health condition worse and stopping a person from getting the help they vitally need.

1.4 This can all significantly affect a person's capacity to care for themselves and others, and to participate in social, family, educational and vocational roles.

1.5 Over 65,000 Australians make a suicide attempt each year; over 3,000 Australians end their lives every year; 75 per cent of those that take their own life are male; the suicide rate in Aboriginal and Torres Strait Islander peoples is twice that of their non-Indigenous counterparts; people in rural

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1 Australian Bureau of Statistics, 'National Health Survey: First results', www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-first-results/2017-18, viewed 20 September 2021; Department of Health, 'Mental health and suicide prevention', www.health.gov.au/health-topics/mental-health-and-suicide-prevention, viewed 20 September 2021.

populations are two times more likely to die by suicide; LGBQTI+ community members experience significantly higher rates of suicide than the rest of the population; same-gender attracted Australians are estimated to experience up to 14 times higher rates of attempted suicide than their heterosexual peers; and suicide was the main cause of death for Australians aged 15 to 49 years in 2019.[2]

1.6 Lifeline Australia estimates that for 'each life lost to suicide, the impacts are felt by up to 135 people, including family members, work colleagues, friends, first responders at the time of death.'[3]

1.7 The COVID-19 pandemic and significant natural disasters such as bushfires, floods, cyclones and drought, global and local economic shifts, and numerous personal traumas took a personal toll on all Australians, heightening feelings of stress in our day to day lives and livelihoods.

1.8 The Australian Institute of Health and Welfare highlighted that the mental health and wellbeing of young Australians has been particularly impacted by the pandemic:

> While COVID-19 affects people in different ways, the social and economic impacts on young people have been substantial. Compared with older age groups, young people have experienced high rates of psychological distress, loneliness, educational disruption, unemployment, housing stress and domestic violence.[4]

1.9 The Committee acknowledges the sense of urgency required to improve services and outcomes for anyone affected by mental ill health and those that support and care for them. The COVID-19 pandemic and recent natural disasters have emphasised this point.

Other recent reports and strategic reviews

1.10 The Committee acknowledges that a number of reports and strategic reviews of the mental health system have been undertaken, or are

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2 Department of Health, 'Mental health and suicide prevention', www.health.gov.au/health-topics/mental-health-and-suicide-prevention, viewed 20 September 2021; Lifeline, 'Lifeline Statistics', www.lifeline.org.au/resources/data-and-statistics/, viewed 24 September 2021.

3 Lifeline, 'Lifeline Statistics', www.lifeline.org.au/resources/data-and-statistics/, viewed 24 September 2021.

4 Australian Institute of Health and Welfare, 'COVID-19 and the impact on young people', www.aihw.gov.au/reports/children-youth/covid-19-and-young-people, viewed 22 September 2021.

underway. Most notably these works have focussed on veterans, people with a disability, and aged care sectors as well as people affected by family, domestic and sexual violence.

1.11 The completed reports have undertaken a thorough examination of the mental health impacts on those individuals and have made a number of significant recommendations.

1.12 The Committee is cognisant of not overlapping or duplicating this vital work. It looks forward to the outcomes of these inquires and the subsequent responses from government. A brief overview of these reports and strategic reviews is included below.

Veterans

1.13 On 8 July 2021, the Governor-General, His Excellency General the Honourable David Hurley AC DSC (Retired) issued Letters Patent establishing the Royal Commission into Defence and Veteran Suicide.[5]

1.14 The Royal Commission is required to produce an interim report by 11 August 2022 and a final report by 15 June 2023.

1.15 On 5 February 2020, the Prime Minister announced that the Australian Government would establish a National Commissioner for Defence and Veteran Suicide Prevention to inquire into, and support the prevention of, the deaths by suicide by Australian Defence Force members and veterans.[6]

1.16 On 29 September 2021, the Interim National Commissioner for Defence and Veteran Suicide Prevention tabled an interim report in Parliament. The report made 41 recommendations including:

> Defence should commission an external review and evaluation of the culture within the Australian Defence Force (ADF) associated with mental ill health and help-seeking behaviour. Following this, Defence should implement a cultural change and de-stigmatisation program throughout the ADF to normalise early access to mental health services.[7]

5 Royal Commission into Defence and Veteran Suicide, 'About the Commission', defenceveteransuicide.royalcommission.gov.au/about, viewed 30 September 2021.

6 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, 29 September 2021, page 1.

7 Interim National Commissioner for Defence and Veteran Suicide Prevention, *Preliminary Interim Report*, 29 September 2021, pages 296-306.

Violence, abuse, neglect and exploitation of people with disability

1.17 On 18 February 2019, the Prime Minister, the Hon Scott Morrison MP, announced the establishment of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (People with Disability Royal Commission).[8]

1.18 On 4 April 2019, the Letters Patent containing the Royal Commission's terms of reference were issued after extensive consultation with people with disability and the disability sector.[9]

1.19 The Royal Commission has a significant focus on the mental health of individuals with disabilities, and mental health service systems that people with disabilities require for life-long care.

1.20 The People with Disability Royal Commission published an interim report on 30 October 2020, and four progress reports between December 2019 and 30 June 2021.

1.21 The interim report noted that while initiatives to improve mental health services were being introduced, evidence that they had received called for substantial additional resources to 'ensure that the initiatives significantly improve mental health services for people with an intellectual disability and a mental illness'.[10]

1.22 The Letters Patent for the Royal Commission require it to submit the final report to the Governor-General by 29 April 2022.

Aged care quality and safety

1.23 The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018 by the Governor-General, His Excellency General the Honourable Sir Peter Cosgrove AK CVO MC (Retired).[11]

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8 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Interim Report*, 30 October 2020, page 3.

9 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Interim Report*, 30 October 2020, page 3.

10 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Interim Report*, 30 October 2020, page 244.

11 Royal Commission into Aged Care Quality and Safety, *Final Report: Care Dignity and Respect*, Vol 1 – Summary and Recommendations, 1 March 2021, page 3.

1.24 The Final Report of the Royal Commission into Aged Care Quality and Safety was presented to the Governor-General on 26 February 2021. It was tabled in Parliament on 1 March 2021.

1.25 The report included a specific focus on mental health services provided to aged persons, and recommended increasing access to older persons' mental health services.[12]

Substance abuse

1.26 In May 2021, the Parliamentary Joint Committee on Law Enforcement completed its inquiry on public communications campaigns targeting drug and substance abuse.

1.27 The Committee's report noted the intersection between mental health, addiction and the justice system, and recommended that the Australian Government support research, potentially by the Australian Institute of Criminology, into the efficacy of addiction treatment programs in reducing drug-related crime recidivism.[13]

Family, domestic and sexual violence

1.28 On 4 June 2020, the House Standing Committee on Social Policy and Legal Affairs (SPLA) adopted an inquiry into family, domestic and sexual violence. The Committee published its report on 1 April 2021.[14]

1.29 As part of the inquiry, the SPLA Committee examined the complex interactions between family, domestic and sexual violence and mental health and wellbeing services.

1.30 The SPLA Committee recommended:

> … that the Australian Government, in conjunction with state and territory governments, resource additional research regarding the intersection between mental health and family, domestic and sexual violence. There should be a particular focus on the lived experiences of victim-survivors and the children

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12 Royal Commission into Aged Care Quality and Safety, *Final Report: Care Dignity and Respect*, Vol 1 – Summary and Recommendations, 1 March 2021, page 249.

13 Joint Committee on Law Enforcement, *Public Communications Campaigns Targeting Drug and Substance Abuse Report*, May 2021, Recommendation 4, page ix.

14 House of Representatives Standing Committee on Social Policy and Legal Affairs, *Inquiry into Family, Domestic and Sexual Violence Report*, March 2021.

of victim-survivors who have experienced both family violence and mental health issues.[15]

Scope of the inquiry

1.31 On 10 December 2020, the House of Representatives resolved to establish a Select Committee on Mental Health and Suicide Prevention (the Committee) to inquire into the findings of recent reports and strategic reviews of the mental health system in light of events such as the 2019 bushfires and COVID-19.

1.32 In addition, the Committee was asked to inquire into and report on a range of other specific matters spanning approaches to early intervention, workforce roles, training and standards, funding arrangements, and the use of telehealth and digital services. The terms of reference for the Committee's inquiry can be found on page xvii of this report.

1.33 The broad terms of reference enabled the Committee to explore a wide range of matters throughout its inquiry. The Committee notes that there are several aspects of mental health, suicide prevention, and social and emotional wellbeing that require further inquiry or ongoing review, noting the substantial investments underway.

1.34 While acknowledging there is a House Standing Committee with responsibility for health, suicide prevention and social and emotional wellbeing are not solely health issues. It is also important to recognise mental health on the same footing as physical health.

1.35 The Committee therefore considers there should be a House Standing Committee on Mental Health, Suicide Prevention, and Social and Emotional Wellbeing established to undertake this policy work and review relevant annual reports, including the National Mental Health Commission annual report.

1.36 Areas the Committee believes require further investigation include:

- the National Suicide Prevention Office, its aims and objectives, and any barriers to its progress
- mental health, suicide prevention, and wellbeing in the workplace
- the impact of the COVID-19 pandemic on substance use and abuse and the intersection with mental health

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15 House of Representatives Standing Committee on Social Policy and Legal Affairs, *Inquiry into Family, Domestic and Sexual Violence Report*, March 2021, Recommendation 76, page xliii.

- the role of medication and novel treatments for mental illness
- the capacity for social and emotional wellbeing initiatives and community-building programs to reduce loneliness and improve social connection
- the cumulative consequences of climate change on mental health and mental illness.

Recommendation 1

1.37 The Committee recommends that the Australian Government propose the appointment of a House Standing Committee on Mental Health, Suicide Prevention, and Social and Emotional Wellbeing, at the commencement of the next parliamentary cycle.

Conduct of the inquiry

1.38 A media release announcing the inquiry was issued on 25 February 2021, calling for submissions from interested individuals and organisations on the terms of reference.

1.39 The Committee also directly invited submissions from industry bodies, agencies, institutions, academics, think tanks and individuals.

1.40 The inquiry received 232 submissions and 47 exhibits, which are listed at Appendix A and B respectively.

1.41 The Committee held 17 public hearings. A list of those hearings and the witnesses and organisations that appeared at the hearings may be found at Appendix C.

1.42 COVID-19 restrictions prevented interstate travel and meant that all the public hearings had to be undertaken in Canberra or by videoconference. The Committee had planned to conduct hearings at various locations across Australia, including Perth, Brisbane, Melbourne and Sydney.

1.43 The Committee thanks all those who participated in the inquiry for giving their time to provide evidence of their experiences to the Committee. The Committee acknowledges that it has been a challenging time for all Australians and that it can be difficult to provide details of these experiences, particularly as part of a public inquiry.

1.44 The first-hand experiences, including from those who have a mental health condition or those who care or have cared for someone with a mental health condition, gave the Committee invaluable insight into understanding

Australia's mental health system and the steps necessary to improve mental health, suicide prevention and wellbeing services in Australia.

Structure of the report

1.45 In April 2021 the Committee presented an interim report which provided an update on work undertaken to date, emerging themes and plans for the remainder of the inquiry.[16]

1.46 This final report of the Committee investigates further some of the major themes identified in the interim report.

1.47 Chapter 2 examines the impact the COVID-19 public health emergency and natural disasters have had on the mental health and wellbeing of Australians.

1.48 Chapter 3 considers the accessibility of mental health services available.

1.49 Chapter 4 discusses the role that telehealth and digital services are playing in expanding accessibility and developing virtual mental health care.

1.50 Chapter 5 details the workforce constraints and the various roles that contribute to mental health and suicide prevention beyond the medical model.

1.51 Chapter 6 outlines the value of coordinated approaches to investment, and how funding reform can support access, workforce, service delivery and holistic care.

1.52 Chapter 7 identifies the current gaps in reporting and data collection on mental health and suicide prevention, and how proper evaluation and research can improve treatment and service systems.

1.53 Chapter 8 defines the value of wellbeing supports and accommodating the social determinants of mental health in system design and treatment.

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[16] House of Representatives Select Committee on Mental Health and Suicide Prevention, *Mental Health and Suicide Prevention - Interim Report*, April 2021.

2. COVID-19 and recent natural disasters

2.1 Global and national life changing events – the COVID-19 pandemic and natural disasters such as bushfires, droughts, cyclones, storms, heat extremes and floods – have substantially elevated levels of anxiety and depression relative to usual population data. The significant impact that these events played on individuals and communities is explored in this chapter.

COVID-19

2.2 Since the start of the COVID-19 pandemic the Australian Government has announced funding for a number of initiatives and programs to support the mental health of Australians and mitigate suicide risks.

2.3 Within the 2021-22 Budget, the Australian Government announced that it would allocate $2.3 billion towards a National Mental Health and Suicide Prevention Plan.[1]

2.4 The Budget contained funding designed to improve a number of mental health and wellbeing services for new and expectant parents, family violence and mental health legal support, employment, aged care, suicide prevention, treatment, supporting the vulnerable, increasing the size of the mental health workforce, boosting allied health professionals in rural and remote

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1 The Hon Scott Morrison MP, Prime Minister, the Hon Greg Hunt MP, Minister for Health and Aged Care, and the Hon David Coleman MP, Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention, 'Historic $2.3 Billion National Mental Health and Suicide Prevention Plan', Media Release, 11 May 2021.

communities, mental health research, supporting veterans and their families, and responding to COVID-19.

2.5 In addition to the funding allocated as part of the 2021-22 Budget, the Australian Government announced further support for mental health and wellbeing services in response to the COVID-19 pandemic.

2.6 As part of the additional funding, $48.1 million was provided for the National Mental Health Commission (NMHC) to develop a National Mental Health and Wellbeing Pandemic Response Plan (the Pandemic Response Plan). The Plan contained three core objectives:

- meet the mental health and wellbeing needs of all Australians to reduce negative impacts of the pandemic in the short and long-term;
- outline core principles and priority areas to inform jurisdictions as they respond to the challenges of COVID-19, including as restrictions ease, to balance national consistency with flexibility for locally-appropriate community-based responses and solutions and ensuring that any risks posed by relaxation of restrictions are assessed and responded to; and
- define governance, coordination and implementation requirements including data collection and sharing across jurisdictions to facilitate informed planning and decision making.[2]

2.7 Appendix D provides further details of COVID-19 mental health funding announcements.

COVID-19 impacts

2.8 The COVID-19 pandemic has impacted all Australians' lives in significant ways: emotionally, socially, and economically. These effects have directly impacted on people of all ages and have taken a particular toll on their emotional health and wellbeing.

2.9 Throughout the inquiry the Committee has received evidence highlighting the impact that the pandemic has had on mental health and wellbeing within organisations, on individuals and across the wider community.

2.10 The Black Dog Institute identified prolonged unemployment, financial stress and debt as the biggest risk factors for the surge in mental health problems.[3]

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2 National Mental Health Commission (NMHC), *National Mental Health and Wellbeing Pandemic Response Plan*, May 2020, page 4.

3 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 3.

2.11 Similar factors were raised by the National Aboriginal Community Controlled Health Organisation (NACCHO):

> Never have mental health and social and emotional wellbeing been so front of mind for so many people, including governments. The immediate impact of COVID-19 on everyone, from job losses to isolation, has seen more people have a lived experience of stress, anxiety and depression.'[4]

2.12 National charity, Prevention United summed up the impact of COVD-19 across society:

> So many Australians are doing it tough right now as a result of COVID-19. We're tired and we're stressed, especially in Victoria and New South Wales, but the whole country has been impacted. Everyone has been affected, but maybe some more than others: our kids and our teens; frazzled parents trying to juggle work, home schooling and other responsibilities; the self-employed; and small-business owners, to name a few. Indeed, we can see in ABS [Australian Bureau of Statistics] data and community surveys by university researchers that there's been a sharp rise in anxiety and depressive symptoms, but not only that; the pandemic has triggered a rise in the incidence of new cases of mental health conditions and so many people now require mental health care. In the background, there are probably literally tens of thousands, if not hundreds of thousands, of people who are languishing and stressed but not clinically unwell.[5]

Increased demand for services

2.13 Overwhelmingly, mental health providers experienced substantial increases in demand for services throughout the COVID-19 pandemic and in particular through extended lockdowns.[6]

2.14 The Black Dog Institute observed:

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4 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (NACCHO), *Committee Hansard*, Canberra, 12 August 2021, page 7.

5 Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, page 18.

6 See, for instance: Australian Physiotherapy Association, *Submission 1*, page 3; SAGE Australia, *Submission 3*, page 6; Ms Patricia Martyn, *Submission 3*, page 6; NMHC, *Submission 9*, pages 16-19; Mental Health Families and Friends Tasmania, *Submission 53*, pages 2-3; First Nations Media Australia, *Submission 58*, pages 2-3; Psychotherapy and Counselling Federation of Australia, *Submission 72*, page 1; Prevention Coalition in Mental Health, *Submission 86*, page 5; La Trobe University, *Submission 89*, page 17; Suicide Prevention Australia, *Submission 92*, page 5; Amaze, *Submission 95*, page 3; Lived Experience Australia, *Submission 106*, pages 4-5.

> … Australia is enduring further periods of lockdown. In Sydney, where I am, that's particularly relevant. We know that's having a compounding impact on the mental health of Australians. We ourselves, through our online services and other services, have seen a spike in distress and people trying to access services.[7]

2.15 MindSpot elaborated on the overall increase in demand experienced, and the spikes around lockdown periods:

> Throughout the COVID period up until now, we saw an overall increase in demand of about 25 to 30 per cent. It increased dramatically during some of the lockdown periods last year. I think we had a 90 per cent increase on regular numbers. MindSpot, on average, will have about 450 to 550 new consumers seeking services every week. In August last year, there was a period when we had about 800 to 900 new people seeking services from MindSpot.[8]

2.16 Smiling Mind, also a digital service provider, noted that the increase in demand over the COVID-19 period has seen 'a huge volume of people coming to seek support through the digital environment':

> I think what we're seeing, particularly as a result of this pandemic, is that the embracing of digital tools and resources has grown significantly. We can see that in terms of the rate of access on our platform in particular and a whole range of other platforms.[9]

2.17 PANDA – Perinatal Anxiety and Depression Australia – saw a significant rise in new parents seeking assistance:

> … we've gone from delivering approximately 19,000 calls to vulnerable parents in 2019 to now being on track to deliver 42,000 calls. So we've doubled in terms of our throughput of services. We've doubled in terms of the new parents reaching out to support and we've seen a real change in the trajectory of the way in which people are accessing care throughout COVID but also the kinds of things that they're presenting for.
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> … Historically, before COVID, we had people calling us predominately at seven to 12 months of their parenting journey following the birth of their bub,

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7 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 3.

8 Professor Nickolai Titov, Executive Director, MindSpot, MQ Health, *Committee Hansard*, Canberra, 19 July 2021, page 23.

9 Dr Addie Wootten, Chief Executive Officer, Smiling Mind, *Committee Hansard*, Canberra, 26 July 2021, page 22.

> and now 25 per cent of our community calls are within that first month of baby's life. We know that this is as a result of the changing service system and increased stressors because people haven't been as exposed to those initial health checks and guides with midwives and maternal health nurses.[10]

2.18 The Gidget Foundation, also a not-for-profit organisation that supports the emotional wellbeing of expectant and new parents, experienced an increase in demand, and highlighted the role of compounding traumatic events – in this case, the 2019 bushfires followed by COVID-19:

> … because bushfires and pandemics are both natural disasters—we are finding that the levels of resilience to manage throughout these periods are reduced, because of the compounding effect of one kind of trauma after another. So, yes, we are, absolutely, seeing such significant demand. Just trying to manage the triage process with people on the ground picking up the phone and calling us, and they're crying on the other end of the phone, saying, 'Please can I get support; please can I get into your services.' That's the reality of it. We've got people begging us for support, but we can only offer what we can offer, because there is only so much capacity that we have—even though, as I said, we are opening seven new sites this year alone. It's just not enough.[11]

2.19 The Black Dog Institute agreed with the view that compounding traumatic events were leading to an increase in the demand for mental health services:

> … the cumulative adversity builds up, but it's not a simple linear relation: most people are resilient until they're not. The problem is, once somebody has developed mental health problems, we know that they are then at increased risk of further mental health problems throughout their life. So we are really concerned about those groups that have had multiple hits through drought, bushfires, floods, COVID.[12]

2.20 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) pointed out that the increased demand in services had also affected the waiting times to access mental health services across the sector:

> I've got colleagues [psychiatrists] who have waiting lists that run into four, five or six months. That has increased during the pandemic. Despite the fact that, in the last 12 to 18 months, the number of services provided through

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10 Ms Julie Borninkhof, Chief Executive Officer, PANDA – Perinatal Anxiety and Depression Australia, *Committee Hansard*, Canberra, 27 August 2021, pages 7-8.

11 Mrs Arabella Gibson, Chief Executive Officer, Gidget Foundation Australia, *Committee Hansard*, Canberra, 13 August 2021, pages 2-3.

12 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 5.

> psychiatry MBS [Medicare Benefits Schedule] has gone up, because people haven't taken holidays and have continued to work, demand has grown significantly, and those waiting lists continue to grow. We have got enough information around that that we are pretty confident that those waiting figures have grown quite significantly across the sector. It's not just in certain areas; it's across the sector.[13]

2.21 It is not only people with mental health problems seeking help that have been impacted. HelpingMinds underscored the impact of carers not being able to access face-to-face services during the pandemic:

> Carers have been impacted by the pandemic, and there's been a marked increase in the level of distress and demand for services noted by our teams. I've been with HelpingMinds since 2013, and in the last six months we have had the most number of people with suicidal ideation contacting us on the phone. We're not a crisis service, and we have never had the number of calls that we have been having with people showing that ideation. We work with other organisations to make sure that we are able to provide the supports that they need at that time. Carers are reporting that they are feeling disconnected because of the move to telehealth and AV [audio visual] sessions, but we have seen that these services are helping, though, to build that social connection in times of lockdown.[14]

2.22 RANZCP suggested that Australia will see an overall increase in the demand for mental health services over the next few years:

> … we will continue to see the increase in demand for mental health services over a slightly longer period of time. There's a bit of a lag period in terms of how these disasters affect people. Some people, of course, got affected quite early on and needed to seek help at that time, but for some people, it is a lag period. We will continue to see that over the next two to three years.[15]

2.23 Further discussion on the accessibility of mental health services is included in Chapter 3.

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13 Associate Professor Vinay Lakra, President, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Committee Hansard*, Canberra, 6 August 2021, page 10.

14 Mrs Deborah Childs, Chief Executive Officer, HelpingMinds Ltd, *Committee Hansard*, Canberra, 19 July 2021, page 25.

15 Associate Professor Vinay Lakra, President, RANZCP, *Committee Hansard*, Canberra, 6 August 2021, page 10.

Impact on vulnerable communities and individuals

2.24 Several witnesses highlighted the effects that the COVID-19 pandemic was having on the more vulnerable sections of our communities including Indigenous communities, people with disabilities, rural and remote communities, low socio-economic regions, LGBTIQ+ communities, children and young people, and women as well as carers and support networks.

2.25 A survey undertaken by Monash University of nationwide mental health during the height of the restrictions in Australia found that 'some groups were especially vulnerable to mental health problems during the COVID-19 restrictions: women and people aged 18–29 years; people living in regional and rural areas or in the lowest socio-economic positions, and those not in paid employment before the pandemic; people who had lost jobs or opportunities for study; people living alone, who have fewer opportunities for daily interactions with family and friends; and people whose main occupation is to provide unpaid care for children or other dependent family members.'[16]

2.26 The Kimberley Aboriginal Law and Cultural Centre commented on the wider impact of the pandemic on its festivals and camps, noting that culturally based programs are a primary protective factor for wellbeing and building resilience in Aboriginal communities:[17]

> Our standard operating procedures, which go to workshops and on-country camps, have been impossible, particularly in the context of remote Aboriginal communities because they are the most vulnerable communities for COVID, so we haven't been able to do our festivals and cultural camps in the way we have in the past.[18]

2.27 Yellow Ladybugs and the Olga Tennison Autism Research Centre spoke about the challenges both non-autistic and autistic adults and children have faced during COVID-19 lockdowns and how it has impacted on their mental health and wellbeing.[19] Yellow Ladybugs stated:

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16 Monash University, *Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey*, MJA 213 (10), 16 November 2020, page 462.

17 Kimberley Aboriginal Law and Cultural Centre, *Submission 206*, pages 1, 6.

18 Mr Wesley Morris, Coordinator, Kimberley Aboriginal Law and Cultural Centre, *Committee Hansard*, Canberra, 19 July 2021, page 18.

19 Ms Katie Koullas, Founder and Chief Executive Officer, Yellow Ladybugs, and Dr Darren Hedley, Senior Research Fellow and Professor Amanda Richdale, Professorial Research Fellow, Olga Tennison Autism Research Centre, La Trobe University, *Committee Hansard*, Canberra,

> I also want to make sure we don't overlook the fact that we've got children who are self-harming, have eating disorders—their cups were already full before COVID, but we're facing a crisis where we don't have access to paediatric psychiatrists. The waiting lists have become so long because of COVID and the general population trying to access supports, let alone the children, teenagers and young adults who are struggling.[20]

2.28 The Australian Rural Health Education Network expressed concern about people in rural and remote communities accessing appropriate mental health care services:

> The difficulty for us in rural and remote is the people in the middle. When you have a look at your stepped care model, they're the people that are too severe for 10 sessions or 20 sessions of Medicare over telehealth but not severe enough for public mental health. They're the ones in our rural and more remote communities that we're the most worried about. The service needs are really high for them, and COVID's impacted on our ability to be able to meet their needs.[21]

2.29 The Queensland Mental Health Commissioner voiced concerns about the long term effects of the pandemic on young people:

> We have become increasingly concerned with the disproportionate impact on children and young people, particularly with recent lockdowns and the impact of the new delta strain. We're starting to see increased presentations for psychological distress, particularly depression, anxiety, suicidal ideation, self-harm and eating disorders, particularly in young people. Overall, though, people are not accessing services early enough, which results in delayed presentations with more complex and severe symptoms.[22]

2.30 PANDA and yourtown, a mental health service provider for young people, commented that they both had seen increases in child protection issues.[23]

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26 July 2021, pages 35-36. See also: Dr Emma Radford, Psychiatrist, Melbourne Health, *Committee Hansard*, Canberra, 26 July 2021, page 36.

20 Ms Katie Koullas, Founder and Chief Executive Officer, Yellow Ladybugs, *Committee Hansard*, Canberra, 26 July 2021, page 36.

21 Dr Sharon Varela, Chair, Mental Health Academic Staff Network, Australian Rural Health Education Network, *Committee Hansard*, Canberra, 17 June 2021, page 2.

22 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 1.

23 Ms Julie Borninkhof, Chief Executive Officer, PANDA, *Committee Hansard*, Canberra, 27 August 2021, page 8; Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 46.

yourtown provided evidence on the serious harm being inflicted on young people since the start of the pandemic:

> … one of the things we've noticed across most of our services and programs is that we are seeing, since COVID struck early last year, much more complex case presentations, particularly among our young people, so more child abuse. As child protection services, when lockdowns curb the ability of departments to get out and investigate notifications of abuse, so young people are turning to us. We are seeing an increase in suicidal ideation. That's 37 per cent of what we call our duty-of-cares, where we have to contact ambulance, police or child protection, and we are also seeing quite a significant increase in family conflict and people needing ongoing support. Where before we might have had more people having occasional contact, for example, with some of our helplines, we are seeing more people requiring ongoing support for quite complex issues.[24]

2.31 National not-for-profit organisation for women, Jean Hailes put forward that overall ‘women's mental health has been disproportionately impacted by COVID-19’, and set out findings of Professor Jane Fisher that:

> … during the pandemic women are experiencing moderate to severe symptoms of depression and anxiety at up to six times higher rates during severe lockdown than at non-COVID times. These are most prevalent among women who've lost jobs, are homeschooling children, are caring for family members with special needs or disabilities and are living in the socioeconomic positions who lack access possibly to telehealth because they are not computer literate or because they lack privacy.[25]

2.32 Jean Hailes highlighted the particular vulnerabilities of young women during the pandemic:

> The other component of it is that there are a lot of young women who are feeling increasingly isolated. They're not mixing with their peers at the moment, they have increased screen time and the only control they have over their lives is through their eating or by self-harming. That's what we're seeing. In our clinics we've seen an increase in both eating disorders and self-harm. You've absolutely identified some key problem areas, which have always existed but have become more prevalent during COVID.[26]

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24 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 46.

25 Mrs Janet Michelmore AO, Chief Executive Officer, Jean Hailes, *Committee Hansard*, Canberra, 27 August 2021, pages 1-2.

26 Mrs Janet Michelmore AO, Chief Executive Officer, Jean Hailes, *Committee Hansard*, Canberra, 27 August 2021, page 5.

2.33 Options for care and additional support when starting a new family have also been impacted. The Gidget Foundation highlighted the loss of support networks for new parents due to COVID-19 restrictions:

> At the moment, we've lost mothers' groups, we've lost fathers' groups, we've lost library visits, we've lost local playgroups, we've lost music opportunities at local centres, we've lost the opportunity to go to see child and family health in a face-to-face, drop-in style of format. There are so many restrictions that are limiting the support networks for this cohort—even something as simple as having your mum with you or your dad with you or your sister with you.[27]

2.34 headspace suggested that the recent crises have 'emphasised the powerful role that friends and families play in early intervention and in supporting a young person's recovery'.[28] However, it may not always be families that are best placed to provide the support needed. The Trans Health Research Group outlined the findings of their recent survey on resilience and support in the trans community during the COVID-19 pandemic which found:

> … trans people describe being stuck at home with transphobic household members and loss of support: 61 per cent were clinically depressed and 49 per cent experienced thoughts of self-harm or suicide in the early months of the pandemic. This is fourfold that of the general population and higher than before the pandemic.[29]

2.35 RANZCP and the Black Dog Institute raised concerns for the welfare of families in low socio-economic areas during the pandemic.[30] The Black Dog Institute noted that the pandemic is:

> … amplifying social disadvantage. Particularly within Western Sydney, the families that are suffering the most are those who had the least resources at the start: the groups who are trying to do home schooling in small flats with limited IT [information technology] resources, who previously had been able to earn extra money while also receiving some government benefits. They're the groups that we're worried about. What we know is that most people and

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27 Mrs Arabella Gibson, Chief Executive Officer, Gidget Foundation Australia, *Committee Hansard*, Canberra, 13 August 2021, page 3.

28 Ms Amelia Walters, headspace Board Youth Advisor, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 24.

29 Sav Zwickl, Researcher, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 1.

30 Associate Professor Vinay Lakra, President, RANZCP, *Committee Hansard*, Canberra, 6 August 2021, page 9; Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 5.

> most communities are resilient but that that resilience gets chipped away as adversity accumulates and as it lasts longer.[31]

2.36 Not-for-profit provider of relationship services, Interrelate, agreed that 'COVID-19 has further magnified social and economic vulnerabilities, factors associated with increases in loneliness, social isolation, poor mental health and lower quality of life'. Interrelate added that it had 'seen increased levels of loneliness for many people, even people who were not previously experiencing mental health issues and are presenting as otherwise healthy.'[32]

2.37 When discussing the impact of the pandemic on disadvantaged groups, the Australian Council of State School Organisations added:

> In terms of our most disadvantaged, their situation has only been made worse by the pandemic, because there is a general perception that everybody has internet at home; everybody has devices at home and everybody has fast internet at home, and that's just not the reality. For those children who don't have one or all of those components, it's made learning remotely extremely difficult, if not impossible.[33]

Impact on health professionals

2.38 Several witnesses commented on the impact the COVID-19 pandemic has had on mental health professionals around Australia. The Western Australian Association for Mental Health (WAAMH) believed that 'COVID exposed the limits of all of our services systems, and that was no different for mental health.'[34]

2.39 The Psychology Board of Australia spoke about the importance of having a healthy workplace, particularly in the health related field with a focus on fatigue management.[35]

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31 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 5.

32 Mr Graeme O'Connor, Acting Chief Executive Officer, Interrelate, *Committee Hansard*, Canberra, 28 July 2021, page 10.

33 Mrs Sharron Healy, President, Australian Council of State School Organisations, *Committee Hansard*, Canberra, 6 August 2021, page 19.

34 Ms Taryn Harvey, Chief Executive Officer, Western Australian Association for Mental Health (WAAMH), *Committee Hansard*, Canberra, 19 July 2021, page 5.

35 Ms Rachel Phillips, Chair, Psychology Board of Australia, *Committee Hansard*, Canberra, 21 July 2021, page 28.

2.40 The Royal Australian College of General Practitioners commented on how challenging and demanding it has been for general practitioners (GPs) to try and 'support patients and look after them with all the uncertainty around COVID'.[36]

2.41 The Queensland Nurses and Midwives' Union called for mental health support for healthcare workers adding:

> COVID-19 has shown the stress and strain that these workers are faced with and the need for workplaces to support their employees and their psychological health and safety.[37]

2.42 The Australian Physiotherapy Association commented that its members found it frustrating being unable to provide a face-to-face service during lockdowns, even though classed as an essential service, and 'seeing the frustrations of the patients regressing, escalating care to accident and emergency departments [EDs] and increasing the impact of isolation on their patients.'[38]

Impact on carers and volunteers

2.43 The Pandemic Response Plan acknowledged the role of volunteers and the unpaid workforce as well as the importance of 'attracting, training, accrediting and retaining key professional and volunteer workforces.'[39]

2.44 Mental Health Carers Australia noted the impact that the reduction in face-to-face mental health services during COVID-19 has had on families:

> The temporary reduction or cessation of services has meant that, again, families have often had to step into the breach to undertake the support that the person would have otherwise received. Obviously concerns around PPE [personal protective equipment], with support workers coming into the home to provide support, and concerns around transmission of the virus have added significantly to people's distress. Also, regarding people moving back home, a

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36 Dr Caroline Johnson, Member, Senior Representative, Royal Australian College of General Practitioners, *Committee Hansard*, Canberra, 24 June 2021, page 9.

37 Ms Kathleen Veach, Assistant Secretary, Queensland Nurses and Midwives' Union, *Committee Hansard*, Canberra, 21 July 2021, page 8.

38 Mr Scott Willis, National President, Australian Physiotherapy Association, *Committee Hansard*, Canberra, 26 July 2021, page 16.

39 NMHC, *National Mental Health and Wellbeing Pandemic Response Plan*, May 2020, page 33.

> year ago a lot of family members were moving back home, and that had an impact on family dynamics.[40]

2.45 Jean Hailes elaborated on women as carers, both in the family and in the workforce, and the additional challenges faced during the pandemic:

> We know from research that's been done in Victoria that most of that work is done by women. What women are trying to do is combine home schooling and caring with, if they are in paid employment, their paid employment. Secondly, a lot of the professions that are at the coalface of COVID are conducted by women. If you're looking at first responders, if you're looking at people in aged-care facilities, if you're looking at nursing staff—I'm not saying all of them are women, but the majority of them are women. Many women are in casual employment. More women are in casual employment or contract employment than men are, so their workplace security has been severely impacted by COVID. So it's a combination of four or five factors in that space which has increased their anxiety and stress levels.[41]

2.46 Volunteering Australia referred to research it conducted with the Australian National University (ANU) which 'showed that Australians who stopped volunteering since 2019 had a greater loss of life satisfaction than those who continued' which led to a sense of loneliness.[42] VolunteeringACT also pointed out that that in the Australian Capital Territory (ACT), volunteers – predominantly in social and health services – were stood down during the pandemic while conversely demand in those services increased.[43]

2.47 Volunteering Australia did however observe that people were very willing to contribute and help the community in times of crisis and suggested developing appropriate infrastructure to be able to deal with surge capacity.[44]

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40 Ms Katrina Armstrong, Executive Officer, Mental Health Carers Australia, *Committee Hansard*, Canberra, 5 August 2021, pages 2-3.

41 Mrs Janet Michelmore AO, Chief Executive Officer, Jean Hailes, *Committee Hansard*, Canberra, 27 August 2021, page 3.

42 Mr Mark Pearce, Chief Executive Officer, Volunteering Australia, *Committee Hansard*, Canberra, 17 June 2021, page 15.

43 Ms Sarah Wilson, Policy Manager, VolunteeringACT, *Committee Hansard*, Canberra, 17 June 2021, page 15.

44 Mr Mark Pearce, Chief Executive Officer, Volunteering Australia, *Committee Hansard*, Canberra, 17 June 2021, page 16.

Positive outcomes of COVID-19

2.48 The Queensland Mental Health Commissioner and ReachOut, an online mental health service for young people and their parents, highlighted that a possible positive outcome from the COVID-19 pandemic was an increase in the willingness for individuals to seek help in times of hardship.[45]

2.49 The Queensland Mental Health Commissioner stated:

> One positive result from COVID-19, if there is a positive result, is that it appears there is a reduction in the overall stigma associated with mental ill-health in our community, which has resulted in an increase in help-seeking behaviours across the board. This of course has resulted in increased demand for supports and services in an already stretched and under-resourced system.[46]

2.50 ReachOut concurred with the view that an increase in the willingness to talk about mental health has seen 'a reduction in stigma and a greater understanding that it's actually okay to seek support.'[47]

2.51 PANDA also accentuated the positive aspects of people seeking support during the pandemic:

> One of the amazing levelling impacts that COVID has had in our experience as a mental health organisation is that we are hearing more and more people open up and talk about vulnerability and not feeling well. That's been an amazing thing to be witness to in Australia, having worked in the mental health space for such a long time.[48]

2.52 PANDA elaborated on the benefits of seeking support earlier and asking for help:

> Ultimately, we keep saying to people: 'If you feel it, say it. Don't sit on this stuff,' because it makes it harder for us to be able to support people. It makes it harder when there's compound grief, loss, trauma and existing mental

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45 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 3; Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 13.

46 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 3.

47 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 13.

48 Ms Julie Borninkhof, Chief Executive Officer, PANDA, *Committee Hansard*, Canberra, 27 August 2021, page 10.

> vulnerability, stressors or suicidal ideation to be able to unpack that box when there's more stuff in there. So we do talk to our community very much by saying: 'Your needs are as great as the next person's. Don't judge yourself; just reach out for help.' We also say that there's no right or wrong way in asking for help. I think quite often people feel that they need to be able to understand it to then be able to share it, and that's not always the case. You don't need to have the right words to talk about it.[49]

2.53 The Productivity Commission and Department of Health pointed out that telehealth, particularly telehealth for mental health services, has been taken up at a huge rate by both health professionals and the community.[50]

2.54 While some witnesses expressed concerns with the move away from face-to-face health services to digital and telehealth services, others believed that it was a positive response to seeking help during the pandemic.

2.55 Dietitians Australia, Stride Mental Health, Speech Pathology Australia, and the Black Dog Institute were all supportive of the utilisation of telehealth services and called for them to be extended.[51]

2.56 Dietitians Australia suggested that not only does telehealth provide access in a more equitable way, it also provides access to those in quarantine or lockdown, as well as:

> … addresses things like stigma—so allowing people with a mental health condition to access these services in their home environment without these increasing levels of anxiety that people may see when seeing a health professional.[52]

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49 Ms Julie Borninkhof, Chief Executive Officer, PANDA, *Committee Hansard*, Canberra, 27 August 2021, page 10.

50 Ms Rosalyn Bell, Assistant Commissioner, Productivity Commission, *Committee Hansard*, Canberra, 18 March 2021, page 2; Ms Tania Rishniw, Deputy Secretary, Department of Health, *Committee Hansard*, Canberra, 18 March 2021, page 12.

51 Professor Tracy Burrows, Expert Representative, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 22; Mr Drikus van der Merwe, Acting Chief Executive Officer, Stride Mental Health, *Committee Hansard*, Canberra, 29 July 2021, page 28; Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, Speech Pathology Australia, *Committee Hansard*, Canberra, 19 August 2021, page 6; Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 4.

52 Professor Tracy Burrows, Expert Representative, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 22.

2.57 The Women's Mental Health Alliance spoke positively about the benefits of telehealth for rural and remote communities commenting that it 'has literally been a life saver for some people':

> COVID has been awful and terrible for many things, but it has shown us such positive things as well. I know from having worked in regional Victoria for some time that people talked about telehealth, and that has been funded because of COVID. It wasn't for everybody; but for regional and rural areas to actually be able to access a service through telehealth or through other means now, with other practitioners and not just GPs, has made a huge difference for people who are isolated. [53]

2.58 NACCHO advocated for the expansion of the telehealth services, adding:

> The COVID-19 pandemic has highlighted the urgent need to develop and invest heavily in telehealth and digital social and emotional wellbeing supports and services for Aboriginal and Torres Strait Islander communities. Opportunities for telehealth expansion should be supported but not at the expense of further development of the local workforce.[54]

2.59 The Australian Association of Psychologists Inc agreed with the above views that telehealth should be kept as part of a suite of other mental health services as it was not always fit for purpose:

> We would also like to see telehealth remain a permanent feature of the MBS. It has many, many benefits that improve access to psychologists. We've seen throughout the COVID pandemic that it has been essential in keeping services going to those that need services. Especially for our rural and remote communities, it is essential.[55]

2.60 Telehealth and digital services are discussed further in Chapter 4.

Responding to the impact of COVID-19

2.61 The long term effects of the COVID-19 pandemic and lockdowns on the mental health and wellbeing of individuals and our communities have yet to be quantified. Witnesses provided a number of suggestions on how best to

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53 Dr Sabin Fernbacher, Member, Women's Mental Health Alliance, *Committee Hansard*, Canberra, 27 August 2021, page 21.

54 Ms Patricia Turner, Chief Executive Officer, NACCHO, *Committee Hansard*, Canberra, 12 August 2021, page 8.

55 Mrs Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc, *Committee Hansard*, Canberra, 21 July 2021, page 13.

respond to possible adverse effects, and reinforced that Australia's response would be critical in supporting mental health going forward.

2.62 The Pandemic Response Plan stated that it 'is essential to safeguard the capacity and capability of existing services to continue core business operations, meeting the needs of current consumers and responding to surges in demand brought about by the pandemic.'[56]

2.63 The Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney outlined three priorities for mental health in the COVID-19 decade identified by the COVID-19 Mental Health Response Independent Think Tank:

> Australia's first mental health think tank has focused on innovative responses. In June this year, the think tank met for the first time, and three areas really became the major areas of focus for that think tank: (1) strengthening the social fabric that connects Australia; (2) tackling the impacts of economic exclusion, especially in our young Australians; and (3) enhancing access to high-quality, comprehensive mental health care across Australia.[57]

2.64 WAAMH called for a holistic response both supporting mental health and implementing social support mechanisms:

> … the massive disruption to social determinants and the vulnerability around social determinants that people with existing mental health issues face in the face of COVID, and then their ability to adapt, mean that it's not necessarily just the mental health interventions that are needed; it's also things like people's level of income, be that through income support or the opportunity to have paid employment. We're seeing big impacts here at the moment in our COVID recovery around housing.[58]

2.65 Suicide Prevention Australia stated that 'having sufficient money to survive is a critical safety element, a preventive factor, for a person reaching suicidal distress.'[59]

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[56] NMHC, *National Mental Health and Wellbeing Pandemic Response Plan*, May 2020, page 14.

[57] Professor Maree Teesson, Director, Matilda Centre for Research in Mental Health and Substance Use, University of Sydney, *Committee Hansard*, Canberra, 29 July 2021, page 2. Professor Teesson is also the Chair of the COVID-19 Mental Health Response Independent Think Tank.

[58] Ms Taryn Harvey, Chief Executive Officer, WAAMH, *Committee Hansard*, Canberra, 19 July 2021, page 4.

[59] Ms Nieves Murray, Chief Executive Officer, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 11.

2.66 Suicide Prevention Australia, the Brain and Mind Centre of the University of Sydney, and the Black Dog Institute noted the benefits of ensuring employees and job seekers maintain financial stability during uncertain times and suggested keeping or extending economic support programs such as JobKeeper and JobSeeker.[60] The Black Dog Institute explained:

> What we know helps is both economic support and being able to maintain their link with their employer to know that they've got a job to go back to at the end. If you look at what are major risk factors for mental ill health and suicide, yes, it's economic adversity and debt, but it's also job insecurity. When those things are combined, as is happening at the moment, that is particularly problematic, and that is why we're now saying, given we know that, at least in New South Wales, a lockdown is going to be continuing for longer, we need to look at resetting some of those economic supports to better meet the mental health needs of what's going on.[61]

2.67 The Committee heard evidence from several witnesses calling for equitable responses to the COVID-19 mental health crises.

2.68 The Brain and Mind Centre contended that 'less was done to support female employment in casual industries, in hospitality, in the caring industries, in tourism and in part-time work elsewhere in those programs', and called for direct economic and employment support for women:

> … just as for men, economic support through [the COVID-19] period was one of the two most important protective factors against poor mental health outcomes—economic support being one and social connection being the other. Economic support is a lot easier to provide than social connection in a particular way. So we had to emphasise for younger women educational opportunities and training opportunities and, for women of workforce age, generally speaking, the need for direct economic support and employment support but also, importantly, child care.[62]

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60 Ms Nieves Murray, Chief Executive Officer, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 11; Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 30; Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 4.

61 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 5.

62 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 30.

2.69 Youth mental health policy think tank, Orygen believed that there was an inconsistency in the delivery of mental health services compared to responding to the COVID-19 crisis directly, adding:

> A mental health life is not valued so highly. We're still happy to turn people away from EDs, many of whom are at risk of dying. They're the same people, potentially. I'm very conscious of the equity issue here. What do we do in COVID? We redeploy people from other areas of the health sector to meet the need. They certainly did this in other countries, where the COVID surge was much stronger; they pulled people out of mental health services and made them work in COVID related activities, as health professionals. We need to do that in reverse now for mental health, because the unmet need level in mental health and the risk of dying are much higher in that space. We lose 3,000 people a year to suicide.[63]

2.70 Orygen suggested applying the same strategies and techniques that have been used to combat COVID-19 to mental health support:

> What I'm trying to say is that we need to have the same mentality. There are many generically trained health professionals, like nurses, doctors and GPs, who could be redeployed, with the right incentives and the right leadership, into meeting this mental health crisis much more effectively than currently.[64]

2.71 headspace advocated for a need to plan holistically to provide mental health services for young people:

> We will see a rise in not just the numbers of people coming forward for supports but actually the complex needs, the trauma that's associated with lockdowns or, indeed, living with the pandemic in an ongoing way. And for that we really do need to plan holistically as a community and as a country—to ensure that young people are not the ones who will be disadvantaged to the point where the hopes and the aspirations that they had pre pandemic are not dashed … We have to think positively about a hopeful future, provide the optimism, but in doing so provide the backup scaffolding that needs to be there for when they do need supports along the way.[65]

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63 Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 28

64 Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 28.

65 Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 26.

Natural disasters

2.72 Natural disasters such as bushfires, droughts, floods, storms and cyclones, and heat extremes destroy lives, homes, properties, land, and businesses. They not only have an economic impact but also a serious and long term emotional impact on individuals and communities.

2.73 The cascading effects of natural disasters have impacted Australian communities, industries and individuals. The cost to the mental health and wellbeing of first responders and people who have experienced or witnessed a natural disaster is significant.

2.74 The report of the Royal Commission into National Natural Disaster Arrangements (Royal Commission) highlighted the extent of natural disasters faced by the Australian community since 2019:

> For many communities, the bushfires were not the only disaster they faced that summer. After the drought and the fires came storms and floods, and before the last fire was extinguished, Australia announced its first case of COVID-19. Australia's ability to coordinate nationally, learn and adapt, in the face of deep uncertainties and rising risks, had been tested.[66]

Bushfires

2.75 A study by researchers at the ANU has shown 'that fires are recurring at far shorter than natural return intervals, such as in forest types that should burn no more frequently than every 75 to 150 years on average.'[67]

2.76 During the 2019-20 bushfire season over 17 million hectares were burnt across New South Wales, Victoria, Queensland, ACT, Western Australia and South Australia.[68] In Victoria, 1.5 million hectares were burnt; the largest area impacted by wildfires since 1939 (when 3.4 million hectares burned).[69]

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66 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, 28 October 2020, page 19.

67 C Taylor and D B Lindenmayer, 'New spatial analyses of Australian wildfires highlight the need for new fire, resource, and conservation policies', *Proceedings of the National Academy of Sciences*, Vol 177, No 22, 12,481–12,485, 2 June 2020, page 12,481.

68 Department of Parliamentary Services, Parliamentary Library, *2019–20 Australian bushfires—frequently asked questions: a quick guide*, Research Paper Series 2019-20, 12 March 2020, page 2.

69 C Taylor, D B Lindenmayer, 'New spatial analyses of Australian wildfires highlight the need for new fire, resource, and conservation policies', *Proceedings of the National Academy of Sciences*, Vol 177, No 22, 12,481–12,485, 2 June 2020, page 12,482.

2.77 In response to the bushfires, the National Bushfire Recovery Agency was established on 6 January 2020, along with an allocation of $2 billion to the National Bushfire Recovery Fund.[70]

2.78 In its submission, the Department of Home Affairs (Home Affairs) stated that the Australian Government also allocated $15.9 million, including:

- $10 million in grant funding to deliver trauma care services, including for post-traumatic stress disorder, to emergency service workers who responded to the 2019-20 Black Summer bushfire season,
- $1.5 million in grant funding to establish a pilot program for a social support and mental health literacy network for emergency services workers and their families, and
- Approximately $4.4 million for the development of the first mental health national action plan for emergency services workers.[71]

2.79 The Australian Government contributed '$40.46 million (cost-shared on a 50:50 basis with relevant states and territories) to support community and emergency services mental health programs in bushfire affected areas of Victoria, New South Wales, Queensland and South Australia.'[72]

2.80 Appendix D outlines the range of mental health support measures that were provided in response to the 2019-20 bushfires.

2.81 Commonwealth grants were provided to the Black Dog Institute and Fortem Australia for the delivery of clinical psychologist mental health services to emergency services workers and volunteers who responded to the 2019-20 Black Summer bushfires and their families.[73]

2.82 On 1 July 2020, Home Affairs established a Mental Health Policy Taskforce which is in the process of developing 'the first mental health national action plan for emergency services workers, including volunteers and former and retired emergency services workers.' Home Affairs added that the 'aim of the national action plan is to lower suicide rates and improve mental health outcomes among Australia's current and former emergency services workers.'[74]

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70 The Hon Scott Morrison MP, Prime Minister, 'National Bushfire Recovery Agency', Media Release, 6 January 2020.

71 Department of Home Affairs, *Submission 175*, page 4.

72 Department of Home Affairs, *Submission 175*, page 4.

73 Department of Home Affairs, *Submission 175*, pages 4-5.

74 Department of Home Affairs, *Submission 175*, page 5.

Royal Commission into National Natural Disaster Arrangements

2.83 Established in response to the 2019-20 Black Summer bushfires, the Royal Commission examined the wide ranging effects that natural disasters have on individuals' mental health, and found:

> There is compelling evidence of the impacts of natural disasters on mental health. Natural disasters give rise to increased rates of stress, depression, anxiety, post-traumatic stress disorder (PTSD), alcohol and substance abuse, aggression and violence, suicide, and exacerbation of other underlying mental health problems. Individuals may also experience somatic symptoms, disorders where a person has excessive or abnormal feelings or thoughts about physical conditions. People can also suffer from insomnia and broken sleep.[75]

2.84 The Royal Commission noted that:

- the mental health effects of natural disasters can also endure over an extended period and it may take time for symptoms to present
- geographical barriers, unsafe conditions and loss of essential services all arise after a disaster and can lead to significant delays in support, prolonging trauma and exacerbating emotional distress
- children, young people and first responders are particularly susceptible to ongoing mental health effects following natural disasters.[76]

2.85 The Royal Commission made two recommendations aimed at supporting the mental health of individuals and communities during and after natural disasters:

- Recommendation 15.3 Prioritising mental health during and after natural disasters. Australian, state and territory governments should refine arrangements to support localised planning and the delivery of appropriate mental health services following a natural disaster.
- Recommendation 15.4 Enhance health and mental health datasets. Australian, state and territory governments should agree to:
  - 1) develop consistent and compatible methods and metrics to measure health impacts related to natural disasters, including mental health; and

75 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, 28 October 2020, page 345.

76 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, 28 October 2020, page 332.

– 2) take steps to ensure appropriate sharing of health and mental health datasets.[77]

Learning from other jurisdictions and systems

2.86 In its report the Royal Commission into National Natural Disaster Arrangements drew attention to the benefits of developing a nationally consistent approach to the delivery of mental health services:

> All state and territory governments should develop and implement plans or policies to guide the delivery of mental health services during and after an emergency incident, such as a natural disaster. This could build on the National Natural Disaster Mental Health Framework, once completed.
>
> We were informed that states are considering the lessons identified during the 2019-2020 bushfire response as part of reviews of their public health emergency plans. Consideration should be given to establishing mechanisms for sharing identified lessons nationally.[78]

2.87 While commending governments for providing responsive and nuanced responses throughout COVID-19, PANDA suggested that more could be done to learn across jurisdictions:

> Interestingly, the same that we saw in Victoria last year played out recently in New South Wales. It was surprising to see that what we learnt in Victoria, about how to guide people through a safe birth and the follow-up limiting of family members and things in Victoria, which was the position they got to once they understood and mapped out the process, wasn't replicated in New South Wales. So it has been surprising to us that we did see the very same issues that had occurred in Victoria occur in New South Wales more recently and that the opportunities for learning hadn't been there.[79]

2.88 Mental Health Australia called for governments across all levels to work together:

> It is imperative that the Australian government also work with the states and territories to create an integrated mental health system—for example, work with the Victorian government to ensure cohesive implementation of federal

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77 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, 28 October 2020, page 42.

78 Royal Commission into National Natural Disaster Arrangements, *Royal Commission into National Natural Disaster Arrangements Report*, 28 October 2020, page 347.

79 Ms Julie Borninkhof, Chief Executive Officer, PANDA, *Committee Hansard*, Canberra, 27 August 2021, page 9.

> and state initiatives that will provide a blueprint for work across other jurisdictions.[80]

2.89 Ms Christine Morgan, the National Suicide Prevention Adviser to the Prime Minister, agreed that it was important to take a 'whole-of-governments' approach to unlock the potential and use the leverage across portfolios as well as adopting national approaches.[81] Ms Morgan elaborated:

> We need each jurisdiction, from the Commonwealth jurisdiction down, to ask, 'What are we doing across our portfolios?' Likewise with each of the states and territories. The national approach, so what are we doing across whole-of-governments? And that is in particular when you look at the national approach, what are those things which, but for taking a national approach, will not benefit everybody.[82]

Surge workforce and long term support

2.90 Witnesses to the inquiry commented on the need to have surge capacity to respond to crisis events as well as provide long term support for communities affected by a pandemic or natural disaster.

2.91 The Queensland Mental Health Commissioner stated that the 'mental health and wellbeing impacts of COVID are not yet fully realised. They will continue to impact over time and will depend on individual practice.'[83]

2.92 As noted above, Volunteering Australia suggested developing appropriate infrastructure to be able to deal with surge capacity in a crisis:

> The barrier that is created is that there isn't the infrastructure to be able to identify, properly resource and allocate volunteers in a surge capacity fashion. So we see these crises occur and people will put up their hand, but oftentimes, because of the fact that the organisations which would benefit from … those volunteers on the ground are not properly resourced, they are not able to take as many volunteers as they would need, for example, to support community at

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80 Dr Leanne Beagley, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, Canberra, 3 June 2021, page 2.

81 Ms Christine Morgan, National Suicide Prevention Adviser to the Prime Minister, *Committee Hansard*, Canberra, 13 May 2021, page 3.

82 Ms Christine Morgan, National Suicide Prevention Adviser to the Prime Minister, *Committee Hansard*, Canberra, 13 May 2021, page 5.

83 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 1.

> that time. So one of the challenges we face is to develop appropriate infrastructure to be able to deal with surge capacity.[84]

2.93 Suicide Prevention Australia considered it critical to have a surge workforce as well as embedding crisis management capability in the existing workforce.[85] Suicide Prevention Australia elaborated on the critical need to provide the right support at the right time:

> You need to have the fundamentals. But then inevitably where you have a natural disaster of some form you are going to have to ramp up and so there needs to be allowance and planning for that, and that needs to be well-coordinated planning. There are multiple different services that can be offered and the timing of those services is often important and making sure that the various different services are linking to each other and are well resourced to link to each other so that they're providing the right support at the right time is critically important.[86]

2.94 While commending the need for preparedness and emergency responses, Wesley Mission observed the need for long term support for communities effected by bushfires, floods or COVID-19:

> In response to some of the natural disasters … our experience is that there is a lot of emergency crisis relief response immediately, whereas the work that we do is longer term … particularly around things like anniversaries, is critical in bushfire or flood-impacted communities.[87]

2.95 Witnesses emphasised that services need to be available in the longer-term to provide ongoing care and support for people to connect to mental health services and re-establish their lives.[88] Suicide Prevention Australia explained:

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84 Mr Mark Pearce, Chief Executive Officer, Volunteering Australia, *Committee Hansard*, Canberra, 17 June 2021, page 16.

85 Ms Nieves Murray, Chief Executive Officer, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 7.

86 Ms Christopher Stone, Acting Director, Policy and Government Relation, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 7.

87 Mr James Bell, Group Manager, Wesley Mission, *Committee Hansard*, Canberra, 16 June 2021, page 5.

88 Wellways Australia, *Submission 139*, page 3; Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 5; Mr Stuart Foster, General Manager, Community Services, The Salvation Army Australia, *Committee Hansard*, Canberra, 28 July 2021, page 41; Ms Nieves Murray, Chief Executive Officer, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 7.

> We've seen examples, for example, in Queensland when we've had cyclones. It's three years after, 2½ years after, when services are withdrawn when that initial push is withdrawn that we see distress increase in communities. While the attention is on that community, particularly the focus that we place in this country on responding to crises exceptionally well, once those resources are withdrawn is when we see distress escalate in communities and suicide increase.[89]

2.96 The Black Dog Institute suggested that the full extent of the cumulative adversity of the bushfires and COVID-19 is likely to be seen over the next 12 to 18 months.[90]

2.97 The Mountains Youth Services Team advocated for a study on the longitudinal impacts of successive community trauma:

> It would be good for us to know, too. We're an early intervention service, but we're dealing with so much crisis, and it's difficult to know how long that will go. If we knew that it was five years, we could go: 'Alright, what can we put in place for five years?' If it's going to be 10 years, it's: 'What do we put in place for 10 years?' We don't really know what we're dealing with, so I think step 1 is actually having the research to understand what's going on.[91]

Prevention and strengthening community supports

2.98 Investment in prevention and early intervention measures, and the benefits that it can provide in the event of a crisis, was raised by several witnesses.

2.99 WAAMH called for investment in prevention measures to build resilience in individuals and communities:

> For us it comes back mostly to the need to invest in prevention and community support options so that, whether it's climate change or some other challenge that arises, we know that people have been supported to have good mental health in as far as they can, like from the get go—so taking a life course approach, taking a prevention approach, taking that population public health type approach to mental health—so that people have had the chance to learn the skills and live in environments and societies that support their mental health up until that crisis point. Then, if that crisis point does arise, that there

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89 Ms Nieves Murray, Chief Executive Officer, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 7.

90 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 5.

91 Ms Kim Scanlon, General Manager, Mountains Youth Services Team, *Committee Hansard*, Canberra, 28 July 2021, page 28.

> are services or options available to people who don't necessarily rely entirely on acute and hospital based services, so that there is a range of support and a range of things people can call on in their time of need that don't all rely on having to go to hospital or having to present to an ED.[92]

2.100 SANE Australia agreed that a consistent investment in additional services and capacity was important:

> … it's beyond mental health. I absolutely think that investments in additional services and capacity and really making those links between the primary care and the face-to-face services and the digital services need to be extended beyond the theoretical end date of regular lockdowns being so likely. We need to continue those investments, because the fallout will continue to appear, particularly because, for people who, coming into the pandemic, already had a pre-existing major distress or incident in their life or an existing mental illness, the pandemic is likely to have been the straw that broke the camel's back, especially when you add home-schooling on top of that.[93]

2.101 SANE Australia also suggested wider investment in the social determinants of mental health noting the benefits that they provide:

> We could also be thinking about things like investment in the arts and in sports, employment and training initiatives, supporting people who are on unemployment, early childhood support and support for people dealing with domestic violence—the kinds of social factors and determinants that sit around and greatly influence someone's ability to cope and even engage in mental health treatment if they're experiencing a mental illness, because it becomes a bit of a Maslow's hierarchy of needs for many people.[94]

2.102 Smiling Mind pointed to a 2016 report from NMHC on the impact of poor mental health on the economic agenda and noted the benefits of investing in prevention and early intervention can reduce the need for more complex and costly interventions.[95] Smiling Mind added:

> This report indicated a return on investment of around $3 for every $1 invested in prevention; however, mental health promotion and prevention

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92 Dr Elizabeth Connor, Senior Policy Officer, WAAMH, *Committee Hansard*, Canberra, 19 July 2021, page 4.

93 Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 27.

94 Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 27.

95 NMHC, *The economic case for investing in mental health prevention*, 12 December 2016, page 2.

> remains significantly underfunded. There's no national mental health promotion approach, and prevention is often confined to discussions of suicide prevention, which is obviously vitally important but does not allow for a full and targeted approach to preventing a range of mental health conditions—particularly relevant right now in the context of the mental health impact of the pandemic.[96]

Committee comment

2.103 In the last 10 years Australians have experienced successive traumatic events such as heatwaves, floods, cyclones, bushfires, hail storms, drought and the COVID-19 pandemic.

2.104 Any one of these events alone can have a significant impact on the mental health and wellbeing of people who experience or witness them. Many will have elevated levels of anxiety and depression and suffer from post-traumatic stress. People who have experienced successive traumatic events even more so.

2.105 In order to implement the most appropriate mental health services before, during and after multiple traumatic events we need to ascertain how they impact the mental health of those involved.

2.106 Understanding extreme events and critical incidents and how they impact on the mental health of individuals, first responders, service providers and the wider community is critical in enhancing policy and decision making and strengthening organisational, institutional and community resilience.

2.107 It is important that the Australian Government invest funding into the longitudinal impacts of compounding trauma and successive disasters on the mental health, suicidality, and the social and emotional wellbeing of individuals and communities.

Recommendation 2

2.108 The Committee recommends that the Australian Government invest in research to determine the longitudinal impacts of compounding trauma and successive disasters including extreme weather events caused by climate change on the mental health, suicidality, and the social and emotional wellbeing of individuals and communities.

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96 Dr Addie Wootten, Chief Executive Officer, Smiling Mind, *Committee Hansard*, Canberra, 26 July 2021, page 19.

2.109 In order to ensure that governments are making the best policy decisions for the communities they represent, it is critical that they receive high quality expert advice.

2.110 Throughout the COVID-19 pandemic, governments at all levels have relied upon the expert advice of chief medical officers before making decisions that affect entire communities. It is particularly important in a long-term crisis such as the pandemic where the spiralling mental health impacts of COVID-19 are evident, as well as the impacts of successive traumatic events, that governments seek the advice of chief psychiatrists.

2.111 The Committee therefore is of the view that chief psychiatrists for Commonwealth, state and territory governments should be present to provide advice at all crisis meetings.

Recommendation 3

2.112 The Committee recommends that the Australian Government ensure that the Deputy Chief Medical Officer for Mental Health is present to provide advice and actively participate at all crisis meetings, and encourage states and territories to adopt an equivalent position, if they have not yet done so.

3. Accessibility

Meeting needs for mental health

3.1 There is a great deal of knowledge as to the treatments and supports people will likely need when experiencing mental health problems or to prevent suicide. However, treatment and supports are not always accessible for a number of reasons.

3.2 Accessibility is a multi-facetted concept. It encompasses the availability of mental health and suicide prevention services, the appropriateness of the services and their delivery, and the barriers impacting entry and navigation of the system.

3.3 If there are no services available then there is no accessibility. However, having services and supports available does not mean they are accessible. If services available do not offer the broad multidisciplinary care and social supports as and when required, if staff do not have training in caring for particular groups of people or particular illnesses, if services are too expensive, if it is too difficult to figure out where to go for help, if there are no options for early intervention, and if services are not culturally appropriate, then treatment for mental health problems, mental illness and suicide prevention is not accessible.

3.4 This chapter discusses a number of accessibility issues and at the same time examines suggestions for making services more accessible. Much of this is well recognised and recommendations in evidence to the inquiry included better funding for a diversity of services and supports, expanding the workforce, addressing bias, training staff, incorporating lived-experience

and co-design, combatting stigma, developing community partnerships, and improving affordability.

Availability of services

3.5 The Committee has heard that across the board, there are insufficient services to treat people, whether with preventive interventions, low-level care, or high level interventions.

3.6 As a consequence, Professor Perminder Sachdev told the Committee:

> … only about one half of people, adults with mood or anxiety disorders, are being given optimum quality care. In children, the evidence is that only 10 to 15 percent are getting adequate care. So there is a big quality gap in our care. This would not be acceptable in any other field of medicine.[1]

3.7 Beyond treatments for people with mood and anxiety disorders, there are shortages for a range of other interventions, including high acuity care, care in rural and remote areas, and care for particular populations.

High acuity care

3.8 The Australian Medical Association (AMA) stated there is an absence of high acuity care that sees patients spill over into emergency departments, particularly after hours. 'These are the people who have the most complex needs, and they are least available to access alternative models of care, such as the private system.'[2]

3.9 Treating people with mental illness and people at risk of suicide in hospital emergency departments because there is no-where else for them to go is, according to witnesses, incredibly expensive and not appropriate.[3] According to the Australasian College for Emergency Medicine:

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1 Professor Perminder Sachdev, *Committee Hansard*, Canberra, 29 July 2021, page 11.

2 Dr Omar Khorshid, President, Australian Medical Association (AMA), *Committee Hansard*, Canberra, 6 August 2021, pages 35-36. Professor Perminder Sachdev similarly suggested a large group of people who need to, are not able to see a psychiatrist and instead have to fall back on seeing a general practitioner and a psychologist. Professor Perminder Sachdev, *Committee Hansard*, Canberra, 29 July 2021, page 11.

3 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, 19 August 2021, page 28; Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 5; Dr Simon Judkins, Immediate Past President, Australasian College for Emergency Medicine, *Committee Hansard*, Canberra, 26 July 2021, page 7.

> If you put somebody who doesn't actually need emergency care in an emergency department, that not only adds to the cost of care for that patient but adds to the cost of care to the system. It also increases morbidity and mortality in patients.[4]

3.10 This situation is compounded by the fact an unknown number of patients who present to emergency departments with a mental illness or disorder are being refused admission or are leaving due to the lengthy delays in assessment.[5] Orygen suggested:

> A mental health life is not valued so highly. We're still happy to turn people away from EDs [emergency departments], many of whom are at risk of dying…People never would imagine that you would redeploy people away from physical health into mental health, even though the need was greater in the mental health side.[6]

3.11 While identifying a clear need for an increase in community mental health services, the Queensland Nurses and Midwives' Union called for additional mental health qualified nurses and separate assessment areas in hospital emergency departments to triage mental health presentations and avoid the risk of walkouts and adverse outcomes.[7] The Queensland Mental Health Commissioner advocated for crisis stabilisation units as an alternative to emergency departments for people with mental health and drug and alcohol

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4 Dr Simon Judkins, Immediate Past President, Australasian College for Emergency Medicine, *Committee Hansard*, Canberra, 26 July 2021, pages 11-12.

5 Queensland Nurses and Midwives' Union, *Submission 113*, page 11; Ms Kathleen Veach, Assistant Secretary, Queensland Nurses and Midwives' Union, *Committee Hansard*, Canberra, 21 July 2021, page 7; Ms Susan Murray, Managing Director, Zero Suicide Institute of Australasia, *Committee Hansard*, Canberra, 29 July 2021, page 32; Dr Simon Judkins, Immediate Past President, Australasian College for Emergency Medicine, *Committee Hansard*, Canberra, 26 July 2021, pages 7-8.

6 Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 28.

7 Ms Kathleen Veach, Assistant Secretary, Queensland Nurses and Midwives' Union, *Committee Hansard*, Canberra, 21 July 2021, page 7.

problems.[8] The Australasian College for Emergency Medicine called for after-hours care in the community.[9]

Care in rural and remote areas

3.12 The barriers to accessible care in rural and remote areas were raised. Western Sydney University identified particular challenges in treating people with longstanding difficulties who had not previously received care:

> [Students from rural Australia] haven't necessarily had a lot of interventions to manage their wellbeing needs prior to coming to university, so, when they do come to university, often it's one of the first times they've actually presented to a support service. The reason I'm saying that is that they present with longstanding difficulties that haven't been addressed, so the difficulty lies in how we begin to address something that's been there for some time. They often haven't had any support. They haven't talked to anyone about it. They've been quite isolated, perhaps, in how they've actually engaged in life, their schooling, their support networks and so forth ... A lot of the time, it was building up that relationship with the student and supporting them there.[10]

3.13 The Queensland Mental Health Commissioner suggested more flexible models of service delivery need to be explored that 'provide a combination of centre based services, supported by hospitals that integrate public, private and NGO [non-government organisation], fly-in fly-out services'. This would be complemented by a range of digital mental health supports.[11]

3.14 Other stakeholders suggested variations of a hub-and-spoke model using regional contact centres and a central hub.[12]

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8 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 5. See also: Ms Susan Murray, Managing Director, Zero Suicide Institute of Australasia, *Committee Hansard*, Canberra, 29 July 2021, page 32.

9 Dr Simon Judkins, Immediate Past President, Australasian College for Emergency Medicine, *Committee Hansard*, Canberra, 26 July 2021, page 7.

10 Mrs Paula Diab, Senior Counsellor, Western Sydney University, *Committee Hansard*, Canberra, 28 July 2021, pages 34-35.

11 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 2.

12 Professor Jayashri Kulkarni, Executive Member, Women's Mental Health Alliance and Director, Cabrini Health, *Committee Hansard*, Canberra, 27 August 2021, page 21; Professor Brin Grenyer, Professor of Psychology, University of Wollongong and Director, Project Air Strategy for Personality Disorders, *Committee Hansard*, Canberra, 19 August 2021, page 9.

Suicide prevention and aftercare

3.15 The Committee heard that in suicide prevention, a combination of mental health services and psychosocial supports – including early intervention, wrap-around aftercare, and support by family and friends – are required to achieve reduced suicide rates.[13]

3.16 According to the Zero Suicide Institute of Australasia, it is the complexity of suicide that requires a multilevel, multipronged approach—inside and outside of the health system.[14]

3.17 The existing siloed mindset is working against achieving optimal care, where according to the Brain and Mind Centre at the University of Sydney:

> We still have a much greater focus on what each professional group does, what that activity does, whether there is a Medicare number and whether there is a state system—not actually the person's set of needs as they move through the system and what they require in a timely fashion, with a strong emphasis on early intervention and secondary prevention, to achieve the maximal outcome. So we often have delayed care, which is costly care, and we very much have siloed care.[15]

3.18 A range of interventions were discussed by witnesses to the inquiry, including peer support.[16] Crisis centre hubs that encompass a call centre and various support teams were also suggested. According to the Zero Suicide Institute of Australasia, crisis hubs have a demonstrated 40 to 45 per cent reduction in cost to health services. Through the hubs, telephone support can de-escalate about 90 per cent of crisis calls:

> For the 10 per cent who require some further support, mobile crisis teams that can be dispatched to the person in a location of their choosing, and they can

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13 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 29; Ms Christine Morgan, National Suicide Prevention Adviser to the Prime Minister, *Committee Hansard*, Canberra, 13 May 2021, page 3; Ms Karen Phillips, General Manager, StandBy Support After Suicide, *Committee Hansard*, Canberra, 21 July 2021, page 38; Adjunct Associate Professor Learne Durrington, Chief Executive Officer, WA Primary Health Alliance and Chair, National PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 10.

14 Ms Susan Murray, Managing Director, Zero Suicide Institute of Australasia, *Committee Hansard*, Canberra, 29 July 2021, page 31.

15 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 29.

16 Mr Christopher Stone, Acting Director, Policy and Government Relation, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 10.

> connect with the person and their family or carer and put them in touch with ongoing services. This also avoids bringing in the police and the stigma that is often experienced due to police turning up at the front door. Seventy-five per cent of the 10 per cent have been resolved in this way, and the remaining 25 per cent have the opportunity to go to a stabilisation centre. And this stabilisation centre is able to provide comprehensive support and mobile crisis workers. They can assess the person to determine whether there is any need for inpatient care.
>
> The model has shown that only three to five per cent of that original cohort that came into the mental health crisis had in fact needed to go to inpatient care. The final element is that all of these services are underpinned by evidence based practices like zero-suicide health care and supports that are available 24 hours a day. These high-tech, high-touch services have demonstrated that they divert people away from emergency departments and from jail.[17]

3.19 The Committee was reminded by Gayaa Dhuwi (Proud Spirit) Australia that any service provision should be underpinned by an 'equity approach' that provides targeted responses. This was recommended by the National Suicide Prevention Adviser to the Prime Minister and acknowledges the disproportionate impact experienced by some population groups, including Aboriginal and Torres Strait Islander peoples.[18]

3.20 The Zero Suicide Institute of Australasia suggested requiring a suicide impact statement in regard to all policies that arise out of legislation would be one way to get the community to think about and engage in providing suicide-safe environments. The Institute contended that suicide impact statements are already regularly completed for a range of other factors, including economic, multicultural, and regional and rural impacts.[19]

3.21 An additional suggestion to support help seeking in a time of crisis was for the implementation of a 3-digit number for a mental health crisis line:

> A simple and fast number that everyone can remember, no matter what state of mind.

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17 Ms Susan Murray, Managing Director, Zero Suicide Institute of Australasia, *Committee Hansard*, Canberra, 29 July 2021, page 32.

18 Mr Thomas Brideson, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, Canberra, 24 June 2021, page 2.

19 Ms Susan Murray, Managing Director, Zero Suicide Institute of Australasia, *Committee Hansard*, Canberra, 29 July 2021, page 33.

> If we have a simple 3-digit number, children can learn this number (as well as the 000 number) in school at an early age. Therefore perhaps finding instant help for themselves, a friend or a loved one when required.
>
> Every second counts for those contemplating suicide, let us make access to help simple.[20]

Justice system services

3.22 The links between the mental health system and the justice system were pointed out by Forensicare, who explained that people coming into prisons and people on community corrections orders are 'among the most vulnerable people in society … almost two-thirds of people who enter prisons have a mental health diagnosis'.[21] Orygen agreed, stating 'there's a huge overlap between offending and the onset of mental illness'.[22]

3.23 Forensicare stated:

> We found that the people who have illness, whose needs are met—that is, they're actually being treated, have not only increased health outcomes but also lower rates of re-offending. So there's a real benefit to society in terms of meeting the mental health needs that often are factors that brought them into custody in the first place.[23]

3.24 In particular, Forensicare noted the manifestation of symptoms and illness varies by culture:

> In my experience in particular, with Aboriginal and Torres Strait Islander people, they oftentimes won't present or request care in the way that non-Indigenous people do, and are often overlooked for care. So it's typically the case around the country that, while we have a significant overrepresentation of Aboriginal and Torres Strait Islander people in our prisons, they're often underrepresented in the mental health services within the prisons, and even

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20 Breanna Waller, *Submission 215*, page [1].

21 Distinguished Professor James Ogloff AM, Director, Centre for Forensic Behavioural Science, Swinburne University of Technology and Executive Director, Psychological Services and Research, Forensicare, *Committee Hansard*, Canberra, 19 July 2021, page 29.

22 Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 29.

23 Distinguished Professor James Ogloff AM, Director, Centre for Forensic Behavioural Science, Swinburne University of Technology and Executive Director, Psychological Services and Research, Forensicare, *Committee Hansard*, Canberra, 19 July 2021, page 34.

> sometimes forensic mental health. I think it's both potentially ideologically driven but also the practical reality of limited resourcing.[24]

3.25 Forensicare said the absence of the Medicare Benefits Schedule (MBS) for people in prison has consequences for the care received by people in the justice system:

> Because Medicare is not available in prison, we typically have a very small workforce of psychologists, particularly clinical psychologists, and there's a large unmet need among people with higher prevalence disorders. It's simply the case that the majority of people with high-prevalence disorders wouldn't be receiving any care. Some would be receiving medication typically prescribed by a GP [general practitioner], and they would receive ad hoc care or sometimes crisis care, but typically not ongoing care.[25]

3.26 It was pointed out that there must be continuity of care across the justice system and 'more particularly on release'.[26]

3.27 Forensicare and Orygen made a number of suggestions for recruiting, retaining and developing an appropriate workforce including, promoting forensic mental health as a profession, creating job appointments that allow for research and clinical work, delivering appropriate clinical supervision, and improving opportunities and incentives for staff development. They also noted growing evidence supported a peer workforce as a key element of any effective and comprehensive forensic mental health workforce.[27]

Services for people with autism

3.28 The Committee heard of high rates of diagnosed mental health conditions and difficulties in accessing services experienced by people with autism. For instance, Amaze told the Committee:

> 75 per cent of autistic respondents had a diagnosed mental health condition and a further eight per cent had an undiagnosed condition. The majority

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24 Distinguished Professor James Ogloff AM, Director, Centre for Forensic Behavioural Science, Swinburne University of Technology and Executive Director, Psychological Services and Research, Forensicare, *Committee Hansard*, Canberra, 19 July 2021, page 32.

25 Distinguished Professor James Ogloff AM, Director, Centre for Forensic Behavioural Science, Swinburne University of Technology and Executive Director, Psychological Services and Research, Forensicare, *Committee Hansard*, Canberra, 19 July 2021, page 31.

26 Dr Shaymaa Elkadi, Executive Director, Strategy Policy and Performance, Forensicare, *Committee Hansard*, Canberra, 19 July 2021, page 34.

27 Forensicare and Orygen, *Submission 75*, pages 9-10.

> reported that they had been previously diagnosed with a mental health condition that was not related to autism. And 69 per cent of respondents experienced significant difficulties finding mental health supports that were autism responsive and they expressed low confidence in health professionals' understanding of autism. Over 90 per cent of adults reported challenges in accessing health care due to anxiety caused by the environment, 84 per cent of adults reported access challenges related to their sensory sensitivities and over one-third of our respondents reported not being able to access mental health support at all.[28]

3.29 In particular, the Committee was told 'being female and autistic is a significant risk for anxiety, depression and poor sleep quality. Being female and autistic is one of the strongest risk factors for those'.[29]

3.30 Yellow Ladybugs called for investment for autistic-led organisations where people can connect with their peers and not experience 'autistic burnout'. Yellow Ladybugs explained 'autistic burnout':

> … its link to mental health and how important it is that we connect autistic people with their peers so that they know that there's nothing wrong with them and that they grow up as happy, content, neurodivergent people and not second-rate neurotypical people.[30]

3.31 Amaze called for people with autism to be identified as a priority group in the next National Mental Health and Suicide Prevention Plan.[31] The Olga Tennison Autism Research Centre urged more extensive professional development for clinicians, stating 'it's often a two-hour lecture on autism, and that isn't enough'.[32]

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28 Mr Chris Templin, Senior Policy Analyst, Amaze, *Committee Hansard*, Canberra, 26 July 2021, page 33.

29 Professor Amanda Richdale, Professorial Research Fellow, Olga Tennison Autism Research Centre, La Trobe University, *Committee Hansard*, Canberra, 26 July 2021, page 35.

30 Ms Katie Koullas, Founder and Chief Executive Officer, Yellow Ladybugs, *Committee Hansard*, Canberra, 26 July 2021, page 38.

31 Mr Chris Templin, Senior Policy Analyst, Amaze, *Committee Hansard*, Canberra, 26 July 2021, page 39.

32 Professor Amanda Richdale, Professorial Research Fellow, Olga Tennison Autism Research Centre, La Trobe University, *Committee Hansard*, Canberra, 26 July 2021, page 40. See also: Associate Professor Alessandra Radovini, La Trobe University, *Committee Hansard*, Canberra, 26 July 2021, page 36.

Perinatal services

3.32 The perinatal period covers the time from conception to the end of the first year after birth. The Committee was told maternal suicide is the leading cause of death amongst expectant and new mothers.[33]

3.33 While the Australian Government has recognised this and introduced universal screening for new parents, the Gidget Foundation told the Committee this will lead to increasing diagnosis and there are insufficient referral pathways—there are many help lines, many triage services, but few referral pathways.[34]

3.34 According to PANDA – Perinatal Anxiety and Depression Australia the supports are not always easy to find. Women have reported they do not know how to navigate the system and become overwhelmed.[35]

3.35 Early intervention is crucial. The Women's Mental Health Service at the Royal Women's Hospital stated:

> Attachment takes place in the first year of life, but actually the mother begins to attach to her infant right from pregnancy onwards. So we want to optimise her mental health right from that point in time. We don't want to wait for the postnatal period when everything goes awry.[36]

3.36 Early intervention was also supported by Prevention United:

> … [promotion and prevention] needs to start in the perinatal period, in infancy and in childhood. That's where, unfortunately, we start to accumulate risk factors and it's where we need to build protective factors. Because by youth it is almost a bit too late. The underlying causes have already happened, and then we're just responding.[37]

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33 Mrs Arabella Gibson, Chief Executive Officer, Gidget Foundation Australia, *Committee Hansard*, Canberra, 13 August 2021, page 1.

34 Mrs Arabella Gibson, Chief Executive Officer, Gidget Foundation Australia, *Committee Hansard*, Canberra, 13 August 2021, page 1.

35 Ms Julie Bornikhof, Chief Executive Officer, PANDA - Perinatal Anxiety and Depression Australia, *Committee Hansard*, Canberra, 27 August 2021, pages 7, 9-10.

36 Professor Marie-Paule Austin, Head, Women's Mental Health Service, Royal Women's Hospital, *Committee Hansard*, Canberra, 27 August 2021, page 24.

37 Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, page 22.

3.37 Early screening and intervention can allow for targeted and appropriate services to be provided that can have positive outcomes. According to the Women's Mental Health Service:

> … what it does, if it is being used, is identify very early on in pregnancy what the woman brings in terms of vulnerabilities and allows us to put programs of care in place at that point in time, rather than waiting for the post-natal care when things might fall apart. That has been a part of capacity building. So we have trained midwives who are doing antenatal care to undertake that screening. That is a two-way thing in that they learn about the women's mental health and they feel empowered to assist with that from an early stage. As you may be aware, midwives are extremely focused on holistic care.[38]

3.38 Appropriate care at this time, according to Mental Health Australia, has the ability to embed strong relationships and provide parenting support that builds resilience in families.[39]

3.39 Like other areas of the mental health system, the workforce is stretched. The Women's Mental Health Service at the Royal Women's Hospital explained that in perinatal and women's mental health there are no problems recruiting female psychiatrists, but there are concerns with 'the ageing workforce and recruiting and retaining that workforce in the public health system'.[40]

3.40 As noted in Chapter 2, the COVID-19 pandemic has had particular impact on perinatal care—some women have been separated from their mothers and family supports, whether in Australia or in other countries. Others have experienced stress through the loss of employment within the family.[41]

3.41 Noting the impact of lockdown on the ability to access traditional services, Mama You Got This advocated for expansion of its 'virtual village' to

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38 Professor Marie-Paule Austin, Head, Women's Mental Health Service, Royal Women's Hospital, *Committee Hansard*, Canberra, 27 August 2021, page 25. The key role of midwives was emphasised also by the Nursing and Midwifery Board. Adjunct Professor Veronica Casey AM, Chair, Nursing and Midwifery Board of Australia, *Committee Hansard*, Canberra, 21 July 2021, page 24.

39 Dr Leanne Beagley, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, Canberra, 3 June 2021, page 2.

40 Professor Marie-Paule Austin, Head, Women's Mental Health Service, Royal Women's Hospital, *Committee Hansard*, Canberra, 27 August 2021, page 25.

41 Mrs Janet Michelmore, Chief Executive Officer, Jean Hailes, *Committee Hansard*, Canberra, 27 August 2021, page 5; Professor Marie-Paule Austin, Head, Women's Mental Health Service, Royal Women's Hospital, *Committee Hansard*, Canberra, 27 August 2021, page 24.

support connection for new parents and provide ready access to masterclasses and expert video series.[42]

3.42 Further discussion on the role of digital services in mental health is included in Chapter 4.

Service capacity

3.43 The Committee heard that many mental health services have long waiting lists.[43] batyr told the Committee there can be waiting times of up to six months after a young person takes the first step to reach out for help.[44]

3.44 The Mountains Youth Services Team told of similar experiences:

> … all of the services are at capacity and are referring on to everybody else, and everyone else is saying they're full … we're seeing such an increase in young people wanting services and we don't have the additional resources to be able to provide that service.[45]

3.45 The pressure on services makes it hard, according to AMA, to ensure referrals meet the needs of the patient:

> The system is just so strained that accessing private psychology or psychiatry is about getting in where you can. And that's not an ideal way to be doing mental health, in particular, where, as you said, building rapport and therapeutic relationships is key. I have a number of patients for whom we'll go, 'Look, let's just try this.' There are patients sitting around in what might not be the best therapeutic relationship—through no fault of the provider; it's just not a great fit—but there just isn't another option at the moment.[46]

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42 Mama You Got This, *Submission 226*, pages [1-2].

43 See, for instance: Dr Louise Flynn, General Manager, Jesuit Social Services, *Committee Hansard*, Canberra, 28 July 2021, page 40; Ms Erin Helleur, Counsellor, Western Sydney University, *Committee Hansard*, Canberra, 28 July 2021, pages 32-33.

44 Bella Cini, National Advisory Group Member and Board Member, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 22.

45 Ms Kim Scanlon, General Manager, Mountains Youth Services Team, *Committee Hansard*, Canberra, 28 July 2021, page 27.

46 Dr Danielle McMullen, NSW President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 43. See also: Ms Erin Helleur, Counsellor, Western Sydney University, *Committee Hansard*, Canberra, 28 July 2021, pages 32-33.

Rigidities in the service provision model

3.46 The Committee heard that there are various barriers to access in the current service provision model meaning people are not receiving the care they need, when they need it—there are rigidities in accessing particular services, and in obtaining wrap-around care.

Accessing particular services

3.47 In terms of service access rigidities, the Australian Association of Psychologists Inc called for improvements to make accessing a psychologist easier:

> At the moment there's a lot of red tape. There are appointments with GPs you need to access. There are review appointments. There are letters going back and forth to unlock access to more sessions. This impacts on the consumer, especially at the moment, when it's really hard to get appointments with GPs. A lot of people are also not wanting to go out, or might not have access to telehealth services in order to access their GP.[47]

3.48 The difficulty of referring patients to inpatient psychiatric units was raised as another issue that puts pressure on hospital emergency departments. Professor Sachdev told the Committee:

> At the moment it's impossible—at least in our hospital, and I hear it's the same in many other hospitals as well—to admit someone directly to an inpatient psychiatric unit. They have to go through an emergency department. So you have to be either very seriously unwell or in a crisis. That's the only way you can get into a psychiatric ward. Even if a psychiatrist says, 'You need to be in hospital,' there's no way a psychiatrist can actually admit someone to a hospital, unless they go to an emergency department. And often there is pressure on emergency department assessments to discharge people because there is a dearth of beds.[48]

Wrap around services that go to those in need

3.49 An accessible, person-centred approach to mental health services means providing for a range of integrated services that meet the specific needs of

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47 Mrs Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc, *Committee Hansard*, Canberra, 21 July 2021, page 13. See also: Mr Scott Willis, National President, Australian Physiotherapy Association, *Committee Hansard*, Canberra, 26 July 2021, pages 16-17.

48 Professor Perminder Sachdev, *Committee Hansard*, Canberra, 29 July 2021, page 11.

the person, across care settings—siloed health systems do not make this type of care easy.

3.50 The Salvation Army told the Committee a service model that combines mental health with other allied health services and that goes to the person who needs assistance rather than the other way around is 'more successful and has a better chance of being successful'.[49]

3.51 Jesuit Social Services agreed:

> For instance, for a service like ours, where people are significantly traumatised and distressed, if they have to travel at all or travel a long way to receive a service, that is a significant barrier. Sometimes the way services see themselves, the culture of them, that 'people need to come to us', is a barrier. It's not a welcoming way of functioning, but also it simply doesn't take into account the state that people are in.[50]

3.52 As a principle, Jesuit Social Services emphasised that system and service design have to acknowledge the needs of the people they are trying to assist.[51] Designing services in this manner, according to the National Mental Health Consumer and Carer Forum (NMHCCF), requires 'shared understandings of person-led approaches to care and support and their implementation in a participatory environment'.[52]

3.53 The National Mental Health Consumer Alliance agreed:

> Many consumers are saying, 'We just don't have choice and we don't have control.' … it's about trying to find the balance in how consumers have choice and control, how they have autonomy and how they are able to pick and choose what services may be useful for them, because we seem to be going straight from very few services in between to crisis intervention, really. Where are the services that are pre crisis? What services do individuals access before they get to that crisis stage?[53]

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49 Mr Stuart Foster, General Manager, Community Services, The Salvation Army Australia, *Committee Hansard*, Canberra, 28 July 2021, page 41.

50 Dr Louise Flynn, General Manager, Jesuit Social Services, *Committee Hansard*, Canberra, 28 July 2021, page 40.

51 Dr Louise Flynn, General Manager, Jesuit Social Services, *Committee Hansard*, Canberra, 28 July 2021, page 40.

52 Mr Keir Saltmarsh, Consumer Co-Chair, National Mental Health Consumer and Carer Forum (NMHCCF), *Committee Hansard*¸ Canberra, 5 August 2021, page 14.

53 Ms Irene Gallagher, Foundation Member, National Mental Health Consumer Alliance, *Committee Hansard*, Canberra, 5 August 2021, page 9.

3.54 The disconnect between service-centred and person-centred care was explained by the Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney:

> When people come to us with their challenges or problems, they don't see it as having an addiction or a mental health concern. What they have are their problems. Yet, our system sees those things differently, and that keeps being perpetuated if we don't form links and don't share knowledge across different areas … How do we build those bridges across those knowledge bases so that we've got a person centred care for the individual in front of us? It won't happen by accident. It needs to happen by design and by bold design.[54]

3.55 The Blackdog Institute concurred with the need for integration:

> One of the biggest challenges for a person entering the mental health system is the confusion that there is in how the different services interact together and, to be frank, the fragmentation, where you start in one system and then fall out before being able to enter into others.[55]

3.56 headspace stated what is required is a system that combines:

> … the face-to-face, the place based, the physical space, the digital space and the consumer at all points along the continuum. They will have those touchpoints where the culture of care is there and the connection and opportunity for further collaboration is there. Shared systems, shared electronic records and a real consumer focus has to be at the forefront of any reform.[56]

3.57 AMA outlined any workable system has to connect at both ends:

> … we're keen to ensure that we don't end up with programs that don't click in and link in with both ends of the spectrum—the primary care end with the usual general practitioner, who is that gatekeeper to care, but also making sure that at the more severe end of the severity spectrum, where patients are accessing public hospital services, there is integration.[57]

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54 Professor Maree Teesson, Director, Matilda Centre for Research in Mental Health and Substance Use, University of Sydney, *Committee Hansard*, Canberra, 29 July 2021, page 4.

55 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 2.

56 Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 31.

57 Dr Omar Khorshid, President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 38. See also: Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 3.

Early intervention across the lifespan

3.58 The Committee heard services to promote mental health, treat mental illness and prevent suicide have to be available across the lifespan—and they have to be offered early. While it is not the case that all people within a particular group will have the same needs, a range of services must be available and easily accessible for those who do.

Children

3.59 Witnesses to the inquiry spoke of early diagnosis and treatment having a positive and protective effect that can prevent cumulative effects.[58] Some issues raised included the early diagnosis of gut issues that can lead to anxiety,[59] and communication difficulties that correlate with later mental health concerns.[60]

3.60 The Committee heard that children are increasingly showing signs of anxiety yet there are insufficient services available, and where services are available, referral times can extend to nine months for the first interaction.[61]

3.61 For services that exist for children, the Committee was told it is important they are informed by children and young people with lived experience, and co-designed with children and young people. In this way, service providers can gain a unique insight into the mental health and wellbeing of families, children, and young people, and the reforms needed.[62]

3.62 Additional discussion on promoting wellbeing in schools is included in Chapter 8.

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58 Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, Speech Pathology Australia, *Committee Hansard*, Canberra, 19 August 2021, pages 1-2.

59 Dr Tetyana Rocks, Expert Representative, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 25.

60 Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, Speech Pathology Australia, *Committee Hansard*, Canberra, 19 August 2021, pages 1-2.

61 Mrs Sharron Healy, President, Australian Council of State School Organisations, *Committee Hansard*, Canberra, 6 August 2021, page 18.

62 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 42; Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, Speech Pathology Australia, *Committee Hansard*, Canberra, 19 August 2021, page 4.

Youth

3.63 Young people are regarded by Orygen as 'the crucial group across the whole lifespan' because 'a big surge of new cases occurs in the period between puberty and the mid-20s, and 75 per cent of mental disorders have already appeared by the age of 25'.[63]

3.64 The Queensland Mental Health Commissioner spoke of rising presentations for psychological distress, particularly depression, anxiety, suicidal ideation, self-harm and eating disorders and expressed concern 'people are not accessing services early enough, which results in delayed presentations with more complex and severe symptoms'.[64]

3.65 As in other mental health spaces, services for young people are under significant pressure. Although highly regarded, concerns were raised about the accessibility of headspace for those who require support:

> Headspace is under dire pressure around the country. The waiting lists have blown out to two months in most places, I would say, and it's closed; we can't get people in …
>
> Headspace has been scaled up superbly across the country, but it's much too thin a green line. You can get in, you can engage but then you're marooned if you've anything more than something very simple. We definitely need this missing middle problem in youth mental health to be addressed in an equitable way, in comparison to what's planned for adult mental health.[65]

3.66 Providing appropriate services, according to headspace, requires a boost in workforce capacity with a mix of professionals in multidisciplinary teams, including clinicians, allied health professionals, peer workers, and Aboriginal and Torres Strait Islander health workers. All workers must be experienced working with young people.[66]

3.67 A number of suggestions were put forward by witnesses to the inquiry to improve accessibility for young people:

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63 Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 24.

64 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, pages 1-2.

65 Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 25.

66 headspace National Youth Mental Health Foundation, *Submission 66*, page 2.

- educating young people before they get to the point where they are quite mentally unwell[67]
- addressing feelings among young people that what they're going through isn't actually help-worthy[68]
- having non-judgemental relationships between members of the mental health multidisciplinary team and young people[69]
- empowering young people to become agents of their own development using a place-based approach that provides local solutions to local issues identified through community consultation and local knowledge.[70]

Women across the lifespan

3.68 Ms Mischa Barr from the Women's Mental Health Alliance and Women's Health Victoria told the Committee women are around twice as likely as men to suffer from mental illness and make up the majority of people seeking mental health services, yet a gender bias means 'most mental health services are designed on a male-centric model that does not recognise the specific needs and experiences of women and girls'.[71]

3.69 The University of Sydney Brain and Mind Centre contended that women are preferentially discriminated against in healthcare services, in terms of purchasing power, diagnoses, and thresholds of care. In particular, there is a 'failure to connect young women in trouble with continuing appropriate care, even though they are in life-threatening situations'. The Centre explained:

> Ongoing care needs for women at critical stages in their life, such as adolescence, the postnatal period and the perimenopausal period, with the

67 Bella Cini, National Advisory Group Member and Board Member, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 24.

68 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 13.

69 Ms Kim Scanlon, General Manager, Mountains Youth Services Team, *Committee Hansard*, Canberra, 28 July 2021, pages 27-28.

70 Mr Stephen Lewin, Chief Executive Officer, Youth Insearch, *Committee Hansard*, Canberra, 28 July 2021, page 36.

71 Ms Mischa Barr, Chair, Women's Mental Health Alliance and Policy and Health Promotion Manager, Women's Health Victoria, *Committee Hansard*, Canberra, 27 August 2021, page 16. See also: Dr Sabin Fernbacher, Member, Women's Mental Health Alliance, *Committee Hansard*, Canberra, 27 August 2021, page 21; Professor Jayashri Kulkarni, Executive Member, Women's Mental Health Alliance and Director, Cabrini Health, *Committee Hansard*, Canberra, 27 August 2021, pages 19-20.

> associated health conditions, are not well dealt with. What we've highlighted is that the gender gap continues. We note the particularly deteriorating situation for young women with regard to self-harm and suicidal ideation, with presentations at younger ages and increasing reliance on other emergency services. But, very importantly, there is the failure to sort those problems out or connect with ongoing care from emergency services.[72]

3.70 According to Ms Barr 'there are few examples of good practice here in Australia or internationally in terms of gender responsive approaches that respond to women's and girls' mental health needs'.[73]

3.71 Professor Jayashri Kulkarni, also representing the Women's Mental Health Alliance and Cabrini Health, spoke of the consequence of this situation:

> I've worked in psychiatry for all my life, nearly four decades now, and over time I've seen some terrible things happen because women are not recognised as having special needs and special presentations of mental ill health.[74]

3.72 The Brain and Mind Centre emphasised 'the needs of women need to be addressed, and particularly those that sit around social support—that is, child care and the capacity to participate in employment, home care and support for other services'.[75]

3.73 Professor Kulkarni called for tailored treatments:

> What we need to do is get to that first base of almost saying that women's mental is different, so think differently, listen differently and then act differently. Then I think we're going to get some more runs on the board.[76]

Men across the lifespan

3.74 The principles that underlie accessible care for children, young people and women are the same that should inform care for men. This approach was

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72 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 28.

73 Ms Mischa Barr, Chair, Women's Mental Health Alliance and Policy and Health Promotion Manager, Women's Health Victoria, *Committee Hansard*, Canberra, 27 August 2021, page 16.

74 Professor Jayashri Kulkarni, Executive Member, Women's Mental Health Alliance and Director, Cabrini Health, *Committee Hansard*, Canberra, 27 August 2021, page 16.

75 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 28.

76 Professor Jayashri Kulkarni, Executive Member, Women's Mental Health Alliance and Director, Cabrini Health, *Committee Hansard*, Canberra, 27 August 2021, page 21.

aptly summarised by the National Suicide Prevention Adviser to the Prime Minister who told the Committee how to design after-care services for men that are accessible:

> If I were running a service for after-care and I was seeing two per cent participation by guys, I would ask that question and I would be looking at those issues. I would be looking at the time I'm making it available, how I'm making it available and whether I'm making it available in a way the guys feel is easy to engage with. I'd probably look across at Men's Sheds and say, 'Why are men's sheds such an easy thing for guys to do, relative to others?' I'd probably then look at: are there any particular language barriers? By that, I don't mean can somebody speak English? I'm talking there about are we trying to ask somebody who's got no innate language to translate their own mental health challenges into a conversation they can have. Is that the issue? Is it the resources we're using? Is it the fact that it's all women who are providing the service? It's not inappropriate, but we do have a workforce where often the front-facing person is female. Does that act as a bit of a barrier for a guy? Then we also need to look at: are there any particular cultural barriers? So, for men from different culturally and linguistically diverse backgrounds, are there challenges there? What is taboo? What is not? Do we need to look at some of those concepts around masculinity? Are there some of those challenges about: 'This is a weakness to do it'? So I think there's a range of complexity … we really do need to start looking at our services to say, 'Why aren't they being accessed by men?' Yes, we could do what I think intuitively we often do, which is to say, 'Let's go and design men's services.' No, actually, that may be required for some, but all of our services should be accessible.[77]

3.75 MATES in Construction’s (MATES) submission argued the importance of the interim report conclusions of the National Suicide Prevention Adviser, that services should be targeted and meet men where they are. MATES explained that:

> We know suicide rates amongst construction workers in Australia are 71% higher than amongst other employed men (Milner, 2016). Further, workers in the mining industry are at risk due to shift work arrangement, remote work locations and higher than average mental stress and alcohol consumption (Kelly, Hazell, & Considine, 2012).
>
> For this reason, MATES developed the workplace suicide prevention and evidence-based program to deliver specific services to the male dominated construction, energy and mining industries. At the core of the MATES

[77] Ms Christine Morgan, National Suicide Prevention Adviser to the Prime Minister, *Committee Hansard*, Canberra, 13 May 2021, page 4.

> Program is the delivery of tailored training and support, onsite, where it is needed most, backed up by a 24/7 helpline and Case management services.[78]

3.76 Appearing before the Committee, MATES explained that men are not particularly good at help seeking behaviours, noting that this often results from stigma and broader societal roles that men can often emulate. MATES clarified that its services are trying to develop these strengths and improve mental health for men, arguing that:

> … if we can remove the stigma within individuals about how they view, then they're more likely to step forward and offer help to those people in need… the reality is you can address the stigma in practical ways, and big burly blokes that traditionally might be associated with needing to be bullet proof and 'toughen up, princess' so to speak can be the ones that genuinely reach out and offer help to someone in need.[79]

3.77 One of the critical aspects of understanding mental health, suicide and comorbidities is how different genders present to, and interact with health services. MindSpot discussed that for example substance use and suicide are more prevalent within men, in lieu of anxiety or depression. It elaborated that:

> … what we know is that, when people are referred by general practitioners, they're more likely to be male than female. What I mean by that is about 36 per cent are male in those instances. I think that actually speaks to the way males engage with health services, not just mental health services but health services more broadly. If they are referred by someone they trust—for example, a general practitioner—they're much more likely to engage. In terms of strategies and solutions, we're developing a number of new service options which we believe will be much more acceptable to males, and we're hoping to roll those out in the next six months or so.[80]

Affordability

3.78 The Committee received a range of views on the extent to which affordability is a barrier to accessing care. Whether it is the only barrier, or one barrier among many, there was little disagreement from witnesses that it

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78 MATES in Construction, *Submission 164*, page 1.

79 Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, page 43.

80 Professor Nickolai Titov, Executive Director, MindSpot, MQ Health, *Committee Hansard*, Canberra, 19 July 2021, page 24.

impacts access to appropriate care for some people with mental illness and at risk of suicide.[81]

3.79 The Salvation Army stated that people living with a mental illness often cannot afford private professional mental health services and have to prioritise other expenses, such as rent, over medication and medical support:

> … honestly all the fat has been trimmed from the budget already. They're making decisions about things that we would consider necessary, like medication—absolutely—psychologist appointments and even GP appointments.[82]

3.80 Jesuit Social Services agreed, 'the reality is that psychiatrists and psychologists sometimes have a gap [fee] which does mean that their services are out of reach for many'.[83]

3.81 batyr was of the view the primary barrier to accessing care is waiting lists, with affordability an exacerbating factor in young people being able to access appropriate and timely care.[84]

3.82 ReachOut suggested the larger issue was getting young people started and understanding they may need to seek help; but affordability 'is of course an issue for young people … it comes up in any of the research and focus groups that we do and conversations that we have with young people'.[85]

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81 See, for instance: Mrs Leanne Hall, Clinical Lead, Youth Insearch, *Committee Hansard*, Canberra, 28 July 2021, page 37; Mr Stuart Foster, General Manager, Community Services, The Salvation Army Australia, *Committee Hansard*, Canberra, 28 July 2021, page 40; Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 28.

82 Ms Jennifer Kirkaldy, General Manager, Policy and Advocacy, The Salvation Army Australia, *Committee Hansard*, Canberra, 28 July 2021, page 42; Mr Stuart Foster, General Manager, Community Services, The Salvation Army Australia, *Committee Hansard*, Canberra, 28 July 2021, page 40.

83 Dr Louise Flynn, General Manager, Jesuit Social Services, *Committee Hansard*, Canberra, 28 July 2021, page 40.

84 Tom Riley, Research and Policy Manager, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 22; Bella Cini, National Advisory Group Member and Board Member, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 22.

85 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 13.

Stigma

3.83 The Committee heard services are not accessible if there is stigma surrounding a mental health diagnosis or obtaining treatment from a service.[86] In some cases, services can also stigmatise certain populations.

3.84 Some organisations have recognised stigma associated with asking for help and developed innovative approaches. For instance, Jean Hailes found the anxiety section of their website was very popular with both men and women because there was a lack of stigma about a women's health organisation website, rather than a particular depression or anxiety website. By focussing on prevention, it was not labelling people with a disease; and as part of a website focussed on whole health, it provided a more approachable environment.[87]

3.85 Other suggestions to deal with a reticence to visit services due to stigma included allowing people to access services in their home environment including through telehealth, and health promotion messages to destigmatise mental illness.[88]

3.86 The Committee heard services may stigmatise people with certain mental illnesses or certain populations. Professor Brin Brenyer, Professor of Psychology at the University of Wollongong and Director of Project Air Strategy for Personality Disorders stated:

> But what we hear from people with personality disorders time and time again is their biggest challenge is access to trained and skilled practitioners who hold positive and hopeful attitudes about them, because stigma is one of the big problems in personality disorders.
>
> … The old, stigmatised message about personality disorder was: 'You don't want to treat these patients. There's nothing we can do about them. They're

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86 See, for instance: Mrs Arabella Gibson, Chief Executive Officer, Gidget Foundation Australia, *Committee Hansard*, Canberra, 13 August 2021, page 3; Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, page 43.

87 Mrs Janet Michelmore, Chief Executive Officer, Jean Hailes, *Committee Hansard*, Canberra, 27 August 2021, pages 4-5.

88 See for instance: Professor Tracy Burrows, Expert Representative, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 22; Ms Katherine Newton, Chief Executive Officer, R U OK?, *Committee Hansard*, Canberra, 28 July 2021, page 20; Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 3.

> just annoying and attention seeking—a 'not for service'—and we should send them away.'
>
> … So training is really critical. One of the things that we do in Project Air is train about a thousand mental health practitioners a year, and our online training attracts another thousand, so we're really pushing the message of hope and treatability.[89]

3.87 SAGE Australia’s submissions identified legislative change as critical to reducing structural stigma, community discrimination and improving access for SGD individuals, further recommending:

- Legislation to ban non-medical emergency, unnecessary surgeries and treatment on intersex children, allowing them to make their own decisions about their bodies when they are educated about their choices.[90]
- Reviews of legislation to support people from sex and/or gender diverse (SGD) groups in changing their identity documents when needed to reflect their identities.[91]
- Reviews of legislation to remove all discrimination against people from SGD groups to dramatically reduce social disadvantage, minority stress and suicidation.[92]
- Attention to Commonwealth bills that risk increasing discrimination:
  - Sex Discrimination and Fair Work (Respect at Work) Amendment Bill 2021
  - Education Legislation Amendment (Parental Rights) Bill 2020
  - Online Safety Bill 2020
  - Religious Discrimination Bill 2019.[93]

Delivering accessible services through community access and partnership

3.88 The Committee received significant evidence outlining co-design and community partnership as being critical to the effective delivery of mental

89 Professor Brin Grenyer, Professor of Psychology, University of Wollongong and Director, Project Air Strategy for Personality Disorders, *Committee Hansard*, Canberra, 19 August 2021, pages 7-9.

90 SAGE Australia, *Submission 3*, page 6.

91 SAGE Australia, *Submission 3*, page 8.

92 SAGE Australia, *Submission 3.1*, page [2].

93 SAGE Australia, *Submission 3.1*, page [2]; SAGE Australia, *Submission 3*, pages 3-4.

health and suicide services and interventions, in addition to being crucial for resolving community access issues.

3.89 Appearing before the Committee, the National Mental Health Consumer Alliance identified that in the delivery of services:

> Consideration also needs to be given to the diversity of our communities, to include the multitude of CALD [culturally and linguistically diverse] communities, LGBTI youth, older adults, forensic services as well as our rural and remote communities—we mustn't forget those, particularly off the back of drought and also the bushfires.[94]

3.90 This was supported by the National Suicide Prevention Adviser to the Prime Minister's final report, which recommended that suicide prevention planning and funding needs to be targeted with an equity approach, to engage communities that are disproportionally impacted by suicide.[95]

3.91 Action Area 3 of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 also focused on building the capacity and resilience of at-risk groups. It called for equality of mental health outcomes for the Aboriginal and Torres Strait Islander population by recommending the government develop strategies with community to support the mental health, and social and emotional wellbeing of:

- members of the stolen generations and their families
- those with chronic health conditions and/or disabilities
- lesbian, gay, bisexual, transgender and intersex people
- prisoners and young people in detention
- elders
- people with co-morbidities, including alcohol and other drug issues and mental health issues.[96]

3.92 The Trans Health Research Group stated that for mental health services to appropriately meet demand and deliver on outcomes, they need to be co-designed with community. This involves services:

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94 Ms Irene Gallagher, Foundation Member, National Mental Health Consumer Alliance, *Committee Hansard*, Canberra, 5 August 2021, page 7.

95 Australian Government, *National Suicide Prevention Adviser to the Prime Minister Final Advice: Executive Summary*, December 2020, page 8.

96 Department of the Prime Minister and Cabinet, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, October 2017, page 25.

> … speaking to leaders of community, speaking to people who are trans who are also people living with disabilities, who are neurodiverse, who are immigrants, who are people of colour, who are First Nations people, and making sure that any service is accessible to them, that it feels safe and it feels appropriate and is fulfilling their needs.[97]

Aboriginal and Torres Strait Islander communities

3.93 Forensicare contended that community partnership is particularly important for Aboriginal and Torres Strait Islander communities, noting the effectiveness of interventions is specifically tied to 'local engagement from community, community leaders and community elders'.[98]

3.94 This was further identified by Wesley Mission through work completed in the Kimberley region of Western Australia:

> That community knew firsthand what the community needed. Those community members had been individually impacted and so they were able to provide a responsive, community-led initiative. Too often we might purely look at the evidence or the different types of rhetoric that we're hearing in the media and look to respond there. But, if we're looking to have that real and timely impact, we need to have a relationship with people with lived experience at the local level to be able to empower them to take action.[99]

3.95 The Queensland Aboriginal and Islander Health Council (QAIHC) recognised the value of the health equity frameworks within Queensland, which effectively hold chairs and chief executive officers of Hospital and Health Services (HHS) accountable to co-design and effective community partnership through Close the Gap reporting. QAIHC stated:

> They have to have the plan they provide to the minister and to our deputy director-general for Aboriginal health signed off, and it has to be co-designed by community controlled organisations, by community, by traditional owner

97 Sav Zwickl, Researcher, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 3.

98 Dr Shaymaa Ekaldi, Executive Director, Strategy Policy and Performance, Forensicare, *Committee Hansard*, Canberra, 19 July 2021, pages 30-31.

99 Mr James Bell, Group Manager, Wesley Mission, *Committee Hansard*, Canberra, 29 July 2021, page 20. See also: Mr Cleveland Fagan, Chief Executive Officer, Queensland Aboriginal and Islander Health Council (QAIHC), *Committee Hansard*, Canberra, 21 July 2021, page 32.

> groups, by Indigenous staff, and by a whole range of other stakeholders listed in that regulation.[100]

3.96 QAIHC further highlighted that where this reporting is not completed, it impacts on HHS funding allocations, identifying that '[f]or once I see a light at the end of the tunnel, because they have to get the sign-off from community and community controlled organisations for that plan to be submitted to the minister for approval'.[101]

3.97 QAIHC explained:

> It's about engaging locally with traditional owner groups, the schools, the police, the men's groups, the women's groups and the mainstream non-government organisations, and having a place where they can sit down around the table and look collectively at what they're going to do and what role each of them will play.[102]

3.98 Operationalising a co-design approach was exemplified within Lifeline Australia's submission, where it highlighted its partnership with Gayaa Dhuwi (Proud Spirit) Australia to develop and deliver a helpline by and for Aboriginal and Torres Strait Islander peoples.[103]

3.99 Gayaa Dhuwi noted that in addition to the shortage of mental health and suicide prevention services in rural and remote areas, not every service is culturally safe or trauma informed for Aboriginal and Torre Strait Islander peoples.[104]

3.100 The National Aboriginal Community Controlled Health Organisation stated that the recent reports have identified what Aboriginal groups have been continually telling government for decades, that 'the key to improving

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100 Mr Cleveland Fagan, Chief Executive Officer, QAIHC, *Committee Hansard*, Canberra, 21 July 2021, page 30.

101 Mr Cleveland Fagan, Chief Executive Officer, QAIHC, *Committee Hansard*, Canberra, 21 July 2021, page 32.

102 Mr Cleveland Fagan, Chief Executive Officer, QAIHC, *Committee Hansard*, Canberra, 21 July 2021, page 32.

103 Lifeline Australia, *Submission 52*, page [6].

104 Mr Thomas Brideson, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, Canberra, 24 June 2021, page 2.

mental health outcomes for Aboriginal and Torres Strait Islander people is through empowerment and self-determination'.[105]

Cultural and linguistically diverse communities

3.101 Wesley Mission identified a range of barriers for culturally and linguistically diverse (CALD) communities in accessing mental health services, including: low social support; immense community stigma or completely different beliefs on mental health and suicide; transient metropolitan communities; issues with service navigation and coordination; personal trauma in an overseas environment; and English as a second language.[106]

3.102 Further barriers were identified by the Centre for Multicultural Youth (CMY) to include intergenerational conflict, cultural adjustment, barriers in education and employment, and experiences of racism and discrimination.[107]

3.103 Noting that current mainstream services are not working for young people in CALD communities, the Multicultural Youth Advocacy Network advocated for recognition of community solutions and supporting community partnerships.[108] CMY explained that building trust and engagement, and providing services that feel safe, has been fundamental to the successful delivery of services for this demographic:

> … whether that's embedding mental health professionals within multicultural youth services or working alongside the cultural community based organisations, anything that brings services out to where young people are and to communities.[109]

3.104 Similarly, NMHCCF outlined that what is required to improve health service access for CALD communities:

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105 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation, *Committee Hansard*, Canberra, 12 August 2021, page 7.

106 Mr James Bell, Group Manager, Wesley Mission, *Committee Hansard*, Canberra, 16 June 2021, page 2.

107 Ms Willow Kellock, Senior Policy Advisor, Centre for Multicultural Youth (CMY), *Committee Hansard*, Canberra, 6 August 2021, page 31.

108 Ms Yatha Jain, Youth Representative, Multicultural Youth Advocacy Network, *Committee Hansard*, Canberra, 6 August 2021, pages 32-33. See also: Ms Willow Kellock, Senior Policy Advisor, CMY, *Committee Hansard*, Canberra, 6 August 2021, page 31.

109 Ms Willow Kellock, Senior Policy Advisor, CMY, *Committee Hansard*, Canberra, 6 August 2021, page 33.

> … is increased and targeted engagement with CaLD communities through spiritual and community leaders to improve mental health literacy and awareness, support community resilience, enhance coping strategies and combat stigmatisation.[110]

3.105 Additionally, CMY argued for recurrent, co-designed mental health literacy programs with young people and communities from migrant and refugee backgrounds. Community partnership in delivering these programs would effectively create trust and dialogue around transcultural understandings, reduce stigma, and promote help-seeking.[111] For example, CMY identified that within the South Sudanese community:

> … we have a lot of mental health issues or mental illness and things like that, but we don't have a word for it per se in English or we can't explain all these things in English. So understanding what it is in our own language or our own way of dealing with everything that we are dealing with and the way we approach it is a bit different from the mainstream.[112]

3.106 This reiterates the importance of developing models with CALD communities, to build common understanding and work collaboratively to find and deliver on outcomes.[113]

LGBTIQ+ and SGD communities

3.107 The Trans Health Research Group advised that 70 per cent of LGBT individuals avoided mainstream services because of fears of discrimination.[114] LGBTIQ+ Health Australia argued that this could be resolved by mainstream services showing ‘a demonstrated commitment to collaborate with LGBTI communities’. This is to ensure that:

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110 NMHCCF, *Submission 71.1*, page 3.

111 Ms Willow Kellock, Senior Policy Advisor, CMY, *Committee Hansard*, Canberra, 6 August 2021, page 31.

112 Ms Tempest Alphonse, Project Officer, CMY, *Committee Hansard*, Canberra, 6 August 2021, page 33.

113 Ms Tempest Alphonse, Project Officer, CMY, *Committee Hansard*, Canberra, 6 August 2021, page 33.

114 Dr Ada Cheung, Senior Research Fellow and Head, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 3.

> … services are co-designed and co-delivered with people with lived experience and the knowledge [community understanding] is embedded in all programs and service design and funding arrangements.[115]

3.108 LGBTIQ+ Health Australia also argued for wider community partnership to support intersectionality, stating that 'having a more integrated holistic approach is really important when we look at designing programs to appropriately support people'.[116]

3.109 The Trans Health Research Group explained that transgender Australians are one of the most socially and medically marginalised communities in Australia, with over 70 per cent having depression and 43 per cent having attempted suicide. Overall transgender individuals have significantly higher risks of unemployment, poverty, physical assault, and both social and medical discrimination.[117]

3.110 This was further supported by SAGE Australia, who noted:

> … there are major problems with trans people getting help. In some quarters that provide help to this group of people, they have to wait six months for an appointment—six months! If you're suicidal, you need attention immediately…[118]

3.111 SAGE Australia recommended community partnership between suicide prevention services and community in the recruitment of SGD individuals for specialist positions. It identified that SGD mental health practitioners can give a higher quality service due to a higher level of community knowledge.[119]

3.112 The Trans Health Research Group also advocated for an expansion of tailored services for the trans community:

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115 Ms Zed Tintor, Deputy Chief Executive Officer, LGBTIQ+ Health Australia, *Committee Hansard*, Canberra, 26 July 2021, page 5.

116 Ms Zed Tintor, Deputy Chief Executive Officer, LGBTIQ+ Health Australia, *Committee Hansard*, Canberra, 26 July 2021, page 5.

117 Dr Ada Cheung, Senior Research Fellow and Head, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 1. See also: SAGE Australia, *Submission 3*, pages 5-6.

118 Dr Tracie O'Keefe, Co-Founder, SAGE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 2.

119 SAGE Australia, *Submission 3*, page 7.

> There is an urgent need for expansion of services tailored to the trans community, such as QLife and DISCHARGED, and a need to consider novel interventions that are co-designed with the community. We as a society need to reduce discrimination. Additionally, research in trans health and suicide prevention must be prioritised to reduce the health disparity and measure the success of targeted interventions to reduce suicide.[120]

3.113 The Committee heard mainstream services do not receive sufficient training and do not understand particular trans and gender-diverse experiences, and other experiences within the LGBTIQ+ community. As a consequence:

> … people who are trans or gender diverse or other members of the LGBTIQ community turn to LGBTI-specific services because that's where they're going to feel most safe, and in a moment of crisis the last thing a person wants is to be misgendered or to be asked inappropriate questions because the person that has picked up the phone simply doesn't understand what it means to be trans.[121]

3.114 SAGE Australia called for specific training in SGD issues across the board for healthcare professions:

> En masse, intersex people do not use gay access health services, and many trans people do not use gay access health services, because an intersex woman does not want to sit before a gay counsellor who doesn't understand anything about her issues.[122]

3.115 The Trans Heath Research Group told the Committee of progress in delivering training for health professionals, and advocated for expansion across Australia:

> In Victoria we've seen investment in a statewide training program for health professionals in trans health, so that's run by a community-controlled organisation, Thorne Harbour Health. They've been operating for 12 months. Their goal is to train GPs and psychologists and all health professionals in providing safe, gender-affirming care, and it's these sorts of initiatives that

120 Sav Zwickl, Researcher, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 1.

121 Sav Zwickl, Researcher, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 3.

122 Dr Tracie O'Keefe, Co-Founder, SAGE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 3; SAGE Australia, *Submission 3*, page 7.

> should be rolled out across Australia to try to improve services for the trans community.[123]

Committee comment

3.116 Within the current mental health and suicide prevention sectors, vital services are not accessible for all who need them, potentially resulting in dire and long running consequences for individuals, their families and friends, and the broader health system.

3.117 The Committee is particularly concerned with evidence delivered by the National Mental Health Consumer Alliance, who stated that:

> Many consumers are actually saying: 'I'm not traumatised by my mental health issues. I'm actually traumatised by the services that I'm accessing that are supposed to be there to assist me to heal.'[124]

3.118 The Committee recognises the tireless work of dedicated professionals who provide support for people with mental illness and those at risk of suicide. These professionals are skilled and compassionate. Similar to people in need of care, the mental health and suicide prevention workforce requires the right supports, structures, knowledge, and experience to provide accessible care. Chapter 5 examines the mental health and suicide prevention workforce.

3.119 The Committee has received significant evidence that services must be available when people need them. Services must have the capacity to treat those who need assistance, and service provision models must be developed so rigidities do not prevent people receiving multidisciplinary care.

3.120 Services must cater to different populations, especially those who require acute care, live in rural and remote areas, or are at risk of suicide. Service delivery also needs to support the unique needs across the lifespan and the gender spectrum to ensure everyone has access to mental health and suicide prevention services in a way that caters to Australia’s diversity.

3.121 System gaps that need to be resolved include:

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123 Dr Ada Cheung, Senior Research Fellow and Head, Trans Heath Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 5.

124 Ms Irene Gallagher, Foundation Member, National Mental Health Consumer Alliance, *Committee Hansard*, Canberra, 5 August 2021, page 11.

- The lack of suitable supports and specialised mental health services or practitioners for autistic individuals with mental illness.
- The lack of available perinatal services, noting the impending increase in demand as a result of lockdowns lifting and escalated diagnosis following the Productivity Commission Inquiry Report on Mental Health's recommended increases to perinatal screening.
- The lack of tailored mental health services for delivering higher intensity supports for men.
- The lack of MBS options for complex and specialist mental health treatments (Chapter 6 discusses funding in detail).

3.122 The Committee is also concerned in the forensic space by the overlap between offending and the onset of mental illness, which is coupled with difficulties in accessing mental health services and an absence of MBS-supported health care within prisons.

3.123 The Committee recognises consumer co-design and community partnership as intrinsic to the equitable access to services by priority populations. This approach ensures both the effectivity of services, programs and interventions, as well as the delivery of desired outcomes.

3.124 The priority populations of concern include Aboriginal and Torres Strait Islanders, LGBTIQ+ and SGD individuals, and the CALD communities. The Australian Government needs to sufficiently support these communities through equitable representation in governance and specific allocation of funding.

3.125 The Committee supports the recommendations of the National Suicide Prevention Adviser to the Prime Minister and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 on equitable responses in mental health and suicide prevention.

3.126 The Committee is of the view that funding has to be increased to meet the needs of people wherever they are and for whatever they need. Absent of such a commitment, it is hard to argue with the proposition that the health system treats some lives as less valuable than others.

Recommendation 4

3.127 The Committee recommends that the Australian Government ensure the principle of accessibility is at the forefront of all policy and funding

programs for the mental health and suicide prevention sector, with a focus on:

- **increased funding for specialist services, such as forensic, perinatal and autism services, to innovate, expand and meet demand**
- **frameworks that include consumer co-design and community partnership requirements to ensure equitable access for priority populations**
- **Indigenous-led and culturally appropriate models improving Aboriginal and Torres Strait Islander experiences with mental health and suicide prevention services.**

4. Virtual mental health care

4.1 Various stakeholders and reports have identified the importance of expanding telehealth and digital mental health to improve treatment access and navigation, bridge service gaps, and function as a key component of a national mental health system.[1]

4.2 The Productivity Commission Inquiry Report on Mental Health (Productivity Commission Report) recommended the expansion of supported online treatment, group therapies and access to mental healthcare via telehealth.

4.3 The Productivity Commission stated that supported online treatment is a means to provide a convenient, clinically effective, low-cost way for individuals to manage mental illness, and called for the Australian Government to implement the following priority actions:

- increase funding to expand supported online treatment for people with mental illness
- instigate information campaigns for consumers and health professionals to increase the awareness of supported online treatment as an effective and convenient treatment option.[2]

4.4 Similarly, in response to the Mental Health Reference Group Report, part of the Medicare Benefits Schedule (MBS) Review (2015-2020), the MBS Review Taskforce, recommended that the Australian Government promote and

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1 See, for instance: Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 2; Professor Nickolai Titov, Executive Director, MindSpot, MQ Health, *Committee Hansard*, Canberra, 19 July 2021, page 22; SANE Australia, *Submission 64*, page 2.

2 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, Action 11.1, page 70.

increase the awareness of digital mental health services and other low intensity options integrated with therapist support.[3]

4.5 In addition, the MBS Review Taskforce Telehealth Recommendations 2020 report recommended the Australian Government '[e]stablish a National Strategy for Virtual Health Care, including telehealth, and an action plan for Australia.'[4]

4.6 Responding to these reports, along with recommendations from the National Suicide Prevention Adviser to the Prime Minister, the Australian Government committed to 'increasing the availability of services, including digital and telehealth services' with an investment of $111.2 million in the 2021-22 Budget. This included:

- $11.6 million to commence the transformation of the existing Head to Health gateway into a comprehensive national mental health platform. This will provide Australians with greater choice and access to high quality, free and low cost digital mental health services and treatment
- $77.3 million to provide support to existing digital mental health services, including to manage the continuing increased demand due to the COVID-19 pandemic and the 2019–20 summer bushfires
- $13.1 million to support ReachOut Australia to continue delivering free, high quality digital mental health services to young Australians aged 12–25, their parents, carers and schools …[5]

4.7 With expansion underway, the Committee sought to consider the use, standards, safety and regulation of telehealth services and the role and regulation of digital and online mental health service providers in delivering safe and high quality care in Australia.

4.8 Accordingly, this chapter outlines the evidence the Committee has received in relation to telehealth and digital services, and then examines potential limitations of digital mental health and investment priorities.

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3 Medicare Benefits Schedule (MBS) Review Taskforce, *Taskforce Findings: Mental Health Reference Group Report*, 14 December 2020, Recommendation 12, page 2.

4 MBS Review Taskforce, *Telehealth Recommendations 2020*, 14 December 2020, Recommendation 1, page 16.

5 Department of Health, *Budget 2021-22, Prioritising Mental Health and Suicide Prevention (Pillar 1) – Prevention and early intervention*, 11 May 2021, page [1].

Telehealth

4.9 Telehealth was discussed in Chapter 2 in reference to the positive outcomes driven by COVID-19 restrictions. While evidence strongly supported the increased availability of telehealth, there was broad agreement that it was most effective as part of a suite of mental health services.

4.10 The Productivity Commission Report identified a need to address healthcare gaps in community mental healthcare, recommending the Australian Government:

> … make permanent the changes to expand access to psychological therapy and psychiatric treatment by videoconference and telephone introduced during the COVID-19 crisis.[6]

4.11 On 26 April 2021, the Australian Government announced that it would invest more than $114 million to extend the telehealth services made available in response to COVID-19 in March 2020 until the end of 2021.[7]

4.12 Referring to the significant uptake of the COVID-19-induced MBS telehealth items, the Hon Greg Hunt MP, Minister for Health and Aged Care, stated:

> From 13 March 2020 to 21 April 2021, over 56 million COVID-19 MBS telehealth services have been delivered to 13.6 million patients, with $2.9 billion in Medicare benefits paid. More than 83,540 providers have used telehealth services.[8]

4.13 The call to make the COVID-19 MBS telehealth item numbers permanent was widely supported by stakeholders.[9]

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6 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, page 71.

7 The Hon Greg Hunt MP, Minister for Health and Aged Care, 'Universal Telehealth extended through 2021', Media Release, 26 April 2021.

8 The Hon Greg Hunt MP, Minister for Health and Aged Care, 'Universal Telehealth extended through 2021', Media Release, 26 April 2021.

9 See, for instance: Mrs Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc (AAPi), *Committee Hansard*, Canberra, 21 July 2021, page 13; Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 2; Ms Tamara Cavenett, President, Australian Psychological Society (APS), *Committee Hansard*, Canberra, 6 August 2021, page 4; Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 25; Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, Speech Pathology Australia (SPA), *Committee Hansard*, Canberra, 19 August 2021, page 6; Orygen, *Submission 127*, page 5; Mental Health Australia, *Submission 69*, page 22.

Improving access

4.14 A strong argument for extending or making permanent the COVID-19-introduced MBS telehealth item numbers has been the significant improvements to accessibility. The Black Dog Institute stated:

> During COVID, we had a rapid expansion in the use of telehealth. There were over 2½ million MBS funded telehealth sessions between March and November last year. Within our own clinic, we saw the dramatic change that telehealth provided, where suddenly we were able to see patients who previously we wouldn't have been able to see, not just because of geographical challenges. We obviously want the extension of telehealth MBS numbers to continue beyond December this year, so that we can have certainty and plan treatment with patients.[10]

4.15 The accessibility benefits derived from telehealth were acknowledged in the MBS Review Taskforce Telehealth Recommendations 2020 report:

> Subject to clinical efficacy and clinical appropriateness, expand telehealth eligibility to patients in defined situations who may otherwise be unable to receive face-to-face care.[11]

4.16 A number of stakeholders observed an increase in telehealth referrals beyond their regular client base. It was noted that this was largely driven by those in areas with service gaps – rural or remote areas or specialist services.[12]

4.17 The Australian Rural Health Education Network (ARHEN) highlighted that from a rural community perspective, telehealth was very welcomed because '[w]e can't always get services on the ground.'[13]

4.18 The Women's Mental Health Alliance advised that while telehealth was not for all users, having it available made a significant difference for isolated

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10 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 2.

11 MBS Review Taskforce, *Telehealth Recommendations 2020*, 14 December 2020, Recommendation 5, page 19.

12 See, for instance: Ms Karen Donnelly, Vice-President, Psychologist, AAPi, *Committee Hansard*, Canberra, 21 July 2021, page 15; Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group, Occupational Therapy Australia, *Committee Hansard*, Canberra, 26 July 2021, page 14; Mr Graeme O'Connor, Acting Chief Executive Officer, Interrelate, *Committee Hansard*, Canberra, 28 July 2021, page 11.

13 Dr Sharon Varela, Chair, Mental Health Academic Staff Network, Australian Rural Health Education Network (ARHEN), *Committee Hansard*, Canberra, 17 June 2021, page 2.

individuals to access compassionate care and other health practitioners besides general practitioners (GPs). The Alliance advocated for continuing the telehealth arrangements:

> … sometimes it can also be hard to access a service or a support that's good around women's mental health if you're more isolated or in a more regional or rural area. So if you have the choice to log in with somebody … that also goes a long way. So I would advocate greatly for keeping telehealth alive. It has literally been a life saver for some people.[14]

4.19 Amaze, the peak body for autistic people, stated that the increase in access to digital clinical interventions such as telehealth was positive.[15]

4.20 Occupational Therapy Australia spoke about the benefits of telehealth services for regional, remote and rural Australia:

> It certainly helps clinicians and clients and people across regional, remote and rural Australia, because it's so difficult to access qualified mental health practitioners. The distance is a factor, but there are not enough services, as you mentioned earlier on. So there is more I think evidence, and I suppose I'm talking from an associate professor perspective and thinking about generating robust evidence, that demonstrates that the results that we get from telehealth are as robust and significant and make an impact on the recovery of people with mental health conditions and their family members as well.[16]

4.21 Speech Pathology Australia (SPA) also identified that the MBS telehealth item numbers have improved general access to specialist health professionals, which means that individuals can receive support and treatments better suited to their needs, regardless of their location.[17]

4.22 The Australian Association of Psychologists Inc (AAPi) also recommended that the Australian Government retain all of the MBS telehealth items, ensuring access to both videoconferencing and telephone items:

> … because we know that in rural and remote areas internet access is often problematic and that it excludes consumers that might have disabilities or

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[14] Dr Sabin Fernbacher, Member, Women's Mental Health Alliance, *Committee Hansard*, Canberra, 27 August 2021, page 21.

[15] Mr Chris Templin, Senior Policy Analyst, Amaze, *Committee Hansard*, Canberra, 26 July 2021, page 39.

[16] Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group, Occupational Therapy Australia, *Committee Hansard*, Canberra, 26 July 2021, page 14.

[17] Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, SPA, *Committee Hansard*, Canberra, 19 August 2021, page 6.

> financial constraints that would see them unable to have access to internet or smartphone technology …[18]

4.23 ARHEN believed that telehealth's been a really good adjunct to enabling the delivery of services that may not have otherwise been available, but suggested it is a supplement to rather than a replacement for mental health services in many regions:

> It supports the delivery of particular type of mental health services by particular professional groups rather than necessarily allowing the full spectrum of services that people may need in a rural and remote community.[19]

4.24 The Royal Flying Doctor Service agreed with ARHEN's view that telehealth worked as part of an integrated suite of services.[20]

Engagement and outcomes

4.25 While the rapid expansion of telehealth was unexpected, it brought about a number of positive outcomes. Witnesses also acknowledged that further evaluation of consumer engagement and outcomes will be important for assessing its role post-pandemic.

4.26 The Australian Psychological Society (APS) advised that approximately 95 per cent of psychologists have been using telehealth for the last 18 months, recommending that the Australian Government permanently support telehealth services. APS further stated that:

> Of course we want that to be high-quality care. We know video is one of the best forms, in that we can still reach connections. The outcomes are good. I would like to see that continue. I'd also like to see the provision of services supported by online integrated treatment. That's where a psychologist can work with programs they know are evidence based, trusted, supported, meet all the privacy quality controls, and they can refer out so that they're integrated within treatment as opposed to either doing an online program or one face to face. Overall, I'd like to see us broaden what we're doing there and how we're integrating it all.[21]

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18 Mrs Amanda Curran, Chief Services Officer, AAPi, *Committee Hansard*, Canberra, 21 July 2021, page 13.

19 Ms Joanne Hutchinson, National Director, ARHEN, *Committee Hansard*, Canberra, 17 June 2021, page 2.

20 Mr Frank Quinlan, Federation Executive Director, Royal Flying Doctor Service of Australia, *Committee Hansard*, Canberra, 17 June 2021, page 9.

21 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 4.

4.27 Stride Mental Health found that telehealth has significantly improved appointment attendance:

> … consumers that were coming into our headspace centres under the NDIS [National Disability Insurance Scheme] model were less likely to miss a telehealth appointment than what they would be to miss an appointment under normal circumstances where they were actually coming in. So the engagement there is higher. Whether or not they would … receive that depends on age groups and people's own technical capabilities and whether or not they would even accept technology as a part of their day to day. Generally, it's actually quite good.[22]

4.28 Similarly, the National Aboriginal Community Controlled Health Organisation (NACCHO) noted that while initially unsure how successful telehealth would be, the reality was pleasing:

> … when we had to lock down under the Biosecurity Act, in partnership with the Commonwealth and the state and territory governments, particularly in the remote areas we embraced telehealth with some trepidation, but it was proven to be highly successful. The people in the communities that we to contact for their chronic care management and to have telehealth consultations embraced it warmly, and we were very pleased with that uptake and we want that to continue.[23]

4.29 The Black Dog Institute advised that it is currently completing a research study into the quality of care and engagement provided through telehealth services. On interim anecdotal evidence, the Institute noted that while there are some patients who struggle to therapeutically connect over telehealth, others found it to be preferable:

> I have a number of patients who have said to me that they feel much more comfortable speaking via videoconference than they used to coming into a clinic. They said that they felt very anxious sitting in the clinic. They were often quite flustered by having to travel across Sydney to get there, and to be able to sit at home in their own surrounds they feel more comfortable and more able to engage. The other thing which I've had a number of patients say

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22 Mr Drikus van der Merwe, Acting Chief Executive Officer, Stride Mental Health, *Committee Hansard*, Canberra, 29 July 2021, page 28.

23 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (NACCHO), *Committee Hansard*, Canberra, 12 August 2021, page 8.

> to me is that they are able to continue treatment while continuing working, which is exactly what we want.[24]

4.30 SPA emphasised the importance of adaptability in therapy and engagement over telehealth, commending the work of speech pathologists in finding ways to make telehealth therapy engaging. SPA also noted that performing some aspects of therapy over telehealth can be exceptionally difficult:

> There are some things we have had to change. For example, it's really hard to do an autism assessment completely online, so we have had to add in some other things because we couldn't stop doing autism assessments altogether. We have some of the trickiest kids in the state, so we need to still do them. So we have been adding in extra things that are helpful—extra questionnaires for different people to get collaborative background and information about the young person.[25]

Committee comment

4.31 The Committee acknowledges the significant increase to service accessibility for individuals as a result of the COVID-19 introduced-MBS telehealth items, and the strong support for retention.

4.32 Access to telehealth numbers should be patient-oriented and based on patient need rather than geographical location.

4.33 The Committee supports Recommendations 3 and 4 of the MBS Review Taskforce's Telehealth Recommendations 2020 report, which advised the Australian Government to '[e]valuate, research and review models of telehealth and virtual health care to ensure the MBS item structures are appropriate for the Australian setting' and '[e]stablish a process to review all MBS telehealth items on a regular basis.'[26]

4.34 Noting the evidence received in relation to extending funding cycles to five years (see Chapter 6 for details), the Committee suggests that the Australian Government implement a complementary review cycle for telehealth. In addition to regular reviews of individual items, a five yearly review would ensure that telehealth MBS items meet the principles of providing high-

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24 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 6.

25 Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, SPA, *Committee Hansard*, Canberra, 19 August 2021, page 6.

26 MBS Review Taskforce, *Telehealth Recommendations 2020*, 14 December 2020, pages 18-19.

value care and that any risks or perverse incentives are managed and mitigated.

Digital services

4.35 The Department of Health has commissioned PricewaterhouseCoopers to develop the National Digital Mental Health Framework, including a review of the current digital mental health service landscape, and challenges and barriers being experienced. The project is currently in progress and will contribute to implementation of future strategic directions in digital mental health, in line with the Fifth National Mental Health and Suicide Prevention Plan.[27]

4.36 While strongly endorsing 'the use of technology as a tool for increasing the accessibility, efficiency and quality of mental health care', MindSpot stressed:

> … technology should be seen as a tool for delivering mental health care and not as a replacement for safe and effective care. We note that successful use of technology requires not only secure infrastructure, but also changes to how healthcare is delivered, training and upskilling staff, profound cultural shifts in practice, and additional governance.[28]

4.37 SANE Australia recommended the urgent expansion of supported online treatment, especially to individuals experiencing trauma or distress, as well as lower prevalence mental health issues. SANE Australia drew attention to the Productivity Commission Report,[29] which stated that:

> … people with more complex mental illness can also benefit from supported online treatment. There is some evidence that specifically designed supported online therapy may be effective in complementing specialist mental health treatment for severe and less prevalent disorders, such as schizophrenia, bipolar disorder and bulimia nervosa.[30]

4.38 The transition towards digital health will also enable greater engagement options for allied health professionals in improving treatment and care. Referencing a report by the Australian Digital Health Agency and the Allied

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27 Department of Health, *Answer to Question on Notice*, 18 March 2021, page [2].

28 MindSpot Clinic, *Submission 63*, page 2.

29 SANE Australia, *Submission 64*, page 2.

30 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, page 506.

Health Professions Australia, Exercise and Sports Science Australia (ESSA), advised that the majority of exercise physiologists were already using electronic record systems for patient notes. ESSA further noted that digital channels for coaching, support and patient review had been quite reasonable for that level of treatment to be delivered.[31]

Digital services improving access

4.39 Earlier chapters outlined issues around accessibility for consumers, workforce shortages and the compounding impact of COVID-19 on demand. Various stakeholders highlighted the possibilities digital services provide for increasing access for individuals who are unable to utilise face-to-face mental health services, including due to distance, cost, stigma or illness.[32]

4.40 In August 2021, the Australian Government announced the launch of #ChatStarter, an online mental health communication program that incorporates social media to promote the benefits of having supportive conversations with young people and children who might be struggling. The program links to resources available through the Australian Government's Head to Health website.[33]

4.41 Describing the purpose of #ChatStarter, the National Mental Health Commission explained:

> … talking may not necessarily be the best way to 'start a conversation'. Sometimes engaging in fun, creative, and productive activities together can transcend barriers to conversation, build trust and help create safe spaces for people to talk about how they're feeling, and the kind of support they need.[34]

4.42 yourtown highlighted that its services have evolved in response to changing needs and preferences of its clients, particularly children and young people:

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31 Ms Joanne Webb, Manager, Policy and Advocacy, Exercise and Sports Science Australia, *Committee Hansard*, Canberra, 21 July 2021, page 48.

32 See, for instance: Professor Nickolai Titov, Executive Director, MindSpot, MQ Health, *Committee Hansard*, Canberra, 19 July 2021, page 22; yourtown, *Submission 183*, pages 8-9; Lifeline Australia, *Submission 52*, page [7]; Mental Health Australia, *Submission 69*, page 21; Orygen, *Submission 127*, pages 5-6.

33 The Hon David Coleman MP, Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention, '#ChatStarter to support the mental health of Australia's children, young people and parents', Media Release, 11 August 2021.

34 National Mental Health Commission, '#ChatStarter', www.mentalhealthcommission.gov.au/chatstarter, viewed 5 October 2021.

> Digital platforms and tools provide a range of benefits to children and young people seeking mental health support, and young people tell us that they turn to Kids Helpline as it helps them overcome the barriers to access, such as stigma, discrimination, cost, and transport.[35]
>
> We understand that's why webchat is becoming the preferred modality for contact, and it's interesting to note that particularly for mental health conditions and young people expressing suicidal ideation, webchat affords them a level of confidentiality and privacy and safety that they may not otherwise have with phone or other modalities of contact.[36]

4.43 The appeal of digital services is not limited to young people, or determined by other demographic or geographic indicators. Evidencing the wide reach and improved access of digital services, MindSpot identified the demographics that engage with its online services, which:

> … are almost a representation of Australian national demographics, except for general. So we have more females than males who use the service. Approximately 70 per cent of the users are female. The age range is quite significant. It ranges from 18 to about 98. And I know it's surprising to a lot of people, but we have an increasing number of older adults using our services. About 40 per cent of people who use MindSpot report that they live outside of major metropolitan areas. When we look at postcodes, we see that there is quite an even distribution across the country. About four per cent of people who use MindSpot report that they have an Indigenous background—they are Aboriginal and Torres Strait Islanders—and about 12 per cent of people report that they are unemployed.[37]

4.44 Smiling Mind suggested that on a stepped model of care, the low intensity digital services are an extremely affordable channel for reaching large numbers of people. Smiling Mind noted that while there are discrepancies in access to digital resources in communities, including access to devices and the internet:

> … there are absolutely opportunities to integrate those into the way we deliver services. For example, having access to digital resources within community

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35 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 42.

36 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 44.

37 Professor Nickolai Titov, Executive Director, MindSpot, MQ Health, *Committee Hansard*, Canberra, 19 July 2021, page 22.

> settings, where people can access a computer or a device when they come in to a service, can overcome some of those barriers.[38]

4.45 Mind Australia outlined its experience with digital services in response to the COVID-19 pandemic. While similarly identifying challenges with devices and internet access, Mind Australia found that:

> … as we provided in particular a whole range of group programs online, that some of the participation improved because people could access the group program and could participate without leaving home. Now, there were many reasons people were reluctant to leave home and not all were related to the pandemic.[39]

Blended service delivery

4.46 The Black Dog Institute stressed that the use of technology in mental health and suicide prevention has to go beyond the use of telehealth, and needs to be blended into service delivery:

> Australia has said it wants to be a leader in terms of digital health. We've got some of the world's leaders in terms of digital mental health. But at the moment it's very fragmented and it's an either/or situation, where individuals use either digital health or face to face. We don't have an ecosystem or a funding system that encourages blended care where people can see psychologists as well as use some of the new technology.[40]

4.47 For a blended service delivery model to work, Transforming Australia's Mental Health Service Systems identified two critical components to consider:

> First of all, it's about getting an optimal balance between telehealth and face-to-face care. The second issue is about ensuring that telehealth practitioners communicate routinely and regularly, particularly in crises, with the designated care coordinators or case managers on the ground, families and the referring general practitioner. As that's not paid for in the payment for telehealth practitioners, a number of them will not adhere to communicating

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[38] Dr Addie Wootten, Chief Executive Officer, Smiling Mind, *Committee Hansard*, Canberra, 26 July 2021, page 21.

[39] Ms Gill Callister, Chief Executive Officer, Mind Australia Ltd, *Committee Hansard*, Canberra, 26 July 2021, page 21.

[40] Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 2.

> with the referring agents or with the people they know on the ground who will attend to crises.[41]

4.48 Blended service delivery requires digital services to be able to build therapeutic relationships and ensure therapeutic outcomes. Appearing before the Committee, MindSpot explained that:

> … a relationship with consumers and between consumers and service providers is critical for establishing engagement and maintaining engagement during treatment, which, of course, can be quite challenging. We have looked at this through therapist engagements and anecdotes, as well as testing this empirically. We've measured therapeutic outcomes online compared with face to face. What we've learned—surprisingly—is that consumers do engage very powerfully. In fact, there's no difference in the level of therapeutic engagement consumers had with MindSpot compared with what we would expect from face-to-face care. That's actually the result of an enormous amount of co-design with consumers and really thinking through the consumer journey—walking the walk with them.[42]

4.49 Smiling Mind proposed that digital services are also a very powerful adjunct to face-to-face clinical services:

> We know a large number of clinicians will recommend their patients use a program like Smiling Mind in the interim periods between those clinical visits, particularly when there is a significant time delay between appointments, as a tool to look after their wellbeing.[43]

4.50 Wesley Mission highlighted the importance of incorporating digital approaches to care in a community-tailored approach. Throughout the COVID-19 pandemic, Wesley Mission noted that:

> … some communities jump in and work well in participating in community network meetings online, whereas some other communities, particularly rural and remote communities and some of the First Nations communities, there is not such a preference for engaging online.[44]

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41 Professor Alan Rosen AO, Chair, Transforming Australia's Mental Health Service Systems, *Committee Hansard*, Canberra, 29 July 2021, pages 3-4.

42 Professor Nickolai Titov, Executive Director, MindSpot, MQ Health, *Committee Hansard*, Canberra, 19 July 2021, page 23.

43 Dr Addie Wootten, Chief Executive Officer, Smiling Mind, *Committee Hansard*, Canberra, 26 July 2021, page 21.

44 Mr James Bell, Group Manager, Wesley Mission, *Committee Hansard*, Canberra, 29 July 2021, page 18.

For at-risk communities

4.51 The Committee heard that digital resources and services can improve access and provide safe spaces for at-risk populations. ReachOut advised that huge numbers of young people who are LGBTIQ+ or sex and/or gender diverse individuals use its online mental health service. It argued that:

> Often that can be because we're so well placed as an entry point for young people to begin exploring things. Often we are able to provide validation around their experience, help them to feel that they're not alone, help them to understand that if they are finding these types of questions confronting or challenging then there are other services as well that can provide really specific support. One of the things we focus on doing is almost helping young people to become more help-ready and then, ideally, helping to introduce them to services that can provide additional layers of support to what ReachOut provides. For instance, we wouldn't say that we are a specialist organisation that is purely focused on that demographic. But, that said, 30 per cent of young people who come to ReachOut identify as gender or sexually diverse. We have done a lot in making the service fit for them as well.[45]

4.52 Appearing before the Committee, the Trans Health Research Group argued the value in developing novel strategies, including digital, to support transgender people all over Australia:

> … whether that be having mental health services or case management remotely using videoconference or perhaps outreach after contact with a crisis support service or ongoing mental health support remotely, or whether that be through video meetings or text-messaging based interventions, with funding I think such strategies using remote technology can be delivered to trans people regardless of their location of residence and help connect people to community.[46]

4.53 Similarly, yourtown identified that a significant portion of its digital mental health service users come from culturally and linguistically diverse communities. yourtown explained that:

> Kids Helpline is currently accessed by children and young people of all ages and of all cultural backgrounds. Five per cent of our counselling contacts are Indigenous children and young people; 34 per cent identify as coming from culturally and linguistically diverse backgrounds; and they come from a

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45 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 15.

46 Dr Ada Cheung, Senior Research Fellow and Head, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 3.

whole range of areas urban, regional, rural and remote in line with geographic demographics.[47]

4.54 In terms of Indigenous communities, the Kimberley Aboriginal Law and Cultural Centre (KALACC) indicated that in general the young people within its communities are 'switched in digitally' through their phones.[48] KALACC explained that:

> It can be fairly haphazard in terms of any number of things from changing phone numbers, lack of follow-through, prepaid accounts not having reach. So they are not necessarily as reliable a source in any way as a research agency on the ground with people knowing their patch. But certainly younger people are more engaged with technology now than they ever have been, which is why KALACC has gone down the route of Mabu Jila as a way of engaging young people in culture.[49]

4.55 Mabu Jila, KALACC explained, is a digital service that it developed as a method of maintaining and sharing culture within Kimberley communities:

> The state government of Western Australia through an entity called Lotterywest has provided KALACC with a substantial amount of money for a program we are calling Mabu Jila, which means 'good water'. What we are doing through Mabu Jila is creating an app that will enable young people—teenagers—in their communities to pull out their phone or whatever technology they have on hand so that they are empowered to capture the important cultural knowledge that their grandmother or grandfather has and to then store, document and share all of that. What we need to be doing is investing in cultural practice, those things that build the resilience and wellbeing within communities.[50]

4.56 However, KALACC confirmed that for certain Aboriginal communities:

> … while young people will engage to some degree in digital platforms, there is nothing that beats word of mouth. There is nothing that beats actual on-the-ground programs that people do sign up for, do join in on, that come to their communities wherever possible. So even though it may well be that taking the

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47 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 42.

48 Mr Stephen Kinnane, Research Coordinator, Kimberley Aboriginal Law and Cultural Centre (KALACC), *Committee Hansard*, Canberra, 19 July 2021, page 18.

49 Mr Stephen Kinnane, Research Coordinator, KALACC, *Committee Hansard*, Canberra, 19 July 2021, pages 18-19.

50 Mr Stephen Kinnane, Research Coordinator, KALACC, *Committee Hansard*, Canberra, 19 July 2021, page 18.

> digital approach is certainly a quicker approach and useful to have as a back-up, it is certainly not going to be the main approach, which is face-to-face.[51]

Managing system efficiencies and overcoming limitations

4.57 The Committee heard the use of digital services in the delivery of virtual mental health care has enabled services to overcome particular pain points intrinsic to physical services in addition to increasing broader system efficiency.

4.58 Investment in a state-wide digital service has enabled the WA Primary Health Alliance to bridge some of its workforce gaps and deliver an evidence-based service:

> … built on the MindSpot model [it] is a GP referred system. It has greatest efficacy because we can effectively really guarantee not only the outcomes that are achieved but also the quality.[52]

4.59 Appearing before the Committee, yourtown highlighted the benefit of digital services in managing surge demands:

> We have found that mental health services, particularly during times of crises, need to be integrated, scalable and able to adapt very quickly during crises, and our experience with Kids Helpline is that virtual services are highly scalable and complementary.[53]

4.60 ReachOut stated that its digital service has not only been able to bridge service gaps and meet demands caused by the capacity constraints on traditional mental health settings, but also meet growing service preferences for services like peer support:

> ReachOut's been providing an aspect of that [peer support] for more than 10 years through our online community forums, which you can conceptualise almost like a chat room. Someone can come in, create an account and share their experiences, ask questions and interact with other young people. In that

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51 Mr Stephen Kinnane, Research Coordinator, KALACC, *Committee Hansard*, Canberra, 19 July 2021, page 19.

52 Adjunct Associate Professor Learne Durrington, Chief Executive Officer, WA Primary Health Alliance and Chair, National PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 8.

53 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 42.

> setting, all of that's very well and tightly managed by ReachOut's team, who have skills across youth work, social work and mental health work.[54]

4.61 Professor Ian Hickie, from the University of Sydney's Brain and Mind Centre, emphasised the importance of information technology (IT) coordinated care – to achieve the right care the first time. However, Professor Hickie was critical that there was still not widespread adoption of smart healthcare technologies:

> We see apps and we see the Australian government continue to support many different organisations to develop very simplistic record systems and tracking systems. They're very inefficient and there's a lack of cross-talk and a lack of coordination. Many people will need to move across many organisations and many different professionals will effectively need to be involved in the care of the same individual over time. So despite the degree of innovation we've had in Australia, despite the great work done by many people here—we've been a real leader, and that was recognised by previous governments and reports—we have not moved the fundamentals to actually support the power of IT to support better care at scale.[55]

4.62 ReachOut contended that consideration needs to be given to the development of connections between systems, and how digital tools and data can be used to overcome pain points that other service models cannot:

> I think a lot of the conversations we might have had are in the past, but there's a really important difference with taking an existing or traditional kind of service model and just making it available online. What that does is solve a really important piece around access, but it's not necessarily speaking to the nuance or the potential to really think about how you use online data technology and blend all of those things together to create a new or different style of service that's actually addressing more than just access.[56]

Online referral, connectivity and triage

4.63 The Productivity Commission recommended the development of an independent assessment and referral process associated with a digital

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54 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 14.

55 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 28.

56 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 17.

platform. Appearing before the Committee, the Productivity Commission explained:

> That's very similar to the Victorian royal commission recommendation. A difference is that I think the Victorian recommendation still had the GP as being the required gateway through which the consumer can access that; whereas we said there should also be just simply the ability for a consumer who needs help to go to that platform and receive moderated help, rather than perhaps relying on Dr Google or other internet searches to try to gain that information.[57]

4.64 The Committee heard that there is already capacity for treatment referral and triage to be delivered via digital services and it is already being facilitated. MindSpot outlined its process:

> By virtue of registering, we know who they are. They then get asked a series of questions about symptoms and about life circumstances, and we automatically generate a report, which is immediately available. With their approval and consent, we'll send a copy of that report to a general practitioner or another health professional. At that point, we also invite people to speak to us. We encourage people to do that, to have a consultation with one of our mental health professionals. The aim of that consultation is to talk through the results, to talk through their life experience, to start to tailor and personalise the recommendations and to make some recommendations about things which might help. It might be treatment with us, it might be some self-help strategies, it might be a referral to another service. At that point we're really hoping to help people make an informed decision about their treatment future.[58]

4.65 Additionally, yourtown's digital services support user navigation of the mental health system, as well as facilitate 'soft' referral and service collaboration. yourtown stated:

> We are currently going through a major digital transformation, and with the use of new technology I think we will be moving towards much greater integrated support where we can have much better developed case planning that can look at a whole range of factors impacting on family dynamics.[59]

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[57] Dr Stephen King, Commissioner, Productivity Commission, *Committee Hansard*, Canberra, 18 March 2021, page 3.

[58] Professor Nickolai Titov, Executive Director, MindSpot, MQ Health, *Committee Hansard*, Canberra, 19 July 2021, page 24.

[59] Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 44.

4.66 ReachOut drew attention to the pilot that it is currently completing with Lifeline Australia. The pilot focusses on how its service can use data it receives to understand a person's thoughts and triage accordingly, without needing to know the end-user:

> We'll look at things like what search terms they come in at through Google, and which parts of ReachOut they're accessing: are they accessing suicide content? Are they accessing content that we would consider could be suggestive of imminent risk or higher risk?
>
> … we'll piece together a profile, and where it meets enough of the criteria we'll do a pop-up that says: 'Hey, we want to check. How are you going? Would you like to speak to someone right now?' If they say yes, then that moves straight into the Lifeline service, so they're actually dealing in real time with Lifeline—digitally, through their web chat functionality. They then have a feedback loop. So, when that session ends they can provide us with feedback to close that out.[60]

4.67 ReachOut identified this as an example of digital services working together to bring aspects of mental health support together in a seamless way. It continued, stating that:

> It's more than just saying, 'Here's a number to call' or 'You should know about this other service.' You're actually seeking to take the step of them stopping their journey with us and starting it with someone else out of it for the person who is seeking help, and that's actually possible through tech these days. We've been running these kinds of pilots because we see a lot more potential if we're willing to be bold around the use of data and if services are willing to think outside of their traditional service boundaries to do a lot more of this heavy lifting on behalf of consumers.[61]

Safety, quality and standardisation

4.68 Various stakeholders recognised the importance of having national digital mental health standards to ensure safety and quality in service delivery.[62]

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60 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 16.

61 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 16.

62 Ms Gill Callister, Chief Executive Officer, Mind Australia Ltd, *Committee Hansard*, Canberra, 26 July 2021, page 21; Dr Kristy Goodwin, *Committee Hansard*, Canberra, 19 August 2021, page 18.

4.69 In November 2020, the Australian Commission on Safety and Quality in Health Care (ACSQHC) released the National Safety and Quality Digital Mental Health Standards (NSQDMH Standards), to improve the quality of digital mental health services and protect users.[63]

4.70 Appearing before the Committee, ACSQHC advised that:

> … there needs to be a whole range of measures in place around governance of these systems. That's a huge area and part of the standards we've looked at. Governance and leadership includes having systems around incident management and complaints, and it includes having really clear and transparent policies around how your data is used. I think that is one of the keys.
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> It obviously has to have very strong consent mechanisms and look at patient rights. That's very important. Usability and accessibility are very, very important elements that, I think, still need to be looked at and worked on and that are part of our standards. And, obviously, risk assessment and responding to deterioration are important. They're all key considerations as part of the proliferation of telehealth and digital mental health over the last little while, particularly during COVID.[64]

4.71 Within the 2021-22 Budget, the Australian Government announced that it would be investing '$2.8 million to support the implementation of the NSQDMH Standards to improve the quality of digital mental health service provision, and protect service users and their support people'.[65]

4.72 Dr Kristy Goodwin recommended wider standardisation of digital practices:

> I think young people are demonstrating their preference through their use of online mental support tools. Kids Helpline data indicates that they have a preference towards seeking help in a digital space. So I think we definitely need consistency in service deliverables and best practice.[66]

4.73 ReachOut explained that it ensures safety and quality in its service delivery through recruitment, its duty-of-care requirements and its technology. It has a clinical lead that oversees its organisation-wide approach, in addition to a

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63 Australian Commission on Safety and Quality in Health Care, *Submission 191*, page 1.

64 Mr Chris Leahy, Director eHealth and Medication Safety, Australian Commission on Safety and Quality in Health Care, *Committee Hansard*, Canberra, 12 August 2021, page 13.

65 Department of Health, *Budget 2021-22, Prioritising Mental Health and Suicide Prevention (Pillar 1) – Prevention and early intervention*, 11 May 2021, page [1].

66 Dr Kristy Goodwin, *Committee Hansard*, Canberra, 19 August 2021, page 18.

clinical advisory group to support multidisciplinary approaches and follow trends, and uses technology to help keep the forums safe:

> We use a tool that we developed with UTS [University of Technology Sydney] around triaging. We use natural language processing to detect posts and conversations that might be a high risk and those immediately get escalated to our team, who intervene. That can include things like imminent suicide or the need to make reports around keeping young people safe.[67]

4.74 Additionally, ReachOut contended that its duty-of-care guidelines ensure that when there is escalated risk approvals are required, which guarantees that multiple individuals are working on any one matter.[68] It also advised that where there is an imminent suicide risk, its system design ensures end-user safety:

> … to post in ReachOut's forums you need to create an account. You can use a pseudonym, but we will have your IP [Internet Protocol] address, and we're really clear about the fact that we will step in where there is imminent risk. What that ultimately looks like is the team working with that individual to make all the clinical assessments around their safety and whether this is an imminent risk or, to your point, another type of risk. Where it's imminent, we will try to work with that person to get them safe, but if we don't feel that that's possible and it's not meeting our threshold then we will escalate to emergency services. We will provide an IP address and the team can go to the particular location. On the other range of issues, whether incidence of violence or sexual assault, we have a mandatory reporting obligation. So, we will always let someone know that we have an obligation to report and then seek to provide them with mental health support through what is also a very difficult stage.[69]

Committee comment

4.75 The Committee has heard extensive evidence from some of the largest mental health and suicide support services about the increasing role and value of digital mental health services, and how these are being used to improve treatment accessibility through blended-care models, particularly for at-risk communities.

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[67] Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 14.

[68] Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 15.

[69] Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 16.

4.76 The Committee recognises the importance of digital services and systems for overcoming challenges across the mental health sector in workforce shortages, coordination and collaboration.

Recommendation 5

4.77 The Committee recommends that the Australian Government review available digital technologies to identify and promote best practice options for mental health and suicide prevention professionals to:

- **increase access to rapid assessment for self-harm**
- **coordinate with other service providers to reduce administrative pressures on professionals and improve the user experience**
- **track outcomes of care to ensure that the right care is being offered.**

4.78 The Committee supports the development of the NSQDMH Standards for promoting safety and quality in the delivery of digital mental health services, but considers that implementation of the standards should be at a minimum mandatory for government funded services.

4.79 The Committee also supports Action 11.1 of the Productivity Commission Report, which recommends the Australian Government consider commissioning an evaluation of the performance of online treatment services, to facilitate ongoing service improvement.[70]

Recommendation 6

4.80 The Committee recommends that the Australian Government make compliance with the National Safety and Quality Digital Mental Health Standards mandatory for all digital mental health service providers who receive Commonwealth funding.

Limitations of virtual mental health care

4.81 Evidence received from stakeholders identified two critical barriers to the implementation of digital mental health services and solutions: digital literacy and digital access.

70 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 70.

4.82 Other barriers to the provision of digital mental health services identified by stakeholders included:

- The lack of privacy individuals had when trying to engage with mental health services from home, due to a limited capacity to control their environment or have a private discussion.[71]
- The inability of children to focus for long durations online which needs to be factored into service design.[72]

Digital literacy

Consumers

4.83 According to Jean Hailes, certain demographics, particularly older people, may not be compatible with a blended or digital service delivery:

> I mentioned also that some older people are not as computer literate as many of us are, so telehealth, while it's a great offering, is sometimes quite difficult. What we know is that our older patients prefer a straight phone call. The first lot of statistics that came out about the use of telehealth was that 90 per cent of those consults were done on the phone. That is what suits older people. Asking them to log on and fire up their computer is just a bridge too far for most of them, and it actually undermines their sense of independence and capacity to cope with this abnormal situation [COVID-19].[73]

4.84 This was observed by AAPi who experienced difficulties with telehealth for certain consumers:

> A lot of people who were elderly or had intellectual impairments or were homeless had difficulty accessing telehealth because of the multiple steps that were required to connect to a service.[74]

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[71] Mr Jonathan Harms, Chief Executive Officer, Mental Health Carers NSW, *Committee Hansard*, Canberra, 5 August 2021, page 3; Ms Katrina Armstrong, Executive Officer, Mental Health Carers Australia, *Committee Hansard*, Canberra, 5 August 2021, page 3; Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, pages 43-44.

[72] Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, pages 43-44.

[73] Mrs Janet Michelmore AO, Chief Executive Officer, Jean Hailes, *Committee Hansard*, Canberra, 27 August 2021, page 3.

[74] Mrs Amanda Curran, Chief Services Officer, AAPi, *Committee Hansard*, Canberra, 21 July 2021, page 16.

4.85 Stride Mental Health outlined the need for governments to action consistent and clear investment in services to support consumers:

> … I think most people, the larger part of our population, are quite comfortable with technology and how to use it. It is about making sure that everybody knows what to use. An example is the apps that we use to scan QR codes when we walk in the front door. If you remember, right at the start of the pandemic it was a free-for-all. Everybody was doing their own thing. Slowly the state governments decided to invest in particular ones, and now everybody's fine with them. They are comfortable using them and understand them. It makes the education piece simple.[75]

4.86 Despite observing low digital uptake within construction industries, MATES in Construction still saw a role for digital mental health solutions:

> They've all got mobile devices. Even doing it through this forum is better than not. Anything that actually connects people in a way that makes them feel that they are closer to another individual, we know, does work.[76]

Mental health professionals and service providers

4.87 Appearing before the Committee, Mind Australia noted the importance of investing in the digital capability of health practitioners, carers and administrative staff:

> It is not automatic that staff can move from delivering services face to face to being able to use devices effectively. There is still a staff skilling up and capability issue to be aware of as we probably move to a more hybrid world of service delivery.[77]

4.88 This was further supported by Stride Mental Health, contending that:

> Telehealth is a technical solution. It requires skill. It requires change. It requires understanding how to pivot your organisation and how to get technology in place. We are lucky we've got a very strong IT team behind us,

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75 Mr Drikus van der Merwe, Acting Chief Executive Officer, Stride Mental Health, *Committee Hansard*, Canberra, 29 July 2021, pages 28-29.

76 Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, page 45.

77 Ms Gill Callister, Chief Executive Officer, Mind Australia Ltd, *Committee Hansard*, Canberra, 26 July 2021, page 21.

> but not all organisations have that and the experience to actually make that change to telehealth.[78]

4.89 MindSpot's submission affirmed the importance of workforce in digital health transition:

> We endorse investment in ongoing training and support of the mental health workforce. The change agenda described in the strategic reviews clearly indicate the future clinical workforce will require skills and support to seamlessly integrate measurement and technology into everyday practice.[79]

4.90 In September 2020, the Australian Digital Health Agency published the National Digital Health Workforce and Education Roadmap, a policy document that identifies a plan for supporting the health workforce transition to the use of digital supports and systems through training and education. This builds upon the National Digital Health Strategy published in 2016.[80]

Digital access

4.91 Various stakeholders identified that a barrier to digital mental health and telehealth solutions for certain demographics was a lack of access to internet or devices, due to remoteness or affordability constraints.[81]

4.92 Appearing before the Committee, yourtown recognised the importance of acknowledging the digital divide for certain individuals:

> … we know from our own experiences with our digital modalities many children drop out of waitlists, when they are trying to connect with our service, due to poor internet coverage. We know young people from disadvantaged areas have maintained that they may not have access to a laptop, tablet or PC [personal computer], and that's why landlines still remain

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78 Mr Drikus van der Merwe, Acting Chief Executive Officer, Stride Mental Health, *Committee Hansard*, Canberra, 29 July 2021, page 28.

79 MindSpot Clinic, *Submission 63*, page 2.

80 Australian Digital Health Agency, *National Digital Health Workforce and Education Roadmap*, September 2020, pages 7, 18.

81 See, for instance: Ms Gill Callister, Chief Executive Officer, Mind Australia Ltd, *Committee Hansard*, Canberra, 26 July 2021, page 21; Carers Australia, *Submission 155*, page 8; yourtown, *Submission 183*, page 9; Australian Association of Social Workers, *Submission 111*, pages 12-13; Gayaa Dhuwi (Proud Spirit) Australia, *Submission 180*, page [11].

> a key part of our service modality for those with poor internet connection and some families who don't have access to appropriate technology.[82]

4.93 Stride Mental Health advised that digital mental health services need to be something that is cheap and easily accessible:

> … because not everybody has availability of wi-fi or the NBN [National Broadband Network], for that matter. It isn't that simple. The more rural and the more isolated people are, the harder it actually is. So, making sure that there's a simple way for people to engage with technology will actually go a very far way.[83]

4.94 Mental Health Carers NSW similarly recognised there are 'significant digital deficits in different parts of the community that render online support difficult to access,'[84] suggesting that:

> … this would invite us … to focus delivery of online supports to people who can access them and find them appropriate for their needs and to use the resources freed up to provide other supports, either bridging the digital divide by direct grant of equipment and data or offering face-to-face supports in appropriate sanitary settings as an alternative.[85]

4.95 To address the 'digital divide' in rural and remote communities, the Australian Association of Social Workers recommended '[t]hat government sets a priority to guarantee reliable telephone and internet connections to all rural and remote communities as an aspect of mental health service delivery.'[86]

Committee comment

4.96 Fostering digital literacy and digital capabilities across the Australian population is essential for the transition to a future of blended-care models, virtual mental health care, and improved mental health systems.

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82 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, pages 43-44.

83 Mr Drikus van der Merwe, Acting Chief Executive Officer, Stride Mental Health, *Committee Hansard*, Canberra, 29 July 2021, pages 28-29.

84 Mr Jonathan Harms, Chief Executive Officer, Mental Health Carers NSW, *Committee Hansard*, Canberra, 5 August 2021, page 3.

85 Mr Jonathan Harms, Chief Executive Officer, Mental Health Carers NSW, *Committee Hansard*, Canberra, 5 August 2021, page 3.

86 Australian Association of Social Workers, *Submission 111*, page 13.

4.97 The Committee commends the Australian Government for the development of the National Digital Health Workforce and Education Roadmap, and for investing in upskilling the digital literacy of health workers.

4.98 A key concern is that certain communities and individuals will not be able to partake in the increased access of mental health services due to low access to quality Internet services or digital devices.

4.99 Therefore, it is critical that mental health services continue to be supported and operate offline and in physical locations, to ensure that the delivery of digital services does not reduce access.

Recommendation 7

4.100 The Committee recommends that the Australian Government ensure the next National Digital Health Strategy (2022-27) explicitly addresses barriers to digital access, and includes specific actions for reducing the 'digital divide'.

Investment priorities

Digital infrastructure

4.101 On 25 August 2021, the Australia Digital Health Agency announced a nationwide online survey on digital health in preparation for the next iteration of the National Digital Health Strategy (2022-27), which will be delivered by mid-2022.[87]

4.102 Stride Mental Health identified that a key focus of investment needs to be in consumer digital infrastructure, ensuring that individuals have a device, stable Wi-Fi and the additional supports that enable service access.[88]

4.103 This focus was further supported by NACCHO, who stated that:

> The COVID-19 pandemic has highlighted the urgent need to develop and invest heavily in telehealth and digital social and emotional wellbeing supports and services for Aboriginal and Torres Strait Islander communities. Opportunities for telehealth expansion should be supported but not at the expense of further development of the local workforce.

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87 Australian Digital Health Agency, 'The future of healthcare is digital - have your say, think about tomorrow', Media Release, 25 August 2021.

88 Mr Ben McAlpine, General Manager, Strategy, Innovation and Growth, Stride Mental Health, *Committee Hansard*, Canberra, 29 July 2021, page 28.

> … It is essential that the infrastructure funding allocations are equitably spread across the country, future focused and enable tele- and digital health services into the future.[89]

4.104 Additionally, yourtown advised that mental health services need to be underpinned by stable, long-term funding in addition to foundational infrastructure, clarifying that:

> When I talk about foundational infrastructure to be able to scale up mental health services in times of need, this includes having an existing, stable and skilled workforce who are versed in a range of service modalities, particularly digital online service modalities …
>
> It is also important to have high-quality digital practice models and training available to staff, quality assurance and supervisory structures for a digital service model which can be replicated or expanded upon. It is also important that funding is made available quickly and it's accessible to organisations to manage those spikes.[90]

4.105 The Australian Physiotherapy Association acknowledged the disjointed nature of current online systems:

> It's very hard for our allied health professionals to actually access the digital health records effectively, because there are some barriers with software access and the investment that hasn't been there from the government to allow us to access that efficiently and effectively, so that's one thing.[91]

4.106 Another gap within digital health infrastructure, raised by Stride Mental Health, is that a lot of organisations struggle with the concept of what a professional and appropriate platform to use in service delivery looks like:

> ... we would commonly use three or four different platforms in any given day as part of our normal operations. They are not really suitable for clinical environments where we are talking to people. It would be a tremendous help to sift through all of the providers that are there and say: 'Here's something that is actually appropriate. It's been cleared. It is useful.' Also the ability for different technology platforms to actually integrate would be helpful. It really needs foresight, a bit of strategy and a bit of vision from the government to

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89 Ms Patricia Turner, Chief Executive Officer, NACCHO, *Committee Hansard*, Canberra, 12 August 2021, page 8.

90 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 43.

91 Mr Scott Willis, National President, Australian Physiotherapy Association, *Committee Hansard*, Canberra, 26 July 2021, page 16.

> say, 'This is actually something that we could possibly invest in and here's an easy way for you and your workforce to actually use it.'[92]

4.107 Smiling Mind noted that Australians are proactively engaging with digital tools and services to support their mental health, and that this needs to be supported with funding and investment. It further noted that:

> The pandemic has resulted in significant demand for our services at Smiling Mind. In 2020, we saw 1.25 million new people sign up to the Smiling Mind app. This is a 350 per cent increase in kids under 12, a 224 per cent increase in teachers and a 150 per cent increase in parents. The challenge is that we just can't keep up with this demand. While technology based approaches allow significant efficiency, great reach and access wherever it's needed, these approaches also require funding, and the mental health system as it currently stands does not value these services as an integral part of the mental health system.[93]

Research

4.108 On 16 September 2021, the Australian Government announced its investment of $10 million in research projects using the latest digital and mobile technology to improve primary health care delivery. Grants are available to Australian researchers to undertake this critical research through the landmark Medical Research Future Fund.[94]

4.109 Mind Australia stressed the urgency for research into telehealth and digital services, before these tools become overused or over-embedded in our mental health supports and responses:

> I think understanding when you can use digital services—as an initial assessment; as a crisis response; as supplementary and re-enforcing to other forms of services or treatments; as services that build strong participation, but only with certain other services in place at the same time, particularly when we're talking about the mix of clinical and psychosocial support and self-re-enforcing services—from a research point of view, before we overdesign our

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92 Mr Drikus van der Merwe, Acting Chief Executive Officer, Stride Mental Health, *Committee Hansard*, Canberra, 29 July 2021, pages 28-29.

93 Dr Addie Wootten, Chief Executive Officer, Smiling Mind, *Committee Hansard*, Canberra, 26 July 2021, page 20.

94 The Hon Greg Hunt MP, Minister for Health and Aged Care, '$10 million to enhance digital frontline health care', Media Release, 16 September 2021.

> policy responses based on something we did because we had to, is absolutely critical.[95]

4.110 Similarly, Smiling Mind suggested that research is required to demonstrate 'for who, for when and for what presenting problems it's [telehealth] best suited'.[96] While supporting the call for further research, Occupational Therapy Australia also noted the need to 'understand that it doesn't necessarily work for everyone'.[97]

4.111 The calls from stakeholders for further research into telehealth and digital mental health services were supported by Recommendation 3 of the MBS Review Taskforce's Telehealth Recommendations 2020 report which recommended the Australian Government:

> Evaluate, research and review models of telehealth and virtual health care to ensure the MBS item structures are appropriate for the Australian setting.[98]

4.112 Further discussion on the importance of data collection, monitoring and evaluation, and research to support innovation is included in Chapter 7.

Committee comment

4.113 The Committee commends the Australian Government for its recent investment into digital health research, and encourages a continued focus on both identifying innovations and solutions to barriers to ensure equitable access to mental health and suicide prevention services.

Recommendation 8

4.114 The Committee recommends that the Australian Government commit ongoing funding for digital mental health research, considering the increased prevalence of mental health problems and rapid expansion of virtual mental health care.

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95 Ms Gill Callister, Chief Executive Officer, Mind Australia Ltd, *Committee Hansard*, Canberra, 26 July 2021, page 22.

96 Dr Addie Wootten, Chief Executive Officer, Smiling Mind, *Committee Hansard*, Canberra, 26 July 2021, page 22.

97 Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group, Occupational Therapy Australia, *Committee Hansard*, Canberra, 26 July 2021, page 14.

98 MBS Review Taskforce, *Telehealth Recommendations 2020*, 14 December 2020, page 18.

4.115 The Committee supports Recommendation 3 of the MBS Review Taskforce's Telehealth Recommendations 2020 report for the Australian Government to invest in an evaluation of telehealth and virtual health care to ensure that its delivery through the MBS is best suited for both virtual mental health and the Australian context.

4.116 The Committee also supports the Australian Government's continued investment in digital health capabilities, and supports any action that further strengthens virtual mental health care, data use and information sharing systems, to maximise system efficiencies.

Recommendation 9

4.117 The Committee recommends that the Australian Government embed and expand virtual mental health care in the next National Digital Health Strategy (2022-27).

5. Workforce

5.1 The Committee's terms of reference identified the mental health workforce as a critical focus for the inquiry both in terms of capacity to respond to events such as the 2019 bushfires and COVID-19 pandemic, and strengthening its capacity meet the increasing demands.

5.2 Accordingly, the Committee examined the roles, training and standards for health and allied health professionals who contribute to mental health care, that are required to deliver quality care at different levels of severity and complexity, and across the spectrum of prevention, early intervention, treatment and recovery support.

5.3 In addition, the Committee considered the valuable contribution of peer workers, carers and volunteers and the support needed for these groups, and workforce wellbeing.

Australian Government review of workforce

5.4 The Productivity Commission Inquiry Report on Mental Health (Productivity Commission Report) identified workforce reforms as integral to healthcare reforms, suggesting that increasing use of supported online treatments and group therapy would help to free up psychologists and other care providers to assist those with more complex needs.[1] Refer to Chapter 4 of the Committee's report for further discussion about digital and online services.

5.5 However, the Productivity Commission anticipated that 'there would still be workforce shortfalls in some specialisations and in some locations' and that

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1 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020.

workforce planning and changes to workforce education could 'help reduce both these workforce shortages and professional stigma.'[2]

5.6 The Productivity Commission Report recommended increasing the efficacy of Australia's mental health workforce, and outlined a series of reforms to workforce planning and established workforce practices, and sector perceptions for consideration by the Australian Government and state and territory governments.[3]

5.7 In responding to the Productivity Commission's Report, the Prime Minister emphasised the centrality and need for a skilled, comprehensive workforce:

> Building up our care workforce, and in particular, our mental health workforce, will be vital to how successful we are. We must build a workforce inside and beyond the health system from peer workers, community workers. And as well, of course, our clinical workforce. It must be compassionate and it must take a recovery-based approach.[4]

5.8 The Australian Government's 2021-22 Budget followed up on the government's commitment with a $128.4 million package of investments to increase capacity and improve the capability of the mental health workforce, including $58.8 million for growing and upskilling the mental health workforce.[5]

5.9 To address workforce issues, the Australian Government established an independent taskforce, the National Mental Health Workforce Strategy Taskforce, to work with the Commonwealth Department of Health and the National Mental Health Commission (NMHC) in jointly developing a 10 year National Mental Health Workforce Strategy.

5.10 The strategy would address the quality, supply, distribution, and structure of Australia's mental health workforce, and integrate with other related workforce strategies including the National Medical Workforce Strategy, the Stronger Rural Health Strategy, the National Aboriginal and Torres Strait

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2 Stephen King, Commissioner, Productivity Commission, 'A Brief Overview of the Mental Health Inquiry Report', *Speech to the Mental Health Coordinating Council*, 6 May 2021, page 5.

3 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, page 700.

4 The Hon Scott Morrison MP, Prime Minister, 'Speech – Parkville', Speech, 16 November 2020, www.pm.gov.au/media/speech-parkville, viewed 5 October 2021.

5 Department of Health, *Overview – How the 2021–22 Budget is investing in the health workforce*, 11 May 2021.

Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031, and state and territory mental health workforce strategies.

5.11 A consultation draft was released in August 2021 to seek views from stakeholders. The final strategy is expected to be provided to the Australian Government before presentation to all governments under the Australian federal relations architecture.[6]

Overarching workforce views

5.12 In its interim report, the Committee expressed concern about workforce shortages and reiterated its intention to hear stakeholder views on the distribution of registered mental health professionals both geographically and across specialities, the role of professional bodies and recognition of the various mental health professions, and the drivers for workforce participation.

5.13 The Black Dog Institute raised concerns around the contradiction of increasingly encouraging help-seeking for mental problems when there are not enough mental health professionals to meet demand. On this basis, the Institute identified workforce issues as the top priority to enabling reform of the mental healthcare system:

> There are simply not enough mental health professionals in Australia. There are not enough psychiatrists, psychologists, mental health nurses, GPs [general practitioners] with a special interest … Of course, part of the solution to this is going to be more funding for training, but that alone is not going to be enough … we need a comprehensive plan around recruitment, around training, around retraining other professionals to come into mental health and around retention.[7]

5.14 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) reinforced access challenges, particularly in regard to psychiatrists. To help alleviate the pressure on psychiatrists, RANZCP suggested increasing 'the capacity and the knowledge and skills of people who interface with patients who present with psychiatric problems', noting this would include general

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6 Department of Health, 'National Mental Health Workforce Strategy Taskforce', www.health.gov.au/committees-and-groups/national-mental-health-workforce-strategy-taskforce, viewed 21 September 2021.

7 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, pages 1-2.

practitioners (GPs), emergency physicians, geriatric physicians and nursing care professionals.[8]

5.15 Similarly, NMHC identified an immediate need to embed in educational processes the importance of mental health training, particularly tertiary education for professional disciplines. NMHC suggested moving this training 'from being optional to being a core component of their education'.[9]

5.16 Equally Well noted that frequently the physical health of people living with mental illness is overlooked. To address this, it recommended:

> Ensuring quality physical healthcare for people living with mental illness be included in the roles, training and standards of all health and allied health professionals who contribute to mental healthcare, including peer workers and general practice.[10]

5.17 Mental Health Australia (MHA) cautioned government 'to resist the urge to do small or targeted pieces of renovation to the system rather than think of the whole system', particularly when considering workforce.[11] Similarly, Mental Health Victoria submitted that a fragmented system cannot be fixed with a fragmented approach to reform.[12] Instead, MHA recommended taking multiple approaches across the spectrum of care.[13]

5.18 A clinical and medical model alone has not provided the complete solution over the last 50 years, said HelpingMinds:

> … we feel that complementary supports—such as peer supports, recovery colleges, alternatives to suicide peer support groups, peer-led Safe Haven cafes—are vital if we're looking to find solutions, going forward.[14]

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8 Associate Professor Vinay Lakra, President, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Committee Hansard*, Canberra, 6 August 2021, page 11.

9 Ms Christine Morgan, Chief Executive Officer, National Mental Health Commission (NMHC), *Committee Hansard*, 18 March 2021, page 18.

10 Equally Well Australia, *Submission 137*, page 7.

11 Dr Leanne Beagley, Chief Executive Officer, Mental Health Australia (MHA), *Committee Hansard*, Canberra, 3 June 2021, page 3.

12 Mental Health Victoria, *Submission 144*, page 3.

13 Dr Leanne Beagley, Chief Executive Officer, Mental Health Australia (MHA), *Committee Hansard*, Canberra, 3 June 2021, page 3.

14 Mrs Deborah Childs, Chief Executive Officer, HelpingMinds Ltd, *Committee Hansard*, Canberra, 19 July 2021, page 26.

5.19 Further, Beyond Blue lobbied for the inclusion of lived experience across all sectors to underpin sustainable, large-scale reform of the mental health and suicide prevention systems:

> This transformational re-centring of lived experience requires a concerted shift and must bring everyone along the journey. It must be done in partnership, not only with consumers and carers, but also the sector organisations, mental health services, peak bodies, clinicians and the non-clinical workforce. The delivery of joined up care involves everyone and an informed and balanced system must embrace all voices and expertise.[15]

Defining roles and scope of mental health professionals in workforce planning

5.20 The National Mental Health Workforce Strategy consultation draft recognised the indivisible connection between people's physical, psychological, social, emotional and cultural wellbeing, noting it drew heavily on the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023. The draft strategy defined the mental health workforce across four categories – health and social and emotional wellbeing workforces; social services workforces; carers, families and communities; and alternative therapists – and included the following distinction:

- people who work exclusively in the mental health sector (for example Aboriginal and Torres Strait Islander mental health workers, mental health nurses and psychiatrists)
- those working in other health settings who frequently treat, interact with, care and support people experiencing suicidality, mental distress and/or ill-health (for example allied health, general practitioners and nurses).[16]

5.21 Noting the chronic workforce shortage, headspace called for a 'greater emphasis and understanding of what exactly is required from a range of different mental health clinicians—those with lived experience, peer workers and others within the primary healthcare system'.[17]

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15 Beyond Blue, *Submission 157*, page 6.

16 Department of Health, 'National Mental Health Workforce Strategy – Consultation Draft', *ACIL Allen*, August 2021, page 3.

17 Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 24.

5.22 Professor Ian Hickie from the Brain and Mind Centre at the University of Sydney pointed out that the first priority should be determining 'what do people do, and what is their role in achieving the outcome of interest', and how that role factors into a multidisciplinary workforce:

> … the appropriate use of professional skills at critical points along the illness journey, results in much more efficient care.[18]

5.23 Family and Relationship Services Australia reiterated that 'workforce issues impacting the mental health sector extend beyond the parameters of the health system', noting that 'many family and relationship services sector workers share common skills, training, knowledge and qualifications'. It recommended that a complementary family and relationship services workforce strategy be developed alongside the National Mental Health Workforce Strategy.[19]

Building a connected, diverse and engaged mental health workforce

5.24 Orygen and SANE Australia called for greater incentives to encourage people to join the mental health workforce, with initiatives to reduce professional stigma and highlight the potential for a career with a great sense of purpose.[20] Professor Patrick McGorry from Orygen suggested a national campaign:

> You know the ads that you see on TV [television] for joining the military? They make it sound like it's the most wonderful experience of your whole life. So marketing and communications would be a key thing as well that could be done straight away.[21]

5.25 The Productivity Commission Report recommended further steps be taken 'to reduce the negative perception of, and to promote, mental health as a career option', and 'to incorporate mental health stigma reduction programs

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18 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 28.

19 Family and Relationship Services Australia, *Submission 152*, pages 8-9.

20 Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 28; Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 27.

21 Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 27.

into the initial training and continuing professional development requirements of all health professionals'.[22]

5.26 The Queensland Mental Health Commissioner identified a number of areas that need to be addressed to attract and retain staff:

- reducing system and back-office requirements placed on clinicians to free them up to spend more time doing what they were trained to do
- place a greater focus on a shared workforce between public, private and non-government sectors
- expand the workforce to include peers and degree level counsellors
- improve training for mental health staff, and enhance mental health skills and capabilities in workforces employed by sectors, such as child safety, education, corrections and housing.[23]

5.27 The Northern Territory Department of Health reinforced the view that the current mental health system remains a medicalised model of care, noting 'access to a skilled workforce remains limited with counsellors and psychotherapists outside of the MBS [Medicare Benefits Schedule] umbrella'. The department identified peer workers as a priority and asserted that 'workforce development should cover associated elements of integrated planning, implementation science and change management'.[24]

5.28 In terms of positioning the workforce for the future, Professor Francis Kay-Lambkin highlighted the national consultation around capacity-building needs of the mental health workforce undertaken by Australia's Mental Health Think Tank, and put forward a series of practical solutions to address the gaps and opportunities:

- For those in the early stages of their career, create a network of peers to promote and support cohort interactions, interactions with key stakeholder groups.
- Short, flexible and easily accessible modules to improve transferable skill development based on evidence, support the development of professional skill building for both service delivery as evidence emerges for Doctors of Philosophy and research embedded in everyday mental

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22 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, Actions 16.6 and 16.7, page 700.

23 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, pages 2, 6.

24 Northern Territory Department of Health, *Submission 186*, page 3.

health service delivery and help people position themselves for clinical and research leadership in mental health.

- Seed funding collaborations and schemes, leveraging and enhancing that link between research and practice, including embedding researchers into mental health services and vice versa.
- A navigation function to help people map and understand the multiple career pathways for mental health workforces in Australia and internationally, including beyond traditional approaches.[25]

5.29 To create workable solutions in mental health, Professor Maree Teesson from the Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney and Chair of Australia's Mental Health Think Tank suggested harnessing Australia's capacity for innovation to bring together major national innovators in workforce education and training, and break down the silos of expertise.[26]

5.30 MHA supported the proposition that the Australian Government 'create a national workforce institute to drive national mental health workforce reform, professional development, and leadership across the mental health sector'.[27]

5.31 Professor Alan Rosen from Transforming Australia's Mental Health Service Systems explained that the institute should be nationally inclusive of other partners to ensure coordination and representation in every state and territory, with a focus on consistent, up-to-date, evidence based modules of care being trained in teams. Professor Rosen also noted the importance of 'all-of-system support':

> … in other words, a platform for consistent supervision. A lot of mental health staff either don't get supervision or don't stay because they don't get sufficient supervision in a complex field. The other piece of that is also having consistent pastoral mentorship and communities of practice so that people have company in developing the best way to sustain those innovations.[28]

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25 Professor Frances Kay-Lambkin, National Health and Medical Research Council Leadership Fellow, University of Newcastle, *Committee Hansard*, Canberra, 29 July 2021, page 3.

26 Professor Maree Teesson, Director, Matilda Centre for Research in Mental Health and Substance Use, University of Sydney, *Committee Hansard*, Canberra, 29 July 2021, pages 1-2.

27 MHA, *Submission 69*, page 17.

28 Professor Alan Rosen AO, Chair, Transforming Australia's Mental Health Service Systems, *Committee Hansard*, Canberra, 29 July 2021, pages 2-3.

Committee comment

5.32 The Committee remains concerned that a career in mental health may be considered by some as a second rate medical career, rather than the opportunity to embark on a pathway dedicated to helping people live their best lives.

5.33 In addition to dealing with any remaining stigma associated with pursuing a career in mental health, the Committee would like to see clearly understood education and career pathways for anyone interested in joining the mental health workforce. To increase the diversity of the workforce, the pathways should be visible, accessible and appropriate and encourage entry of people from vulnerable and disadvantaged populations.

5.34 The Committee endorses the concept of a national workforce institute for mental health, and would like to see this realised as a priority. Innovation and collaboration will help drive forward the reforms needed to build a connected, diverse and engaged mental health workforce.

Recommendation 10

5.35 The Committee has found that a workforce strategy is key to improving the mental health of all Australians and on this basis recommends that the Australian Government provide funding and other supports needed for the immediate development of a national workforce institute for mental health. The institute must:

- **include Aboriginal and Torres Strait Islander peoples and lived experience expertise**
- **incorporate professional stigma and burnout reduction strategies**
- **develop avenues for mental health supervision and debriefing for all participants in the mental health workforce.**

Competing for professionals

5.36 An unintended consequence of the substantial increase in demand for mental health services and additional funding being provided to help address service shortages is competition for scarce human resources across the public, private and non-government sectors.

5.37 Evidence received from across the sectors acknowledged the challenges of attracting and retaining staff, and the increasing difficulty where there were compounding issues such as funding shortfalls and geographical challenges.

5.38 Acknowledging the supply side challenges, SANE Australia noted that the introduction of the National Disability Insurance Scheme (NDIS) had exacerbated competition for people with skills and qualifications both for junior levels and clinical roles:

> … especially when a number of measures are announced at once we're now … in competition and trying to get our job ads out as quickly as possible.[29]

5.39 In Western Australia, Adjunct Associate Professor Learne Durrington highlighted the relatively mobile workforce and the difficulties non-government organisations (NGOs) face in attracting mental health professionals:

> … particularly those psychologists and clinical psychologists that we'd want to see working in not-for-profit organisations in our country areas. They're often employed in the state system for no other reason than salaries, conditions, wages and other things that an NGO can't afford.'[30]

5.40 Stride Mental Health explained that the limited pool of people and direct competition with public services meant it was not always possible to retain experienced and qualified people:

> It's across our sectors, our revenue streams and our service streams. So it doesn't matter if it's a psychologist, practitioner, support worker or residential worker—it is about finding people. It becomes more and more difficult the more you enter into the rural areas. It becomes, in some cases, near impossible to find somebody that could actually help us, even if we had funding.[31]

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[29] Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 28.

[30] Adjunct Associate Professor Learne Durrington, Chief Executive Officer, WA Primary Health Alliance and Chair, National PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 8.

[31] Mr Drikus van der Merwe, Acting Chief Executive Officer, Stride Mental Health, *Committee Hansard*, Canberra, 29 July 2021, page 28.

5.41 headspace agreed that ‘it's always been hard in rural and remote and regional Australia’ but pointed out that outer metropolitan areas equally struggle to attract and retain mental health professionals.[32]

5.42 Acknowledging the competitive labour market system employers face, headspace outlined the impact of this, including the breaking of therapeutic relationships, impacting the trust that had been established and potentially seeing people disengaging from services:

> They might associate themselves with coming to headspace, and that might be great, but it's actually about the relationship and rapport that they build with the individual worker. In some cases it can be a peer worker or a clinician. If there's a high turnover, that's not good for managing a service and keeping up with the demands and complex needs people are presenting with.[33]

Regional, rural and remote workforces – growing local services

5.43 Beyond Blue suggested that to address psychologist and psychiatrist shortages it is necessary to invest in new and different workforces, including peer workers and mental health coaches, as a means to deliver early intervention services in rural and remote communities:

> … where there are ongoing difficulties in attracting the workforce, we can really build up the capacity of the community to support their own community and to look after their mental health. That's an important piece of the puzzle.[34]

5.44 The Australian Rural Health Education Network (ARHEN) acknowledged the importance of medical practitioners, but noted that GPs in rural and remote areas are stretched and people’s mental health needs could be supported by increasing availability of a range of health professionals:

> There's recognition across the range of recent reports and inquiries about the role and value of allied health, particularly the capacity of allied health professionals to work from the continuum of early intervention and health promotion through to acute care and through to rehabilitation and support for people with chronic conditions. Being able to grow that capacity in rural and

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32 Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard,* Canberra, 26 July 2021, page 28.

33 Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard,* Canberra, 26 July 2021, page 28.

34 Ms Carolyn Nikoloski, Chief Strategy Officer, Beyond Blue, *Committee Hansard*, Canberra, 26 July 2021, page 29.

> remote communities would be very welcome and, I think, would go a long way to helping to support the wellbeing of people in the bush.[35]

5.45 In addition, the Royal Australian College of General Practitioners (RACGP) research indicates 'GPs practising in rural and remote locations would like to engage in advanced mental health training but are deterred by the financial cost and the time away from practice'. RACGP recommended 'incentive schemes equivalent to those for procedural skills would support GPs to develop or refresh advanced skills in mental health'.[36]

5.46 In terms of encouraging mental health professionals to live and work in rural and remote areas, ARHEN noted that many of the barriers are non-monetary and these need to be addressed in order to entice people to come and those who are already there to stay:

> … it's also about personal factors; professional factors; how well people are supported by their health service, by their colleagues, by their team; their quality of life; where they live; how their family is supported; the kids' schools; the partner's employment options and so forth.[37]

5.47 ARHEN recommended modelling the investment in pathways in medicine in rural and remote regions for allied health and nursing students.[38] ARHEN suggested helping students understand what a career pathway could look like in a rural and remote location provides both an incentive to go there and stay longer term:

> … one of the new models we're developing is a student led clinic. We encourage students to come and do their psychology placements or clinical placements in rural Victoria. They come for 20 weeks and they carry a case load, so those students are providing care to some of our patients and freeing up our senior clinicians to concentrate on complex care …
>
> Even if they [return to] work in an urban area, they just tend to be more supportive of rural practitioners.[39]

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35 Ms Joanne Hutchinson, National Director, Australian Rural Health Education Network (ARHEN), *Committee Hansard*, Canberra, 17 June 2021, page 3.

36 Royal Australian College of General Practitioners (RACGP), *Submission 190*, page 6.

37 Ms Joanne Hutchinson, National Director, ARHEN, *Committee Hansard*, Canberra, 17 June 2021, page 3.

38 Professor Lisa Bourke, Chair, ARHEN, *Committee Hansard*, Canberra, 17 June 2021, page 3.

39 Professor Lisa Bourke, Chair, ARHEN, *Committee Hansard*, Canberra, 17 June 2021, pages 3-4.

5.48 The 2021-22 Budget included $11 million to boost the psychiatrist workforce by increasing the number of training places available, including in regional and remote areas, as well as additional funding to provide scholarships and clinical placements for nurses, psychologists and allied health practitioners.[40]

Committee comment

5.49 Over the years Australian governments have made commitments to providing equity of services to regional, rural and remote communities. Yet, Australia still has unacceptably high numbers of people unable to access the services they need in the right place at the right time.

5.50 The Committee was pleased to see the additional money in the 2021-22 Budget to increase training places for psychiatrists, and scholarships and clinical placements to develop other mental health professionals. Noting the skewed distribution of the mental health workforce, the focus of these placements should be on strengthening the regional, rural and remote mental health workforce.

Recommendation 11

5.51 The Committee recommends that the Australian Government leverage the existing Australian Rural Health Education Network by providing funding for clinical placements in regional, rural and remote university clinics, and using these clinics to trial multidisciplinary, hybrid mental health hubs that integrate digital services and face-to-face services.

Aboriginal and Torres Strait Islander workforce

5.52 There has been extensive research, strategies and frameworks developed over many years by governments, Aboriginal and Torres Strait Islander organisations, academics, NGOs and more, yet limited progress has been made toward building the Aboriginal and Torres Strait Islander mental health workforce.

5.53 The draft National Mental Health Workforce Strategy background paper acknowledged the 'difficulties in accessing data on the size of the Aboriginal and Torres Strait Islander workforce', and as with other areas that lack data,

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[40] NMHC, *2021-22 Federal Budget: Initiatives for the mental health and suicide prevention workforce*, www.mentalhealthcommission.gov.au/getmedia/5672c984-3471-4428-8c22-330d5d9e0c03/2021-2022-Federal-Budget-mental-health-workforce-information-sheet.pdf, viewed 24 September 2021.

this impedes workforce planning. However, the paper was clear that Aboriginal and Torres Strait Islander peoples are under-represented within the mental health workforce, and there has been no real improvement.[41]

5.54 The Australian Government 2021-22 Budget included '$8.3 million to support greater representation of Aboriginal and Torres Strait Islander peoples in the mental health workforce through additional mental health-specific scholarships and to provide training to support healthcare workers to deliver culturally safe care'.[42]

5.55 A refreshed co-designed National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031 is expected to be launched soon.[43]

5.56 The National Aboriginal Community Controlled Health Organisation (NACCHO) confirmed the 'lack of Aboriginal and Torres Strait Islander mental health service providers, and culturally competent services', noting this as 'one of the main drivers of poor access to services and poorer mental health outcomes for our people':

> Sufficient recommendations to address this shortfall were missing from the recent reports presented to government. There is a significant shortage of Aboriginal and Torres Strait Islander psychiatric leadership and trained mental health professionals, particularly clinical psychologists.[44]

5.57 NACCHO called for new funding measures to attract and retain mental health professionals within the Aboriginal Community Controlled Health Organisations:

> Long-term and sustainable funding is needed to ensure that our Aboriginal Community Controlled Health Organisations can create integrated and sustainable workforces and ensure existing staff receive appropriate training

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41 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, pages 21, 29.

42 NMHC, *2021-22 Federal Budget: Initiatives for the mental health and suicide prevention workforce,* www.mentalhealthcommission.gov.au/getmedia/5672c984-3471-4428-8c22-330d5d9e0c03/2021-2022-Federal-Budget-mental-health-workforce-information-sheet.pdf, viewed 24 September 2021.

43 Department of Health, 'How we support the Aboriginal and Torres Strait Islander health workforce', www.health.gov.au/health-topics/indigenous-health-workforce/how-we-support, viewed 1 October 2021.

44 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (NACCHO), *Committee Hansard*, Canberra, 12 August 2021, page 8.

> to provide consistent access to services for clients. This needs to occur in line with the strategies for the upcoming national Aboriginal and Torres Strait Islander Work Force Plan 2021-31.[45]

5.58 The Queensland Aboriginal and Islander Health Council called for governments to 'establish an Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing workforce target', and develop the Aboriginal and Torres Strait Islander Community Controlled Health Organisations sector's capability to develop a local skill-based workforce to meet local demand.[46]

5.59 The Aboriginal Health and Medical Research Council of NSW drew attention to the 'lack of scholarships available outside mainstream organisations to expand the existing workforce, noting that mainstream organisations have an inconsistent approach to cultural competency practices including in training staff.'[47]

5.60 The Committee heard improving access and outcomes for Aboriginal and Torres Strait Islander peoples will require growing the workforce capability and capacity. Gayaa Dhuwi (Proud Spirit) Australia advised it is working with key partner organisations to 'encourage enabling opportunities for the immediate establishment of a highly skilled and supported Aboriginal and Torres Strait Islander workforce, operating in a clinical, competent and culturally safe way within community controlled services and within the mainstream system', including by:

> … [developing] career pathways for the Aboriginal and Torres Strait Islander mental health workforce, and by having Aboriginal and Torres Strait Islander led national standardised assessments for cultural safety and the services of staff in mainstream mental health and human services.[48]

5.61 Both Gayaa Dhuwi and the Kimberley Aboriginal Law and Cultural Centre (KALACC) advocated for training to take place on the ground rather than bringing people into cities. KALACC stated:

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45 Ms Patricia Turner, Chief Executive Officer, NACCHO, *Committee Hansard*, Canberra, 12 August 2021, page 8.

46 Queensland Aboriginal and Islander Health Council, *Submission 142*, page 2.

47 Aboriginal Health and Medical Research Council of NSW, *Submission 88*, page 6.

48 Mr Thomas Brideson, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, Canberra, 24 June 2021, page 2.

> … nothing beats actually engaging a local Aboriginal owned and directed institution with the resources to deliver that learning on the ground. In that sense I think it's more about partnerships than training … on the ground, people are working side by side with dealing with day-to-day issues that are requiring immediate responses, so they will draw on that expertise. That expertise needs resourcing within community based organisations.[49]

5.62 Noting that COVID-19 had driven increased use of digital services, Gayaa Dhuwi suggested exploring options of ‘a good mixture of place based education and training, but also enabling people to come together.‘[50]

5.63 Professor Rosen from Transforming Australia’s Mental Health Service Systems highlighted the importance of national consistency of training and supervision, and ensuring that Aboriginal mental health workers and healers are included in every interdisciplinary team. However, he noted that to do this required sufficient Aboriginal mental health workers trained:

> There is only one coherent degree training program in Australia. That's Charles Sturt at Wagga, and some other states, particularly Edith Cowan, feed into that and send their students there, sometimes virtually. But the important thing is that these should be established consistently around the country.[51]

5.64 Professor Rosen pointed out that one state and one territory had set important precedents by legislating to require that ‘when somebody is being considered for involuntary care, they should be assessed by an Aboriginal mental health worker or a traditional healer within the team setting’. However, he raised concerns that ‘we haven't got the workforce trained to be in those positions’.[52]

Committee comment

5.65 The Committee is acutely aware of the need to make real progress on increasing the number of Aboriginal and Torres Strait Islander peoples in the mental health workforce across all professions. There is not a need for

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49 Mr Stephen Kinnane, Research Coordinator, Kimberley Aboriginal Law and Cultural Centre, *Committee Hansard*, Canberra, 19 July 2021, page 17.

50 Mr Thomas Brideson, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, Canberra, 24 June 2021, page 4.

51 Professor Alan Rosen AO, Chair, Transforming Australia’s Mental Health Service Systems, *Committee Hansard*, Canberra, 29 July 2021, page 4.

52 Professor Alan Rosen AO, Chair, Transforming Australia’s Mental Health Service Systems, *Committee Hansard*, Canberra, 29 July 2021, page 4.

more words. Instead, this is a call to action for all those in decision-making positions to take note of the work that has been done and focus on implementation.

5.66 While acknowledging the tangible step of making funding available in the 2021-22 Budget for scholarships, the Committee remains concerned that those taking up these scholarships may find themselves in learning institutions that are not teaching culturally appropriate, trauma-informed programs that have been co-designed with Aboriginal and Torres Strait Islander peoples.

5.67 The Committee draws attention to the comments and recommendation in Chapter 8 on improving cultural competency across the mental health workforce.

5.68 In addition, the Committee calls for more to be done to open the pathways to careers in mental health and suicide prevention, support Aboriginal and Torres Strait Islander students who have chosen to follow a mental health or suicide prevention pathway and improve university completion rates.

Recommendation 12

5.69 The Committee recommends that the Australian Government led by Aboriginal and Torres Strait Islander representatives, engage with state and territory governments, education authorities, schools and tertiary institutions to increase visibility and promote careers in mental health and suicide prevention for Aboriginal and Torres Strait Islander peoples, including students at high school and tertiary institutions.

Coordinated care for suicide prevention, intervention and postvention services

5.70 Recommendation 4 in the National Suicide Prevention Adviser Final Advice to the Prime Minister proposed 'evidence-based and compassion-focused workforce development to drive cultural change in and improve the capacity and capability of all (formal and informal) workforces involved in suicide prevention'. [53] Ms Christine Morgan, in her capacity as National Suicide Prevention Adviser to the Prime Minister, outlined the immediate actions required for implementation:

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53 National Suicide Prevention Adviser Final Advice, *Executive Summary*, December 2020, page 7.

- clinical health staff evidence-based contemporary training so that anybody in health services knows what to do about suicide and suicidal ideation
- compassion-based training for frontline workers responding to distress, especially financial, employment and relationship support, which will assist the responder to identify distress and work toward safe containment
- development of a national suicide prevention workforce strategy.[54]

5.71 Guided by the final advice of the National Suicide Prevention Adviser, the Australian Government's 2021-22 Budget allocated $298.1 million towards suicide prevention, including funding:

> - for a National Suicide Prevention Office to oversee the national whole-of-government approach to suicide prevention [including workforce reform], and
> - to expand the National Suicide Prevention Leadership and Support Program.[55]

5.72 Suicide Prevention Australia advised that while it had not quantified the clinical workforce needed for suicide prevention services, 'less than half of the people who die by suicide access or need access to the mental health system'. Instead, it suggested that the first step is to ascertain where the need is coming from and what supports are most appropriate:

> It's often other life events that can lead a person to suicidal distress, such as marriage breakdown, economic instability and/or job loss, and housing distress. They are the elements that have an impact on a person's potential suicide risk …
>
> There is that model of peer support, where it's not about a clinical issue but mates helping mates … Those sorts of workforces, so to speak, are critical in ensuring there's that safety net for people, preventing them from getting to suicidal distress.[56]

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54 Ms Christine Morgan, National Suicide Prevention Adviser to the Prime Minister, *Committee Hansard*, Canberra, 13 May 2021, page 6; National Suicide Prevention Adviser Final Advice - Slide Presentation, *Additional Information*, 13 May 2021, page [11].

55 The Hon Greg Hunt MP, Minister for Health and Aged Care et al, 'Generational change and record investment in the health of Australians', Joint Media Release, 11 May 2021, page 6; the Hon Greg Hunt MP, Minister for Health and Aged Care, 'A New National Approach on Suicide Prevention', Media Release, 10 September 2021.

56 Ms Nieves Murray, Chief Executive Officer, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, pages 9-10.

5.73 The Northern Territory Department of Health encouraged a strong focus on evidence-based decision making to ensure that approaches taken in different areas match the needs:

> Workforce capability across the care continuum should focus on ensuring that skillset gaps are targeted across all roles and responsibilities, as opposed to only strengthening suicide prevention focussed roles. All roles, when taking into account a health and wellbeing approach to suicide prevention, have the capacity to prevent trajectory towards suicidal behaviours.[57]

5.74 Referring to suicide prevention in Aboriginal communities, KALACC noted that funding continues to go toward building evidence, despite the extensive research base already available, 'some 40 reports over a period of 15 years'. KALACC referred to a 2012 paper 'Cultural wounds require cultural medicines', in which the author concluded that 'cultural wounds require cultural healing; they don't require more health workers'. The role of culture in mental health is explored further in Chapter 8.

5.75 The Zero Suicide Institute of Australasia proposed that 'until such time as prevention is achieved establishing services to meet immediate need for de-escalating a crisis is critical and should be done in an integrated way'.[58] Further, the Institute flagged insufficient suicide prevention content in undergraduate courses, meaning that 'many of the people who are mental health trained have not had that additional experience of being trained to work with suicidal people'. It suggested that training include increasing capabilities around undertaking suicide risk assessments and developing safety plans with at-risk individuals.[59]

5.76 Wesley Mission noted the importance of training front-of-house staff to intervene and support people at risk of suicide:

> … if they can recognise that Joe, who called in today, sounded different from the day before and wanted an imminent appointment with the GP, perhaps with that training there's a mechanism whereby the administration workers are able to create a five-minute window in the GP's day and that enables

57 Northern Territory Department of Health, *Submission 186*, page 6.

58 Zero Suicide Institute of Australasia, *Submission 110.1*, page [2].

59 Ms Susan Murray, Managing Director, Zero Suicide Institute of Australasia, *Committee Hansard*, Canberra, 29 July 2021, page 33.

> access. It also enables a greater sense of support and common language to assist the GP operating day-to-day in that practice.[60]

5.77 Forensicare called for 'additional training and support for GPs and frontline staff, including psychologists, regarding additional considerations for suicide and self-harm risk assessment and management of people released from prison'. Forensicare noted that experience has shown that 'they're often ill-equipped to manage the group, let alone to deal with the suicide and self-harm risk'.[61]

5.78 More broadly, Lifeline Australia recommended 'the inclusion of suicide prevention training standards in the National Mental Health Workforce Strategy for all health and allied health professionals to ensure people at risk of experiencing suicidal behaviour are supported into appropriate care'.[62]

5.79 With a focus on aftercare, StandBy highlighted the need for greater capability in postvention across all workforces who may be in touch with people bereaved by suicide, including clinical and non-clinical staff, as well as health, justice, education and housing. StandBy recommended a national workforce competency based framework to improve coordination and capability, noting that it had started work at the state level with funding from New South Wales (NSW) Ministry of Health.[63]

A holistic approach to upskilling for suicide intervention

5.80 The Zero Suicide Institute of Australasia commended its Zero Suicide Healthcare Framework as a highly effective means of achieving reductions in suicides in people who present to the health system, and outlined the workforce requirements:

> ... a commitment by leadership to a just and restorative culture, one that removes blame when an adverse event occurs, one that has a belief that suicide is an unacceptable outcome in a modern healthcare setting and that lived experience leadership is integral to their service. There is also a

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60 Mr James Bell, Group Manager, Wesley Mission, *Committee Hansard*, Canberra, 16 June 2021, page 3.

61 Distinguished Professor James Ogloff AM, Director, Centre for Forensic Behavioural Science, Swinburne University of Technology and Executive Director, Psychological Services and Research, Forensicare, *Committee Hansard*, Canberra, 19 July 2021, page 30.

62 Lifeline Australia, *Submission 52*, page [8].

63 Ms Karen Phillips, General Manager, StandBy Support After Suicide, *Committee Hansard*, Canberra, 21 July 2021, pages 40-41; Mr Stephen Scott, Partnerships Manager, StandBy Support After Suicide, *Committee Hansard*, Canberra, 21 July 2021, page 41.

> teamwork approach where staff are trained and competent and confident to work with people who are suicidal in a respectful manner that is free from discrimination; collaborative management of suicidality that actively involves the individual, their clinician and their support network; and data and implementation signs are used to deliver continuous improvement.[64]

5.81 The Gold Coast Mental Health and Specialist Services (GCMHSS) began implementing the Zero Suicide Healthcare Framework in 2016 and '[w]ithin a three year period, they had achieved a better than 23 per cent reduction in suicides for those who came to their healthcare system'.[65] Clinical Director, Dr Kathryn Turner, provided additional background on the change in management processes, training, and support put in place at GCMHSS:

> It really was around changing attitudes and beliefs of clinicians. That whole-of-service approach, that whole framework, is what makes this different from just implementing a new team or implementing a particular intervention. What it also does is allow you, within that framework, to implement interventions effectively. A lot of it is about a change management process, which is incredibly difficult to achieve in complex services. We engaged all of the workforce. We trained all of the workforce, in specific interventions, so they had greater confidence. We gave a clear pathway ... It's both that clinical focus and that cultural focus, and that's about engaging with families following incidents and supporting them, and it's about supporting clinicians and about having a learning organisation where we can learn and continuously improve …
>
> We've worked in partnership with, in state-wide training, the Queensland Centre for Mental Health Learning. They had some training directly targeted towards emergency departments. We liked some components of that, particularly that they were training in the chronological assessment of suicide events but also about attitudes and beliefs, well, and about risk factors et cetera. They are the basics that we've probably all been doing for a long time, in terms of the basic risk assessment. The Chronological Assessment of Suicide Events is from the US, from Shawn Shea, and it particularly skills clinicians. It's often very difficult to elicit suicidal intent when you are seeing someone, and it gives clinicians increased skills ...
>
> The other sort of investment that we had was in a senior psychologist who can go out to teams and continually supervise, model and provide feedback. So it's

64 Ms Susan Murray, Managing Director, Zero Suicide Institute of Australasia, *Committee Hansard*, Canberra, 29 July 2021, page 31.

65 Ms Susan Murray, Managing Director, Zero Suicide Institute of Australasia, *Committee Hansard*, Canberra, 29 July 2021, page 31.

> an ongoing process after that initial training, because you can't expect that you will get much change with one day of training ...
>
> … we see huge volumes of consumers and you can't predict who will go on to suicide. Yet, when something happens, the old way of doing incident reviews used to make the assumption that someone could have predicted it. That contributes to a sense of, 'How can we make a difference if we can't even predict who will go on to suicide?' So this shifts the whole thinking to a prevention oriented one: we can't predict but we can put in a whole range of steps and we can support staff and engage with consumers and provide a better level of care that we believe will prevent many suicides.[66]

Committee comment

5.82 Zero suicides are what Australia is seeking to achieve. While aspirational, this reminds us that there should not be any suicides that occur because there were no effective services available at the time of need, or in the after-care period of an attempt.

5.83 The Committee commends the sizeable investment in suicide prevention in the 2021-22 Budget, but notes that successful implementation will depend on building capability and capacity of a dedicated suicide prevention workforce, as well as upskilling the existing mental health workforce and those in frontline services.

5.84 The establishment of the National Suicide Prevention Office is a good first step and the Committee looks forward to seeing meaningful progress on workforce reform, including the integration of lived experience, and coordination with states and territories.

5.85 While the National Mental Health Workforce Strategy consultation draft includes references to suicide prevention, the Committee would like to see a discrete section on the development of the suicide prevention and aftercare workforce, and endorses Lifeline Australia's recommendation to include suicide prevention training standards in the National Mental Health Workforce Strategy.

5.86 The Committee was impressed by GCMHSS's complete redesign of services and change in management process to shift the workplace culture for suicide prevention. It is critical that there is a mechanism to harness these best

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66 Dr Kathryn Turner, Clinical Director, Gold Coast Mental Health and Specialist Services, *Committee Hansard*, Canberra, 13 August 2021, pages 13-14, 17.

practice examples and enable them to be embedded in education and training, and hospital settings around Australia.

5.87 In relation to the workforce to support Aboriginal and Torres Strait Islander peoples, the Committee encourages an increased focus on prevention and postvention through integrating culture into suicide prevention services and training and education for the Aboriginal and Torres Strait Islander mental health workforce.

5.88 The Committee also believes that the mainstream health, mental health and suicide prevention workforces would benefit from learning more about the role of culture, both in terms of supporting Aboriginal and Torres Strait Islander services, and in looking at ways to engage other vulnerable communities.

Recommendation 13

5.89 The Committee recommends that the Department of Health and the National Mental Health Workforce Strategy Taskforce include in the National Mental Health Workforce Strategy:

- **suicide prevention training standards for all health and allied health professionals and other professionals that form the suicide prevention workforce**
- **national standardisation of suicide training in risk assessments and safety plans, to ensure consistency and evidence-based training delivery**
- **specific references to the workforce development requirements for suicide aftercare and postvention.**

Professions contributing to the mental health and suicide prevention workforce

5.90 The following section reviews the professions contributing to the mental health and suicide prevention workforce. A number of recent reports, including the draft National Mental Health Workforce Strategy background paper,[67] have provided details on the role, training, regulation and supply of

[67] Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft), *ACIL Allen*, August 2021, pages 12-19.

component occupations. The discussion below reflects the areas that the Committee believed warranted further examination.

5.91 Chapter 6 explores funding arrangements for medical professionals, including through the Medicare Benefits Schedule (MBS) and Primary Health Networks (PHNs).

General practice

5.92 RACGP advised that member surveys indicated that psychological problems have been the most common reason for visiting the GP, particularly during COVID-19:

> General practice is definitely a very attractive place for people with mental health problems to go; they genuinely want to do it. I would say that for most GPs, at least 20 per cent of their workload would be directly dealing with people with mental health conditions.[68]

5.93 The Australian Medical Association (AMA) asserted that GPs should retain the role of first point of contact and care coordinator for mental health problems to 'deliver the right care to the right patient in the right way'. However, this was predicated on the basis patients in Australia should have access to a regular GP.[69]

5.94 AMA raised concerns that policy discussions have been 'shifting away from medically informed models of care and moving towards a more fragmented system':

> We believe that more has got to be done to bolster the mental health workforce and to support patients to access care in a coordinated and, of course, timely manner, and that's where GPs come in. They are the best place to coordinate mental health care treatment. GPs are at the core of our current system. They respond most rapidly to the needs of health in the community, partly because the rest of the system is so hard to access.[70]

5.95 This was a view supported by RACGP, which noted that while it may be tempting for people to go directly to a psychologist, this would remove the opportunity to do a physical health assessment prior to treatment being

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68 Dr Caroline Johnson, Member, Senior Representative, RACGP, *Committee Hansard*, Canberra, 24 June 2021, pages 8-9.

69 Dr Danielle McMullen, NSW President, Australian Medical Association (AMA), *Committee Hansard*, Canberra, 6 August 2021, page 40.

70 Dr Omar Khorshid, President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 35.

recommended. In addition, RACGP suggested that GPs are well-placed to support patients to adjust the intensity of treatment with a step-up, stepdown, or sideways to another mental health provider, as needed. Finally, acknowledging the shortage of psychiatrists, RACGP suggested that GPs have been able to filter those who may do well with a lower intensity intervention.[71]

5.96 However, the Productivity Commission found that the Australian Government needed to take action 'to improve practitioners' training on medications and non-pharmacological interventions'.[72] Appearing before the Committee, the Productivity Commission explained that after taking feedback from GPs, consumers, psychologists and psychiatrists, the evidence was clear that mental health treatment plans were variable in quality:

> Some are great, but many are not really fulfilling the function that they're meant to be. They're really little more than a referral.[73]

5.97 AMA commended the Australian Government's 2021-22 Budget inclusion of $15.9 million to help support GPs and other practitioners through training,[74] which included:

- subsidies for approximately 3,400 GPs to undertake training to provide focused psychological therapies under the General Practice Mental Health Standards Collaboration
- developing a nationally recognised Diploma in Psychiatry for medical practitioners.[75]

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71 Dr Caroline Johnson, Member, Senior Representative, RACGP, *Committee Hansard*, Canberra, 24 June 2021, page 10.

72 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, Action 16.3, page 700.

73 Dr Stephen King, Commissioner, Productivity Commission, *Committee Hansard*, Canberra, 18 March 2021, pages 3-4.

74 Dr Omar Khorshid, President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 35.

75 NMHC, *2021-22 Federal Budget: Initiatives for the mental health and suicide prevention workforce*, www.mentalhealthcommission.gov.au/getmedia/5672c984-3471-4428-8c22-330d5d9e0c03/2021-2022-Federal-Budget-mental-health-workforce-information-sheet.pdf, viewed 24 September 2021.

Education and training

5.98 According to RACGP, mental health is 'embedded in GP training and is a core part of RACGP's Curriculum for general practice and The Fellowship in Advanced Rural General Practice: Advanced Rural Skills Training – Curriculum for mental health'.[76]

5.99 RACGP explained that GP training starts in medical school, with the introduction of the concepts of diagnosis and treatment of mental illnesses and communication skills to support discussion of psychological concerns. This training is then complemented with 'at least two years in the hospital sector, where they will meet people who experience psychological difficulties or, indeed, mental illness'.[77]

5.100 RACGP noted that mental health is interwoven into the three-year GP training program, and subsequently, GPs have the option to do an extra six hours of Mental Health Skills Training:

> Over 90 per cent of Australian GPs have done that training, and then a smaller number of GPs have done up to 20 hours of training in focused psychological strategies. There are probably 500 to 1,000 GPs who have done that training …
>
> Focused psychological strategies are skills that are evidence based [and include] teaching patients simple cognitive and behavioural strategies, relaxation techniques, behavioural activation, structured problem solving—those kinds of techniques.[78]

5.101 However, RACGP raised concerns that disincentives are in place in the way Medicare funding for focused psychological strategies is structured within the Better Access initiative. RACGP recommended that:

> Access to mental health services in general practice will be improved by not counting mental health treatments provided by FPS [focussed psychological strategies] registered GPs in general practice as part of the capped number of psychologist services that are available to patients.[79]

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76 RACGP, *Submission 190*, page 6.

77 Dr Caroline Johnson, Member, Senior Representative, RACGP, *Committee Hansard*, Canberra, 24 June 2021, pages 6-7.

78 Dr Caroline Johnson, Member, Senior Representative, RACGP, *Committee Hansard*, Canberra, 24 June 2021, pages 6-7.

79 RACGP, *Submission 190*, page 8.

5.102 Reflecting on the education and training that junior doctors and medical students receive, AMA observed that most of their practical experience is likely to be in the public hospital sector:

> … often the education and training is focused on more severe, complex illnesses such as schizophrenia and other psychotic illnesses. We think there is much more to mental health care than what ends up in the public hospital ward.[80]

5.103 AMA noted that while continuing professional development requirements are about to change, there will continue to be no compulsory ongoing education in terms of mental health. While there is some financial incentive, this may be borne by the patient in non-bulkbilling practices:

> There is some degree of training, not mandated, that is linked to Medicare for mental health, to provide mental health treatment plans and a couple of other mental health items. If you've done further training, that is rebated to the patient at a higher rate than it is for GPs who haven't done that additional mental health training. So, while it's not compulsory, there is a financial incentive to the patient or to the doctor, depending on the billing model, to have undertaken some further training in mental health.[81]

5.104 Further discussion on MBS funding is included in Chapter 6 of the Committee's report.

5.105 The Black Dog Institute suggested that one of the more immediate actions to address gaps between primary and secondary mental health care would be to provide a clear pathway for training more GPs who have a special interest in mental health.[82]

5.106 To address urgent and growing needs in the community, Brisbane South PHN and Metro South Addictions and Mental Health Services facilitated research to identify potential improvements in delivering collaborative and coordinated, integrated care developed around the child and their family. The report recommended '[improving] the capacity and capability of GPs to assess and manage the mental health needs of children and young people', including through:

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80 Dr Danielle McMullen, NSW President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 36.

81 Dr Danielle McMullen, NSW President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 36.

82 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 4.

- Implementation of GP Psychiatrist Support Line, to connect GPs with psychiatrists who can provide advice on diagnosis, investigation, medication and safety planning.
- GP-focused capability development project with a focus on common child and adolescent mental health clinical dilemmas for GPs … This will include practice guidance/resources, education/training and specialist advice/support (as directed by GP reps), and leverage resources already in existence.[83]

5.107 AMA pointed out that 'at the moment, the Medicare rebates for mental health care are not equivalent to these similar physical health presentations' and contended that the general practice workforce should be remunerated and valued for the 'complexity and challenging nature of dealing with mental health problems'.[84]

5.108 In addition, AMA lobbied for:

- targeted investments into areas of the workforce, including mental health nurses and counselling services, 'to support GP clinics to deliver optimum and coordinated mental health care':
  - We want to see a commitment to medically governed, multidisciplinary teams supporting mental health care through both GP clinics and, of course, psychiatry practice at the higher acuity end. Of course, these things need to be designed at the local level to be responsive to local needs.[85]
- recognition of both the time and potential effect on clinicians undertaking complex mental health consultations:
  - AMA suggests that the government may wish to consider options around a formalised process of voluntary clinical supervision to allow debriefing and support for doctors working in mental health.[86]

Committee comment

5.109 The Committee agrees that the ideal scenario is for all people to have a regular GP who is able to provide holistic, comprehensive care, encompassing physical and mental health. However, the reality for many

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83 Brisbane South PHN and Metro South Addictions and Mental Health Services, *Submission 218*, page 5.

84 Dr Danielle McMullen, NSW President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 39.

85 Dr Omar Khorshid, President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 35.

86 AMA, *Submission 81*, page 3.

people, especially those socioeconomically or geographically disadvantaged, is that the best GP is the one that you can afford and is accessible at the point of time where a referral is needed.

5.110 Further, while a GP may list mental health as an area of interest, there does not appear to be a standardised requirement to indicate whether the GP has completed the training necessary to access the higher MBS rebate. The question becomes how people know in advance whether their GP has mental health training and how to ensure that patients are not disadvantaged with lower rebates because of a decision of the GP.

5.111 The Committee also notes that on graduation, GPs may have had limited exposure to the sorts of mental health presentations most prevalent in the community, and may benefit from placements in community settings to have greater exposure to people experiencing lower intensity mental health problems, including mild to moderate anxiety and depression.

5.112 The Committee would like to see universities increase the focus on mental health and suicide related education to reflect the high level of exposure that all medical doctors, and particularly GPs, are likely to experience.

5.113 The Committee notes that RACGP has taken a leadership role, including through chairing the government funded General Practice Mental Health Standards Collaboration (GPMHSC) Committee,[87]which has developed the 'Mental health training standards 2020–22: A guide for general practitioners'. The Committee would like to see further promotion of this training and the development of incentives to encourage GPs to undertake GPMHSC approved training and complete ongoing mental health continuing professional development.

5.114 In addition, the Committee supports the introduction of a diploma of psychiatry for medical practitioners and implementation of a national GP psychiatrist support line, to connect GPs with psychiatrists.

Recommendation 14

5.115 The Committee recommends that the Australian Government work with the Medical Board of Australia and the Royal Australian College of General Practitioners to:

[87] General Practice Mental Health Standards Collaboration, *Mental health training standards 2020–22: A guide for general practitioners*, October 2019.

- **review the core competencies required in mental health and suicide prevention for all medical students**
- **identify pathways for general practitioners in training to complete mental health and suicide prevention clinical placements that will expose them to the types of mental health presentations likely to be seen in practice**
- **develop incentives for general practitioners to access General Practice Mental Health Standards Collaboration approved training and continuing professional development.**

Psychiatry

5.116 Many people who would benefit from access to a psychiatrist are either unable to do so or face lengthy waitlists, particularly for specialty areas including child psychiatrists.[88] The draft National Mental Health Workforce Strategy background paper identified a critical shortage of psychiatrists, with only 66 per cent of the National Mental Health Service Planning Framework target reached.[89]

5.117 According to RANZCP, Australia has become reliant on international medical graduate specialists, particularly for gaps in outer metropolitan, rural and regional areas.[90]

5.118 As AMA noted, mild to moderate mental health problems are often able to be managed by GPs, working with a psychologist, counsellor or other allied health support. Nevertheless, there is a significant number of people who need psychiatry input for more severe or complex presentations.[91]

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88 RANZCP, *Submission 141.1*, page [2].

89 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, page 17.

90 Associate Professor Vinay Lakra, President, RANZCP, *Committee Hansard*, Canberra, 6 August 2021, page 8.

91 Dr Danielle McMullen, NSW President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 39.

5.119 The Australian Government 2021-22 Budget provided $11 million to boost the psychiatrist workforce by increasing the number of training places available, including in regional and remote areas.[92]

5.120 RANZCP pointed out that government funding for more training positions would not necessarily have an impact straightaway but 'if there are more training positions and we can attract more people into psychiatry straightaway it would help to distribute the workload and meet the demands we are facing'.[93] RANZCP set out for the Committee the training required to become a psychiatrist:

> In order for someone to become a psychiatrist, first of all, they need to do a medical degree. They need to have an MBBS [Bachelor of Medicine/ Bachelor of Surgery], or the equivalent medical degree, from a university in Australia or internationally. Once they have a medical degree and they've completed their internship, they can apply to get into a training position to become a psychiatrist—which is similar to all other specialties, whether you want to be a surgeon, a physician or a paediatrician. That training program is over a five-year period.[94]

5.121 RANZCP submitted that while it does not have a set number of accredited psychiatry posts, there are a number of factors that limit the number of training positions:

- Funding for training positions from the relevant state departments of health.
- Availability of RANZCP Fellows who are able to provide supervision. This can impact positions in rural locations.
- The capacity for the position to be able to meet RANZCP accreditation standards.
- The requirements and decisions of the service (including the service having mental health services and capacity to facilitate trainees).[95]

92 NMHC, *2021-22 Federal Budget: Initiatives for the mental health and suicide prevention workforce*, www.mentalhealthcommission.gov.au/getmedia/5672c984-3471-4428-8c22-330d5d9e0c03/2021-2022-Federal-Budget-mental-health-workforce-information-sheet.pdf, viewed 24 September 2021.

93 Associate Professor Vinay Lakra, President, RANZCP, *Committee Hansard*, Canberra, 6 August 2021, page 10.

94 Associate Professor Vinay Lakra, President, RANZCP, *Committee Hansard*, Canberra, 6 August 2021, pages 7-8.

95 RANZCP, *Submission 141.1*, page [2].

5.122 To increase access to psychiatric expertise, RANZCP suggested leveraging Commonwealth funding around training positions in the private sector:

> The MBS services are there. If there is a private psychiatrist who's working in a group practice or in a hospital practice and doing outpatient clinics, if they can have one, two or three—whatever number—of training positions, suddenly what happens is that that trainee can see more patients. It expands the number of people that psychiatrists can provide care to.[96]

5.123 The Black Dog Institute agreed that while part of the solution is more funding for training, it advised that the status of mental health, and observing the overwhelming burden in the system, discourages interest in a psychiatry career. To address this, the Institute recommended development of 'a comprehensive plan around recruitment, around training, around retraining other professionals to come into mental health and around retention'.[97]

5.124 Professor Perminder Sachdev expressed a similar sentiment about professional stigma in psychiatry, but noted there has been a gradual process bringing about change. Professor Sachdev suggested that there needed to be more done to address 'the pressure on psychiatrists and their disempowerment':

> … there is more managerial control of mental health services, much more so than other medical disciplines. Psychiatrists' power has gradually been taken, and students notice that. They notice the kind of work psychiatrists do and that probably does not really endear them to the profession to some extent.[98]

5.125 The Independent Private Psychiatrists Group raised concerns about a perceived move away from a psychiatrist led system of mental health treatment, suggesting that the lack of a 'requirement to liaise with the treating psychiatrist, has led to extreme fragmentation of care, and increased chance for adverse outcomes'.[99]

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96 Associate Professor Vinay Lakra, President, RANZCP, *Committee Hansard*, Canberra, 6 August 2021, page 10.

97 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 2.

98 Professor Perminder Sachdev, *Committee Hansard*, Canberra, 29 July 2021, page 13.

99 Independent Private Psychiatrists Group, *Submission 84*, page [6].

5.126 While supportive of multidisciplinary models, especially for community psychiatry, Professor Sachdev contended that the model should respect the different disciplines and the expertise the different disciplines bring:

> … these are serious illnesses, a big burden on the individual as well as the family. We have good treatments available, if they're applied appropriately. We can do much better than what we are currently doing. For that, you need a team with a psychiatrist leading that team and a number of different disciplines coming together to assist in that process—liaison with other services, rehabilitation services and the community in general.[100]

5.127 One further area explored by the Committee was models to enhance the capacity of psychiatrists to provide care, as well as potentially reduce stress and burnout. RANZCP highlighted the former Mental Health Nurse Incentive Program (MHNIP) and lobbied for it to be reinstated, noting it could be used to encourage other allied health practitioners to engage in multidisciplinary collaboration:

> … [the program] provided an incentive payment to community-based general medical practices, private psychiatrist services and other appropriate organisations who engage mental health nurses to assist in the delivery of clinical care for people with severe mental health conditions. It was reviewed in 2010 which found that 'overall there was wide acceptance of the program and feedback from all stakeholders was extremely positive'. In 2016-17, MHNIP funding was transitioned to the PHN primary mental health flexible funding pool. Since that funding move, it has been incredibly difficult for private psychiatrists to secure funding from the program to employ a nurse to support them in practice.
>
> In December 2020 the MBS Review Taskforce released the report from the Nurse Practitioner Reference Group, where the introduction of MBS funding for nurse practitioners was not supported. This was disappointing given it could have delivered a clear avenue of funding for mental health nurses within private practice.[101]

Committee comment

5.128 The Committee is of the view that immediate action needs to be taken to ensure that those who need access to psychiatric expertise are able to do so at the point in time it is required.

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100 Professor Perminder Sachdev, *Committee Hansard*, Canberra, 29 July 2021, page 12.

101 RANZCP, *Submission 141.1*, page [3].

5.129 The Committee acknowledges that when dealing with complex and serious mental illness, a psychiatrist may be best placed to provide care and lead the attendant multidisciplinary team.

5.130 However, noting the long lead time for training psychiatrists, more needs to be done to allow psychiatrists to operate at top of scope. This could be achieved by more psychiatrists being utilised in a consultancy model, for example as a contributing expert in a multidisciplinary team, or providing advice to mental health trained GPs via a helpline or chat service.

5.131 An additional option to support psychiatrists in private practice may be to incentivise models for mental health nurses to be employed and utilised to support consultations and provide a triage facility.

Recommendation 15

5.132 The Committee recommends that the Department of Health and the National Mental Health Workforce Strategy Taskforce engage with psychiatry peak bodies to develop a workforce strategy that maximises access to the expert skills of psychiatrists for those with complex and serious mental illness, including through:

- **increasing support for mental health nurses to provide pre- and post-appointment services**
- **a multidisciplinary team or consultancy function, where other health professionals can quickly access psychiatry expertise.**

Nursing

5.133 The Nursing and Midwifery Board of Australia (NMBA) highlighted the key role that mental health nurses and midwives play, particularly in relation to perinatal anxiety and depression, in the current mental health workforce. NMBA outlined that:

> There are currently 377,000 practising registered nurses and 72,000 practising enrolled nurses in Australia. In 2018, almost one in 15, or about seven per cent of nurses, including registered and enrolled nurses, who were employed in Australia indicated that they were working principally in mental health.[102]

[102] Adjunct Professor Veronica Casey AM, Chair, Nursing and Midwifery Board of Australia (NMBA), *Committee Hansard*, Canberra, 21 July 2021, page 24.

5.134 Recognising nursing as a critical component of the mental health workforce, Orygen and Forensicare raised concerns about ongoing shortages, particularly those with mental health expertise and specialist skills for working with vulnerable groups.[103]

5.135 The National Rural Health Alliance highlighted the pivotal role that nurses play in the provision of rural and remote health care services, with nurses standing out as the 'most well distributed of all the health professions in rural Australia'. The Alliance drew attention to the fact that generic nursing training may not include specific expertise in mental health issues, and also noted research indicating a projected shortfall in the future due to an older age structure outside major cities.[104]

5.136 Drawing data from the Modified Monash Model, the draft National Mental Health Workforce Strategy background paper indicated:

- an apparent oversupply in urban areas of registered nurses and enrolled nurses
- a significant oversupply of enrolled nurses in mental health but a shortage of registered nurses
- pronounced shortages in FTE [full-time equivalent] availability as rurality increases
- a projected shortfall of mental health nurses of between 11,500 and 18,500 by 2030.[105]

5.137 The Productivity Commission Report recommended the addition of a discrete unit on mental health in all nurse training courses, along with the development of a new curriculum standard for a three-year direct-entry undergraduate degree in mental health nursing.[106]

5.138 Nurses were included in the 2021-22 Australian Government Budget measure, which provided funding for scholarships and clinical placements to increase the number of practitioners working in mental health settings.[107]

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103 Orygen and Foresnicare, *Submission 75*, page 9.

104 National Rural Health Alliance, *Submission 136*, page 9.

105 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, pages 13, 16.

106 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, Action 16.4, page 700.

107 NMHC, *2021-22 Federal Budget: Initiatives for the mental health and suicide prevention workforce*, www.mentalhealthcommission.gov.au/getmedia/5672c984-3471-4428-8c22-330d5d9e0c03/2021-

Education and training

5.139 NMBA advised that education for both enrolled and registered nurses provides 'integrated knowledge of care across the life span, across all body systems and across all main contexts of nursing practice'. In addition:

> The current NMBA approved programs leading to registration as a registered nurse in Australia all include standalone subjects with foundational education in mental health.[108]

5.140 However, the Queensland Nurses and Midwives Union (QNMU) contended that mental health training in the undergraduate degree does not go into sufficient depth and raised concerns that mental health placements are not mandatory:[109]

> The QNMU believe that undergraduate nursing or midwifery degrees should be bolstered with more mental health content that includes models of suicide prevention and relevant clinical placement. Mental health should not be a separate curriculum but be included in the nursing or midwifery undergraduate degree to build a flexible, holistic and integrated mental health workforce with the capacity to address mental health concerns and suicide prevention across all health services.[110]

5.141 QNMU outlined the postgraduate qualification pathway from graduate certificate to masters available for nurses who wish to gain a specialist qualification in mental health or register as a nurse practitioner. Noting that cost was a barrier for many nurses, QNMU commended the Victorian Government's scholarships made available through its Chief Mental Health Nurse's office.[111]

2022-Federal-Budget-mental-health-workforce-information-sheet.pdf, viewed 24 September 2021.

108 Adjunct Professor Veronica Casey AM, Chair, NMBA, *Committee Hansard*, Canberra, 21 July 2021, page 24.

109 Mr Allan Shepherd, Professional Officer, Team Leader, Queensland Nurses and Midwives' Union (QNMU), *Committee Hansard*, Canberra, 21 July 2021, page 9.

110 Ms Kathleen Veach, Assistant Secretary, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 7.

111 Ms Kathleen Veach, Assistant Secretary, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 8.

Further developing the role of nursing in the mental health workforce

5.142 NMBA recognised the need to bolster placements, supervision and incentives, including financial, in the transition to specialty practice for nurses post registration.[112]

5.143 The mental health nursing workforce includes services led by mental health nurses, nurse navigators, nurse practitioners, school nurses and midwives. In order to leverage this workforce, QNMU stated that nurses and midwives must be empowered to work autonomously and to their full scope of practice.[113]

5.144 The Gidget Foundation outlined its innovative efforts to overcome the barriers presented by Medicare's Better Access initiative, which excludes rebates for mental health nurses, and enable nurse-led services:

> We brought the New South Wales government together with the local PHN—being Murrumbidgee in this case—and with Tresillian in the family care centre and with Gidget, offering our services. The state funded Tresillian to have the family care centre. Gidget came into the family care centre and we spoke to Murrumbidgee PHN and said: 'There are no clinicians in Wagga that we can access to run this service. We need a mental health nurse. We have identified two that are fabulous and that have the right experience who could be delivering this service. Will you support us to have an alternate workforce?' They said yes. So that was one of those moments and times where it's like: 'Wow! How great is this? We have got state and federal governments and two independent NGOs all working together to create this wonderful service in regional New South Wales that didn't previously exist.'[114]

5.145 AMA commended the huge role mental health nurses are able to play in a joined-up system, but noted the lack of proper access in general practice.[115]

5.146 QNMU proposed the development of mental health incentive opportunities, along the lines of the general practice nurse incentive program, where GPs are incentivised to employ nurses in general practice:

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112 Adjunct Professor Veronica Casey AM, Chair, NMBA, *Committee Hansard*, Canberra, 21 July 2021, pages 26-27.

113 Ms Kathleen Veach, Assistant Secretary, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 7.

114 Mrs Arabella Gibson, Chief Executive Officer, Gidget Foundation Australia, *Committee Hansard*, Canberra, 13 August 2021, pages 3-4.

115 Dr Omar Khorshid, President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 38.

> … many people with their first experience in mental health issues front up to their GP. It's the first place where health services get alerted to the fact that someone has a mental health problem, and that early intervention by a mental health nurse in the general practice environment would be of substantial benefit.[116]

5.147 Additional areas highlighted by QNMU for a stronger, sustainable mental health workforce included:

- Leveraging the leadership capacity of nurses and midwives in the community to expand nurse-led programs.[117]
- Developing the role of mental health nurse navigators, and increasing its coverage across communities, and in the private and aged care sectors.[118]
- Implementing minimum standards for clinical supervision that are financially supported by the workplace and can be adjusted based on the professional judgement of the nurse.[119]
- Recognising the value of mentorship and peer support, and provide training in these skills.[120]

5.148 Finally, to provide leadership and coordination, and to improve mental health services in both inpatient units and the community, QNMU strongly recommended the introduction of a chief mental health nurse for all states and territories.[121]

Committee comment

5.149 Nurses and midwives are the backbone of the health system. They are embedded and experienced in working in multidisciplinary environments,

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116 Mr Allan Shepherd, Professional Officer, Team Leader, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 10.

117 Ms Kathleen Veach, Assistant Secretary, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 10.

118 Ms Kathleen Veach, Assistant Secretary, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 10.

119 Ms Kathleen Veach, Assistant Secretary, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 11.

120 Mr Allan Shepherd, Professional Officer, Team Leader, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 11,

121 Ms Kathleen Veach, Assistant Secretary, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 7.

providing wrap around services supporting people through all manner of life events.

5.150 Noting the increasing prevalence of mental health problems and suicide-related presentations, and the frontline nature of nursing, the Committee considers that more needs to be done to increase mandatory mental health components in undergraduate study.

5.151 Likewise, with as many as one in five Australian women experiencing 'diagnosed perinatal depression and anxiety',[122] midwives must be skilled on graduation to address the common mental health issues of pregnant woman and mothers.

5.152 Similar to GPs, many nurses will work in community settings and therefore training and subsequent placements need to reflect the broad range of mental health problems they may encounter rather than just the more serious and complex cases likely to present in a hospital setting.

5.153 The vital importance of the role of nursing in the mental health workforce needs to be recognised. This can be done by ensuring mental health nurses have clear career pathways and there are chief mental health nurses to work alongside the chief psychiatrists at both the federal and state and territory levels.

5.154 Chief mental health nurses could work with stakeholders to:

- review the curriculum to ensure nurses and midwives are skilled and experienced in supporting mental health problems and suicide related presentations
- develop innovative placement opportunities across public, private and NGO sectors
- promote the capabilities of mental health nurses for expansion of mental health services in community settings
- share learnings with state and territory counterparts to embed best practice across Australia.

Recommendation 16

5.155 The Committee recommends that the Australian Government appoint a chief mental health nurse to work alongside the Deputy Chief Medical Officer for Mental Health, and encourage states and territories to adopt an equivalent position, if they have not yet done so.

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122 Gidget Foundation Australia, *Submission 221*, page [1].

Psychology

5.156 Psychologists are experts in mental health and wellbeing, and an integral part of the mental health workforce. According to the Australian Psychological Society (APS), psychologists 'should be differentiated from medical and allied health professionals who provide mental health services as an adjunct to their profession'.[123]

5.157 The Psychology Board of Australia's latest report on national registration and accreditation indicated that there are 41,817 registered psychologists in Australia, and 6,491 provisional registrants. Of the registered psychologists, approximately 80 per cent are women and around 35 per cent hold an endorsement for one of the nine areas of practice,[124] with the majority of endorsements in clinical psychology (10,380). The Board noted that:

> An endorsement does not restrict the scope of practice for the psychology profession. The only practice limitations for psychologists relate to their knowledge and skills and their obligation to practise within the boundaries of their own scope of competence.[125]

5.158 The draft National Mental Health Workforce Strategy background paper identified psychologists as having the largest shortfall compared to the National Mental Health Service Planning Framework workforce targets in terms of absolute workforce gaps. Consistent with other mental health professions, the deficits remain more pronounced in rural regions.[126]

5.159 APS called for the psychological workforce to be expanded, 'given the unprecedented demand for mental health services across the community in the wake of recent events'.[127]

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123 Australian Psychological Society (APS), *Submission 140*, page 8.

124 The nine areas of endorsement are: clinical neuropsychology, clinical psychology, community psychology, counselling psychology, educational and developmental psychology, forensic psychology, health psychology, organisational psychology, and sport and exercise psychology.

125 Ms Rachel Phillips, Chair, Psychology Board of Australia, *Committee Hansard*, Canberra, 21 July 2021, page 23; Psychology Board, Australian Health Practitioner Regulation Agency (AHPRA), 'Statistics – June 2021', www.psychologyboard.gov.au/about/statistics.aspx, viewed 26 September 2021.

126 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, page 17.

127 APS, *Submission 140*, page 8.

5.160 Between April 2020 and April 2021, the Australian Health Practitioner Regulation Agency (AHPRA) and the National Board implemented a temporary pandemic response sub-register to provide a pathway for experienced and qualified psychologists to return to the workforce to assist with the COVID-19 pandemic. There were 652 psychologists listed on the sub-register, though there was no obligation to practice.[128]

5.161 The Committee heard calls to enable provisional psychologists 'to provide an agreed level of Medicare-subsidised services, including a loading for psychologists providing services in rural and remote areas'.[129]

5.162 However, the Australian Clinical Psychology Association (ACPA) disagreed with any proposal that would lower requirements for psychologists, even on a temporary basis:

> During the time of COVID, waiting lists for both public and Better Access subsidised psychology services have blown out. There appears to be some suggestion from government about increasing the number of psychologists by shortening the training requirements, but this is problematic. Australia currently holds the lowest minimum standards for training for the registration of psychologists in the Western world.[130]

5.163 The Australian Association of Psychologists Inc pointed out that the Psychology Board of Australia adopted the International Declaration on Core Competencies in Professional Psychology, 'as part of its commitment to developing an internationally recognised and endorsed set of core competencies for the psychology profession'.[131]

5.164 In its Green paper, the Psychology Board advised that the 'aim of the Declaration is to serve as the foundation for a coherent global system for equating psychology registration, accreditation and training and conduct at the time of entry into the profession'. However, the Board also noted that:

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128 AHPRA, 'Pandemic response sub-registers – updated 22 September 2021', www.ahpra.gov.au/News/COVID-19/Pandemic-response-sub-register.aspx, viewed 26 September 2021.

129 APS, *APS Pre-Budget Submission 2021-22*, January 2021, page 15
See also: Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 1; Tegan Carrison, Executive Director, '2021-22 Budget Summary', *Australian Association of Psychologists Inc* (AAPi), posted on 13 May 2021, aapi.org.au/Web/News/Articles/budgetsummary.aspx, viewed 26 September 2021.

130 Professor Caroline Hunt, President, Australian Clinical Psychology Association (ACPA), *Committee Hansard*, Canberra, 29 July 2021, page 36.

131 AAPi, *Submission 85.1*, pages 1-3.

> … there are opportunities to better align competencies of the psychology workforce in Australia with international benchmarks and to maximise the endorsement framework as a regulatory mechanism for the benefit of the public and profession.[132]

Education and training

5.165 While reviewing the regulatory mechanisms and registration requirements are important, ACPA argued for increased funding to support specialist training programs to 'increase the number of practitioners who can provide the right level of expertise'.[133]

5.166 Witnesses raised concerns that a significant barrier to providing the right type and level of expertise was the 'crisis of diversity' in the psychology workforce and education programs available. APS explained:

> We are not a flat mental health profession. Psychology has nine different areas where additional accredited training brings value to the Australian population. These programs—including those providing special focus on children or workplaces or custodial populations, for example—are, devastatingly, closing under university funding pressures. Psychology is the only workforce with this type of training. Once lost, it's simply not going to be replicated within the system elsewhere.[134]

5.167 In addition to 'a lack of government funding', Dr Davis-McCabe noted that the combined impact of the introduction of the Better Access initiative in 2006 has led to 'quite devastating consequences for postgraduate university programs':

> We've seen in recent years many areas of practice endorsement programs close across the country. This means that the number of work-ready graduates is falling, and this is a real problem for the Australian people, who will ultimately lose access to the specialist skill set of these psychologists. This is a pressing concern at a time where the public need quick access to advanced psychology services.[135]

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132 Psychology Board of Australia, *Psychology Board of Australia: Green paper, Professional competencies for psychologists provide for safe practice and sustainable community access*, February 2020, pages 7, 19.

133 Professor Caroline Hunt, President, ACPA, *Committee Hansard*, Canberra, 29 July 2021, page 36.

134 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 1.

135 Dr Catriona Davis-McCabe, *Committee Hansard*, Canberra, 19 August 2021, page 12.

5.168 APS called for government funding to enable universities to 'keep training both general psychologists and area of practice endorsement psychologists', and suggested modelling strategies that have worked in medical training 'to correct workforce maldistribution':

> … things such as zone allowances, funded supervision, scholarships and supported supervisor training, particularly in rural and remote locations.[136]

5.169 In addition to the decreasing diversity of specialisation options available at the postgraduate level, ACPA advised that additional barriers included the cap on Commonwealth supported places and funding to support placements. ACPA called for expansion on the basis that the demand is there:

> At the University of Sydney we get 500 applications every year for 20 places so there are a lot of people who do want to do clinical psychology training ... Schools of psychology struggle to fund programs to give the necessary training that we have to do on the ground.[137]

5.170 Dr Davis-McCabe noted that one of the factors restricting universities increasing the diversity of specialisation was that the costs of placement and supervision vary across programs:

> I have 45 students, for example, in the master of psychologist professional, and we have only about 10 in the counselling psychology and clinical psychology, and that's due to the cost of placement. If we are able to get a placement that has supervision, that's great. But quite often placements don't come with supervision, so it falls to the university to pay for that … For general registration, students only have to complete one placement, but for the areas of practice endorsement they need to complete three.[138]

5.171 In addition to cost as a barrier to increasing places, ACPA advised that placements for clinical psychology students in public settings were becoming increasingly difficult to secure:

> One of the reasons we wouldn't increase our places is that we think, 'Are we ever going to be able to provide placements?' because that would be our responsibility. Again, this flows on to the lack of clinical psychology services in the public sector, because if the supervisors aren't there we can't place

136 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 1.

137 Professor Caroline Hunt, President, ACPA, *Committee Hansard*, Canberra, 29 July 2021, pages 37-38.

138 Dr Catriona Davis-McCabe, *Committee Hansard*, Canberra, 19 August 2021, page 13.

> students there. Private practice is not very helpful because often there are not those sorts of supports. And, of course, we can't have students charging for Medicare, so private practitioners don't want to take students on.[139]

5.172 In its pre-Budget submission, APS made three recommendations to address the shortage of placements for psychology students and 'a lack of willingness from organisations, including Government organisations, to offer postgraduate psychology student placements':

- Review the funding model for psychology courses to reflect the actual cost of these courses, or alternatively review the model and the requirement for intensive placement and supervision, which is expensive and difficult to source.
- Provide incentives to higher education providers to offer 5th year psychology programs, including through distance education.
- Fund the APS to develop a placement and internship coordination program to ensure provisional psychologists and course providers are financially supported to complete their training. This is required to address the increasing trend for organisations, including public sector services, charging fees to take on provisional psychologists undertaking a placement or internship.[140]

5.173 The APS submission identified additional solutions to improve the number of psychology program places and placements:

- Provide scholarships for students on placement – particularly in rural and remote locations.
- Provide a public sector salary loading to those psychologists who agree to supervise.
- Develop health system training positions within hospitals, similar to medical training.
- Federally fund payment for supervisors.
- Provide targeted funding for placements and supervision in nominated areas of greater need.[141]

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139 Professor Caroline Hunt, President, ACPA, *Committee Hansard*, Canberra, 29 July 2021, page 38.

140 APS, *APS Pre-Budget Submission 2021-22*, January 2021, page 15.

141 APS, *Submission 140.1*, page 2.

Career pathways

5.174 According to ACPA, early career clinical psychologists often seek to work in the public sector ‘because they see that that's where they can hone their skills and get appropriate supervision and appropriate support’. However, due to the lack of positions and a need to make a living, they move into private practice.[142]

5.175 There was broad agreement by Beyond Blue, SANE Australia and headspace that while they are able to attracts students and early career psychologists, retention has been difficult.[143] headspace explained:

> We get students who come through. They think it's fantastic to work in a team based environment in the very vibrant type of arrangement that we have. Some of them come back as graduates and do their early training post their work through the university. Then it comes to, 'Now I need an ongoing job.' All too often we see young people—graduates and students—leaving for private practice somewhere else because they can make a better income.[144]

5.176 The PHN Cooperative reinforced the dilemmas around attraction and retention in the not-for-profit sector, noting that new graduates are ‘often employed in the state system for no other reason than salaries, conditions, wages and other things that an NGO can't afford’.[145]

5.177 Gidget Foundation came up with an innovative approach to attract psychologists to an NGO environment, enabling them to build specialist skills and the Foundation to expand the service. The Foundation worked closely with the state service, Sydney North Health Network, and was able to secure some support from the Commonwealth, on a project to recruit supervisors:

> … within our network of the 68-plus clinicians that we have, we have people with significant experience. So perhaps we need to be utilising that experience to recruit those people as supervisors to train, mentor and supervise more

142 Professor Caroline Hunt, President, ACPA, *Committee Hansard*, Canberra, 29 July 2021, page 37.

143 Ms Carolyn Nikoloski, Chief Strategy Officer, Beyond Blue, *Committee Hansard*, Canberra, 26 July 2021, page 29; Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 28.

144 Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 28.

145 Adjunct Associate Professor Learne Durrington, Chief Executive Officer, WA Primary Health Alliance and Chair, National PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 8.

junior clinicians to deliver psychological treatment and to specialise in the areas of perinatal mental health.[146]

5.178 While early in career, the public and NGO sectors may be an attractive option, ACPA noted that the private sector offers established psychologists more flexibility to practice in a location and in areas of their choice, and set their own working hours.[147]

Committee comment

5.179 Psychologists are the specialist workforce able to deal with the full spectrum of mental health problems, mental illnesses, and suicide prevention and postvention. Psychologists are registered and regulated, and able to make a valuable contribution in public, private and NGO settings.

5.180 The importance and value of professional supervision for psychologists cannot be understated, especially for providing support to new psychologists and maintaining the resilience of the psychological workforce.

5.181 The Committee recognises this, and would like to see governments work with the growing number of psychologists within the private sector to expand supports for professional supervision, to increase practitioner access.

5.182 However, we are losing the opportunity to grow specialisation into critically important areas such as educational and developmental psychology and forensic psychology.

5.183 Chapter 6 refers to the lack of Australian studies available that compare the outcomes between registered psychologists with clinical endorsement and other registered psychologists. It also discusses how MBS inequities are impacting on demand for other psychological specialities.

5.184 The Committee calls for the diversity of psychology specialties to be supported through both regulatory acknowledgement and increasing university master's level programs to improve distribution across the nine areas of practice endorsement.

5.185 The Committee would also like to see support for specialisation that provides and promotes career pathways that enable progression and opportunities to contribute to public, private and NGO sectors.

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146 Mrs Arabella Gibson, Chief Executive Officer, Gidget Foundation Australia, *Committee Hansard*, Canberra, 13 August 2021, page 2.

147 Professor Caroline Hunt, President, ACPA, *Committee Hansard*, Canberra, 29 July 2021, page 37.

Recommendation 17

5.186 The Committee recommends that the Australian Government support the growth and diversity of psychology specialties by:

- **funding ongoing Australian research to compare outcomes across the nine areas of practice endorsement in the psychology profession, and using this research to inform future policy and funding decisions**

- **increasing university master's level programs to improve distribution across the nine areas of endorsement, with at least one educational and developmental psychology program in every state and territory**

- **dedicating a percentage of Commonwealth funded scholarships to psychology specialisations outside of the primary clinical psychology pathway**

- **providing funding or tax incentives to registered psychologists:**

  - **to increase their capacity to offer placements to psychologists in training and ongoing clinical supervision**
  - **for continuing professional development.**

Allied health professionals

5.187 Allied health professionals include professions such as pharmacists, counsellors, social workers, occupational therapists, dietitians, exercise physiologists and physiotherapists, and speech pathologists. Individually and as part of multidisciplinary teams, allied health professionals play a pivotal role in helping people achieve, reclaim or maintain physical, social and emotional wellbeing.

Pharmacists

5.188 Pharmacists are involved across the spectrum of mental health, from providing highly accessible community hubs to being part of a multidisciplinary team in a psychiatric ward.

5.189 In response to the bushfire crisis and the COVID-19 pandemic, the Australian Government further utilised pharmacists to ensure Australians had continued access to medicines even if they could not get to the doctor

for a renewed prescription.[148] The temporarily expanded arrangements – Continued Dispensing (Emergency Measures), which includes most Pharmaceutical Benefits Scheme medicines supplied through community pharmacies – were subsequently extended until 31 December 2021.[149]

5.190 Research funded under the Fifth Community Pharmacy Agreement revealed that community pharmacies have 'potential value as an accessible, inexpensive and safe health space that empowers consumers through information and connection to relevant support services'.[150]

5.191 Pharmacists are regulated through the AHPRA supported Pharmacy Board of Australia. The Board noted that:

> Pharmacists are often the most accessible health professionals the public encounter and pharmacy is among the most trusted professions in Australia. Pharmacists have earned this trust through their competence, demonstrating consistently high standards of skill and care and building strong relationships with the community.[151]

5.192 The Pharmacy Guild of Australia highlighted its efforts to encourage the concept of a pharmacy as a safe space, and noted that the majority of pharmacies now have consultation rooms, where people who are experiencing mental health issues are able to have an initial discussion with the pharmacist:

> An episode doesn't wait for a doctor's appointment. In some country areas we have to wait eight weeks to see a doctor. We do have the health lines. We do have various phone services at your fingertips, but ultimately, when it comes to mental health and health care in general, people like human-to-human

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148 The Hon Greg Hunt MP, Minister for Health and Aged Care, 'Ensuring continued access to medicines during the COVID-19 pandemic', Media Release, 31 March 2020.

149 Department of Health – The Pharmaceutical Benefits Scheme, 'PBS News: Pharmaceutical Benefits Scheme Continued Dispensing Arrangements', www.pbs.gov.au/info/news/2021/03/pharmaceutical-benefits-scheme-continued-dispensing-arrangem, viewed 25 October 2021.

150 Mr David Heffernan, National Vice-President and New South Wales (NSW) Branch President, Pharmacy Guild of Australia, *Committee Hansard*, Canberra, 19 August 2021, page 21.

151 Pharmacy Board, AHPRA, 'National Board recognises important role of pharmacists in improving community health', www.pharmacyboard.gov.au/News/2021-09-25-National-Board-recognises-role-of-pharmacists-in-improving-community-health.aspx, viewed 25 October 2021.

> interaction and the ability to have that interface and sit down and talk with that person.[152]

5.193 Pharmacists have also been able to work with patients and doctors as part of a comprehensive medication review, 'ensuring there is a diagnosis that matches a pharmacotherapeutic need' and addressing matters such as deprescribing, interactions and referral pathways. The Pharmaceutical Society of Australia noted pharmacists could do this work across a range of settings, including within GP practices and community pharmacy, or through a program such as Integrating Pharmacists within Aboriginal Community Controlled Health Services.[153]

5.194 As pharmacists increasingly engage in mental health matters at the community level, the Pharmaceutical Society of Australia, advised of efforts underway to ensure graduating pharmacists are well prepared to 'tackle the conversations around suicide and severe mental health crises'.[154]

5.195 The Pharmacy Guild of Australia highlighted programs aiming to further develop pharmacist capabilities that had been developed through collaboration with states and territories, NGOs and universities. These included the Mental Health Community Pharmacy Program in NSW, and the PharMIbridge Randomised Control Trial, funded by the Commonwealth Department of Health as part of the Sixth Community Pharmacy Agreement.[155]

5.196 The NSW program was designed and delivered to community pharmacists and pharmacy assistants to build confidence and skills 'to recognise and respond to people in distress and those with mental health conditions, to refer to local mental health services where appropriate and to improve referral pathways between community pharmacists and local area mental health services'. The Pharmacy Guild of Australia stressed the importance of

[152] Mr David Heffernan, National Vice-President and NSW Branch President, Pharmacy Guild of Australia, *Committee Hansard*, Canberra, 19 August 2021, page 22.

[153] Ms Hannah Loller, Senior Project Pharmacist, Pharmaceutical Society of Australia, *Committee Hansard*, Canberra, 19 August 2021, page 25.

[154] Ms Hannah Loller, Senior Project Pharmacist, Pharmaceutical Society of Australia, *Committee Hansard*, Canberra, 19 August 2021, page 23.

[155] Mr David Heffernan, National Vice-President and NSW Branch President, Pharmacy Guild of Australia, *Committee Hansard*, Canberra, 19 August 2021, pages 21-22.

involving the whole staff in training as pharmacy assistants are often the first point of contact.[156]

5.197 However, the Pharmaceutical Society of Australia mentioned that whilst ongoing training has been made available, 'it can be in a slightly ad hoc, reactionary manner', and recommended a continuous funding source:

> So bushfires roll out one lot; drought rolls out one lot. It would be nice to see some more coordinated, comprehensive, ongoing programs that exist in a funded capacity to ensure it's not ad hoc and depending on different trends, because mental health needs will remain ongoing.[157]

Committee comment

5.198 Pharmacists are one of the most accessible in-person health professionals, and their value was clearly demonstrated throughout the COVID-19 pandemic, providing an accessible, trusted service throughout. This has been particularly important for people who have experienced mental health problems exacerbated by the bushfires and pandemic and needed to have a consistent supply of medication when access to GPs was constrained.

5.199 Mental health and suicide prevention needs to be considered a core part of a pharmacist's education. This should be followed up with coordinated, ongoing and compulsory mental health training for pharmacists and pharmacy assistants.

5.200 Training provided to pharmacists empowers them to take on an active role in ensuring the welfare of people who come through the door. Further, it will allow them to feel more confident and position them to have their opinions taken more seriously in the broader mental health workforce if they are empowered and trained appropriately.

5.201 If we are going to leverage this widely accessible, professional community resource to further enhance the mental health workforce, funding should be provided to enable the training and education required.

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156 Mr David Heffernan, National Vice-President and NSW Branch President, Pharmacy Guild of Australia, *Committee Hansard*, Canberra, 19 August 2021, pages 21-22, 24.

157 Ms Hannah Loller, Senior Project Pharmacist, Pharmaceutical Society of Australia, *Committee Hansard*, Canberra, 19 August 2021, page 23.

Recommendation 18

5.202 The Committee recommends that the Australian Government consider continuing and expanding the Continued Dispensing arrangements, which have enhanced access to vital medicines and improved patient outcomes during the COVID-19 pandemic including for those living with mental ill health, especially in regional, rural and remote areas.

Recommendation 19

5.203 The Committee recommends that the Australian Government evaluate the efficacy of pharmacy mental health training programs and strengthen funding to support an expansion of best practice training in mental health and suicide prevention for all pharmacists and pharmacy staff.

Registered counsellors

5.204 The role of counsellors as part of the mental health workforce, and the use of the term 'counsellor', has been identified as an area that needs clarification. Counsellors are not recognised by the MBS and therefore are not entitled to rebates for their services. As further outlined in the draft National Mental Health Workforce Strategy background paper, there is no national minimum standard of training in this self-regulated industry or national standardised data set on the workforce.[158]

5.205 This has led to concerns such as those expressed by ARHEN. Dr Sharon Varela noted that while she had worked with 'some very excellent counsellors in remote areas, and their skill set is really important,' it was necessary to ensure the counsellor had a suitable standard of qualification:

> … if we are going to allow unregulated professionals in to be doing work, we have to have really clear parameters around what that looks like and who is going to hold duty of care, because there is always a risk to the public.[159]

5.206 There are two main bodies that represent counsellors - the Australian Counselling Association (ACA) and the Psychotherapy and Counselling Federation of Australia (PACFA). Together, they have established the Australian Register of Counsellors and Psychotherapists to provide an

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158 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, pages 14.

159 Dr Sharon Varela, Chair, Mental Health Academic Staff Network, ARHEN, *Committee Hansard*, Canberra, 17 June 2021, page 6.

independent, national register to help potential clients identify practitioners that:

- have completed professional qualifications in counselling or psychotherapy
- meet ongoing professional development requirements and have clinical supervision of their practice to ensure they provide a quality service to clients
- abide by the ethical guidelines of the profession.[160]

5.207 However, the two bodies have differing standards, membership categories, and thresholds for qualifications in order to be recognised as a counsellor.[161]

5.208 In terms of regulation, ACA noted that it is seeking to trademark the term 'registered counsellor', and compared its system to that of social workers, noting that:

> We self-regulate through the peak bodies as opposed to being regulated through AHPRA. However, we provide exactly the same processes, standards and quality of service as any AHPRA regulated industry. The only difference is that, obviously, we don't have the legislative authority or powers that AHPRA has.[162]

5.209 Noting the strong demand for mental health support and the extensive waitlists for many psychologists, PACFA recommended designing 'a policy environment where counsellors could assist more people and complement the work of psychologists, social workers and mental health nurses in supporting the Australian community'.[163]

5.210 ACA shared this view, calling for more to be done to expand services for all Australians and enable the development of multidisciplinary teams:

160 Australian Register of Counsellors and Psychotherapists, www.arcapregister.com.au/, viewed 27 September 2021.

161 Australian Counselling Association (ACA), 'Membership: Becoming a Member', www.theaca.net.au/becoming-a-member.php, viewed 27 September 2021; Psychotherapy and Counselling Federation of Australia (PACFA), 'Eligibility Criteria', https://www.pacfa.org.au/portal/Membership/Portal/Membership/Join-PACFA/Eligibility.aspx?hkey=ce88e54a-224e-463a-afc1-90d3ee925075, viewed 27 September 2021.

162 Mr Philip Armstrong, Chief Executive Officer, ACA, *Committee Hansard*, Canberra, 21 July 2021, page 19.

163 Dr Dianne Stow, President, PACFA, *Committee Hansard*, Canberra, 13 August 2021, page 8.

> Waiting six to eight years for more psychologists and psychiatrists to graduate is too long, when thousands of tertiary qualified counsellors are available to enter the workforce now.[164]

5.211 The Black Dog Institute and Wesley Mission identified the need for a group of professionals that could be utilised to fill gaps between primary and secondary care and potentially provide immediate access for those who may need only brief or lower level interventions.[165] By way of example, the Black Dog Institute described the UK experience with retraining groups, such as counsellors, to fill gaps:

> The most prominent of that was the IAPT system in the UK, the Improving Access to Psychological Therapies … The IAPT system trained a whole range of other health professionals to be able to deliver those brief psychological treatments, and it has done that at scale. There are certainly a number of publications that have demonstrated that that has been able to fill a gap that was there and has resulted in some improved outcomes.[166]

5.212 However, the Black Dog Institute also noted the importance of clear pathways to clinical psychologists and psychiatrists for 'those that do not recover from those initial brief treatments'.[167]

5.213 PACFA asserted that having immediate access to a counsellor can provide both early intervention and a triage opportunity, particularly for people with suicidal ideation, 'a counsellor is ready and able to refer a person to specialist services'. PACFA noted that counsellors are substantially more accessible across the country than psychologists, with a recent member survey indicating that 62 per cent could see a new client within two weeks and 23 per cent could see a new client within 48 hours.[168]

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164 Mr Philip Armstrong, Chief Executive Officer, ACA, *Committee Hansard*, Canberra, 21 July 2021, page 19.

165 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 4; Mr James Bell, Group Manager, Wesley Mission, *Committee Hansard*, Canberra, 16 June 2021, page 4.

166 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 4.

167 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 4.

168 Dr Dianne Stow, President, PACFA, *Committee Hansard,* Canberra, 13 August 2021, pages 7-8.

Committee comment

5.214 Registered counsellors provide valuable support to people through talk therapies, are already widely used by the NDIS and other support services, and have the potential to provide a larger contribution to the mental health and suicide prevention workforce.

5.215 However, the Committee has reservations about the current registration and regulatory structures for counsellors. It was noted that the peak bodies representing counsellors do not have consensus on the academic and experiential requirements for registration.

5.216 The Committee notes that, unlike psychologists, counsellors are not covered by AHPRA. While acknowledging the self-regulatory role taken on by the peak bodies, membership is not mandatory and there are no legal requirements to have specific qualifications or experience. Instead it relies on employers to set standards of training and consumers to assess credentials.

5.217 Counsellors are already dealing with vulnerable people as NGOs struggle to afford the higher costs of psychologists or access them due to shortages. While not wanting to raise the cost of doing business, people need to know that the care they are receiving is safe.

5.218 Accordingly, if this workforce is to be leveraged to relieve the pressure on existing mental health services, the regulation of counsellors must be effective. This requires consensus on national minimum standards set for education, supervision requirements, continuing professional development and adequate oversight.

Recommendation 20

5.219 The Committee recommends that the Australian Government review the existing self-regulated standards being used by the counsellor and psychotherapist peak bodies and use the results to determine appropriate terminology, national minimum standards for education, supervision, continuing professional development and oversight requirements.

Social workers

5.220 The peak body, the Australian Association of Social Workers (AASW), contended that social workers have a ‘unique professional position on mental health’, as when ‘working with people experiencing mental ill health, social workers take a whole-of-person approach rather than treating presenting symptoms’:

> While social work plays a key role in providing counselling to individuals, couples and families, the profession strongly believes that health and wellbeing, including mental health and wellbeing, are socially determined.[169]

5.221 The draft National Mental Health Workforce Strategy background paper noted that 'social workers are self-regulated and accredited by the Australian Association of Social Workers', and 'there are no FTE counts for the supply of social workers'.[170]

5.222 Agreeing that it is difficult to confirm numbers, AASW estimated there are approximately 40,000 social workers at any one time in the profession. Of these, around 15,000 choose to be a member of AASW.[171]

5.223 AASW outlined its self-regulation model, noting that it develops professional standards, a code of ethics and practice standards, manages complaints and accredits higher education providers and specialised streams including mental health:[172]

> ... social workers who are members of the AASW and have gone on to develop their learning and experience in mental health can seek an accredited mental health status … the postnominal they'd have is Accredited Mental Health Social Worker. The AASW is an accrediting authority recognised by the federal government, and we have more than 2,500 accredited mental health social workers across Australia. [173]

5.224 While AASW advised that it takes its regulatory and credentialing role seriously, it strongly recommended 'that the social work profession be registered under the national registration scheme to ensure that only qualified social workers with the necessary skills can support and work with

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169 Cindy Smith, Chief Executive Officer, Australian Association of Social Workers (AASW), *Committee Hansard*, Canberra, 6 August 2021, page 44.

170 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, page 18.

171 Cindy Smith, Chief Executive Officer, AASW, *Committee Hansard*, Canberra, 6 August 2021, page 46.

172 Cindy Smith, Chief Executive Officer, AASW, *Committee Hansard*, Canberra, 6 August 2021, page 44.

173 Cindy Smith, Chief Executive Officer, AASW, *Committee Hansard*, Canberra, 6 August 2021, page 44.

people experiencing vulnerabilities, including people experiencing mental ill health, and for broader public safety and protection'.[174]

5.225 This view was shared by ARHEN on the basis that 'they work in a lot of spaces that psychology work in, their degrees are four years so they're no different than any other allied health, and they're working in spaces that are quite remote, where regulation would be really important'.[175]

5.226 AASW also noted that Australia is the 'only country in the English speaking world where social work is not registered'. In addition, of particular concern to AASW was the fact that users of social worker services and decision makers may not be aware that there is no official oversight or regulation of the use of the title.[176]

Committee comment

5.227 Social workers provide significant value in mental health support and suicide prevention, actively addressing and accommodating the full range of social determinants that intersect with individual wellbeing.

5.228 The Committee shares the concerns expressed by witnesses in regard to the lack of protections around the use of the title 'social worker', noting that the profession often deals with society's most vulnerable individuals.

5.229 It is critical that when vulnerable people interact with services, that they can trust the professionals to have met and maintained professional standards.

5.230 The Committee would like to see 'social worker' become a protected term, and the implementation of a more robust regulatory and oversight mechanism.

Occupational therapy

5.231 Occupational Therapy Australia highlighted that mental health service provision has been 'a longstanding and core area of practice in occupational therapy':

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174 Cindy Smith, Chief Executive Officer, AASW, C*ommittee Hansard*, Canberra, 6 August 2021, page 44.

175 Dr Sharon Varela, Chair, Mental Health Academic Staff Network, ARHEN, *Committee Hansard*, Canberra, 17 June 2021, page 6.

176 Cindy Smith, Chief Executive Officer, AASW, C*ommittee Hansard*, Canberra, 6 August 2021, page 46.

> Occupational therapists work across the full spectrum of mental health, treating relatively common conditions, such as anxiety and mood disorders, as well as those which require more targeted interventions, such as psychosis and trauma-related conditions.[177]

5.232 Similar to social workers, occupational therapists consider the whole person and how they 'engage in meaningful and important activities such as self-care, school, work, leisure activities and social interactions':

> Through our client-centred approach, occupational therapists use a range of evidence-based interventions to support recovery in the person's meaningful environments. This means that occupational therapists work across the full spectrum of mental health, from prevention and early intervention to discharge.[178]

5.233 While occupational therapy complements other mental health services and can form a valuable part of a multidisciplinary health team, Occupational Therapy Australia noted a lack of awareness as one of the 'significant barriers to the most effective deployment of occupational therapists in mental health care':

> The profession's holistic role in occupational performance is not well understood either in the community or by other professionals. This negatively impacts the uptake of occupational therapy services, which in turn impacts the number and kinds of mental health roles which are available to occupational therapists.[179]

5.234 Occupational therapists are one of the allied health professions regulated through an AHPRA supported board – the Occupational Therapy Board of Australia.[180] The draft National Mental Health Workforce Strategy background paper noted that 'accredited mental health occupational therapists are not required to complete any additional training, unless delivering services under the Better Access program'.[181]

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177 Occupational Therapy Australia, *Submission 211*, page 1.

178 Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group, Occupational Therapy Australia, *Committee Hansard*, Canberra, 26 July 2021, page 12.

179 Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group, Occupational Therapy Australia, *Committee Hansard*, Canberra, 26 July 2021, page 13.

180 Occupational Therapy Board, AHPRA, https://www.occupationaltherapyboard.gov.au/, viewed 28 September 2021.

181 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, page 16.

5.235 Occupational Therapy Australia advised that all occupational therapy programs are accredited by the Occupational Therapy Council of Australia and meet strict national and international standards:

> To receive accreditation, occupational therapy courses must provide holistic training addressing and treating both physical and mental health-related illnesses, disabilities, challenges and limitations. As such, all occupational therapy courses include education on mental health conditions and their treatment through a range of evidence-based and occupation-focused interventions.[182]

5.236 In addition to the education component, Occupational Therapy Australia noted that in order to meet the international standards set by the World Federation of Occupational Therapists, occupations therapy students are required to complete a supervised clinical placement of least 1,000 hours:[183]

> During this time, all will work with clients presenting with some degree of psychosocial or emotional difficulty. These accreditation requirements ensure that all occupational therapists graduate with a sound knowledge of mental health assessment and intervention and mental health services. Suitably experienced occupational therapists are endorsed to provide focused psychological strategies through the Commonwealth government's Better Access initiative and … deliver psychological treatments for eating disorders under the Medicare Benefits Schedule.[184]

5.237 Commenting on the importance of strong supervision, Occupational Therapy Australia highlighted issues 'around availability of discipline-specific supervision, mental health occupational therapists supporting mental health occupational therapists in the different areas of practice'.[185]

5.238 Noting the lack of discipline-specific mental health roles and entry-level programs, Occupational Therapy Australia proposed thinking more innovatively about ways to expand access to clinical supervision proposing a stepped supervision model:

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182 Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group, Occupational Therapy Australia, *Committee Hansard*, Canberra, 26 July 2021, page 12.

183 Occupational Therapy Australia, *Submission 211*, page 3.

184 Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group, Occupational Therapy Australia, *Committee Hansard*, Canberra, 26 July 2021, page 12.

185 Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group, Occupational Therapy Australia, *Committee Hansard*, Canberra, 26 July 2021, pages 15-16.

> … [it] is about rethinking models of supervision where we could have a more experienced clinician supervising younger clinicians who then can have more students … We have to think beyond all the boxes that we ever thought that we had, to enhance the number of placements, the way that we provide placement in clinical education and the delivery of our services.[186]

Committee comment

5.239 Despite delivering valuable mental health supports and targeted interventions, the Committee was concerned to hear that the value of the occupational therapy workforce is not widely understood in the community and even across the cohort of health professionals that may be involved in prescribing mental health services.

5.240 Exposure to multidisciplinary settings and engagement with other faculties in early stage education may help to boost mutual understanding across professions.

5.241 Providing detailed information back to the GP, who make referrals to the occupational therapist, on the interventions and outcomes could also help increase understanding about the extent of improvement that can be realised through allied health services.

5.242 The Committee is also very interested in the concept of a 'stepped supervision' model to increase access to supervision, and considers this an area that warrants further exploration.

Dietitians

5.243 Dietitians have an important role to play in mental health and wellbeing. Dietitians Australia explained that the modification of diet and lifestyle factors is both cost effective and 'one of the first steps in clinical guidelines for the treatment of mood disorders':[187]

> Well-delivered dietary interventions lower healthcare costs, reduce hospitalisations and reduce burden on individuals and society. According to a

186 Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group, Occupational Therapy Australia, *Committee Hansard*, Canberra, 26 July 2021, page 16.

187 Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 21.

> very recent New Zealand health workforce report, for every one dollar invested in dietary intervention there's a five-dollar return.[188]

5.244 The draft National Mental Health Workforce Strategy background paper noted that the dietetic workforce is self-regulated through Dietitians Australia, and there is no national standardised data set. The lack of data, along with no requirement to be a member of Dietitians Australia, 'makes it challenging to estimate the size, distribution or sufficiency of supply of this workforce'.[189]

5.245 While not accounting for the full dietetic workforce, Dietitians Australia outlined its role, estimated membership, and minimum training standards for membership:

> Dietitians Australia is the peak body for nutrition and dietetic professionals, representing over 8,000 members … We have a self-regulation system that is modelled on AHPRA registration. Dietitians complete a minimum of five years university and intensive planning and have a rigorous professional development program ...
>
> … at least 30 hours of professional development each year.[190]

5.246 Dietitians Australia contended that upon graduation, entry-level Dietitians have 'enough knowledge to conduct assessment and monitoring of mental health disorders. They understand how to inform clients on nutrition intervention, and they also have enough knowledge for successful collaboration with multidisciplinary teams'. It also noted that through continuing professional development (CPD), additional training is available for those who wish to specialise in mental health, in either severe mental disorders or eating disorders specifically.[191]

5.247 Dietitians Australia raised concerns that despite having completed training in mental health and evidence showing that the most effective dietary

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188 Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 21.

189 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, page 15.

190 Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, pages 21-22.

191 Dr Tetyana Rocks, Expert Representative, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 25.

interventions are those delivered by Dietitians, referrals are low and funding pathways are inadequate:

> … accredited practising dietitians are not recognised as mental health practitioners … and there are far too few dietitians funded to work in mental health in an inpatient setting.[192]

5.248 The Committee heard that a lack of visibility, access and funding may be leading to delays in referral to a Dietitian, missing the important early intervention window. Dietitians Australia noted that it is important that people have access to support that is safe and appropriate, and that this is available by providing access to accredited practising dietitians:

> At the moment, we have a workforce that is ready and able to work in mental health nutrition. We see the easiest way to facilitate that is by recognising us as mental health practitioners.[193]

5.249 In addition, Dietitians Australia suggested establishing phone counselling and other initiatives to help increase visibility in the community, and understanding of the role and qualifications of an accredited practising dietitian.[194]

Committee comment

5.250 With the prevalence of disordered eating and development of eating disorders, Dietitians need to be front of mind as part of the mental health treatment team well before hospital presentation.

5.251 Dietitians are qualified professionals providing health advice to people, many of whom are being seen due to disordered eating or other health concerns.

5.252 While it is positive that the term Dietitian is protected, it is concerning that as with other self-regulated professions, there is no requirement to be a member of Dietitians Australia and meet the standards set for the industry.

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192 Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 21.

193 Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, pages 24-25.

194 Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 25.

5.253 On this basis and noting the serious nature of eating disorders, the Committee would like to see the regulation and oversight of Dietitians reviewed.

Exercise physiology and physiotherapy

5.254 There is broad consensus on the interrelationship between physical and mental health, and the significant burdens of both mental health problems and chronic pain. As stated by the Australian Physiotherapy Association, in addition to the impact on healthcare systems, '[u]ntreated or inappropriately treated pain can be a major factor in mental health':

> So any person with reduced or poor physical mobility, loss of function or experiencing chronic pain is less able to participate in aspects of life, and that includes work, social, exercise and travel. The pain impacts on family and physical relationships.[195]

5.255 However, Exercise and Sports Science Australia (ESSA) pointed out that despite recognition of the importance of physical health and the role of exercise in maintaining or regaining mobility and pain management, uptake has been slow in both the mental health and medical space.[196]

5.256 The draft National Mental Health Workforce Strategy background paper did not include physiotherapists or exercise physiologists within its definition of the mental health workforce.[197] While still not referred to as part of the mental health workforce, the National Mental Health Workforce Strategy consultation draft does refer to these groups in priority area 3 – 'The entire mental health workforce is utilised', identifying physiotherapy as an occupation with its scope to be confirmed and exercise physiology as an occupation with its scope to be developed.[198]

5.257 While physiotherapy is regulated through an AHPRA supported board – the Physiotherapy Board of Australia, exercise physiology is a self-regulated profession. ESSA advised that while its professions have been mapped

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195 Mr Scott Willis, National President, Australian Physiotherapy Association, *Committee Hansard*, Canberra, 26 July 2021, page 14.

196 Mrs Anita Hobson-Powell, Chief Executive Officer, Exercise and Sports Science Australia (ESSA), *Committee Hansard*, Canberra, 21 July 2021, page 49.

197 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021.

198 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, pages 16-18.

against the standards required by national regulation, it does not meet the risk criteria set by the government to cross the threshold for regulation through an AHPRA supported board.[199]

5.258 The Australian Physiotherapy Association reiterated the need for removing siloed treatment of physical and mental health and fully embracing multidisciplinary team-care arrangements. The Australian Physiotherapy Association recommended that 'governments undertake transformational change'[200] and recognise physiotherapists 'as valued participants of multidisciplinary mental health care'.[201] It noted that:

> … accredited physiotherapists know that exercise is incredibly valuable in the treatment of some forms of depression, PTSD [post-traumatic stress disorder] and other disorders. Improving mobility and addressing health issues that are barriers to exercise should be recognised as part of assessment and treatments for people experiencing mental illness.[202]

5.259 In order to raise the profile of how exercise can support mental health, ESSA recommended starting by better educating GPs:

> … patients still believe in the word of the GP. If the GP is going to tell them to do something, they're going to look at it, so we need the doctors to go, 'Right, we need to get you moving. How do we do that?' So that is a bit of the barrier, that it's not suggested as one of the options.[203]

5.260 Likewise, the Australian Physiotherapy Association recommended 'investment in education across the mental health sector to raise understanding of the important role of physiotherapy in recognising, assessing and treating many physical illnesses and painful conditions'.[204]

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199 Mrs Anita Hobson-Powell, Chief Executive Officer, ESSA, *Committee Hansard*, Canberra, 21 July 2021, pages 47-48.

200 Mr Scott Willis, National President, Australian Physiotherapy Association, *Committee Hansard*, Canberra, 26 July 2021, page 13.

201 Australian Physiotherapy Association, *Submission 1*, page 5.

202 Australian Physiotherapy Association, *Submission 1*, page 7.

203 Mrs Anita Hobson-Powell, Chief Executive Officer, ESSA, *Committee Hansard*, Canberra, 21 July 2021, page 50.

204 Australian Physiotherapy Association, *Submission 1*, page 5.

Committee comment

5.261 The Committee was surprised to see physiotherapy and exercise physiology excluded from the listed occupations in the National Mental Health Workforce Strategy consultation draft, noting the mounting support for the role of exercise and pain management in mental health treatments.

Speech pathology

5.262 Speech pathologists help with swallowing and communication difficulties. Speech Pathology Australia explained that in addition to treating individuals, speech pathologists are able to work with clinicians to modify interventions, such as cognitive behavioural therapy, to increase accessibility:

> For this reason, Speech Pathology Australia believes that speech pathologists should be an essential part of each multidisciplinary mental health team across Australia to ensure effective prevention, early detection, diagnosis, treatment and recovery across the whole of life.[205]

5.263 However, Speech Pathology Australia noted a lack of awareness across other health professions as to the skills speech pathologists can bring to a multidisciplinary mental health team. While currently a challenge, Speech Pathology Australia speculated that this will change as more speech pathologists undertake specialist mental health training:

> We're going to have our own speech pathologists that are trained not only in the speech pathology area but also in the mental health area because it really is important that we understand consumers' mental health needs as well as their physical needs, especially in our ageing population.[206]

5.264 The draft National Mental Health Workforce Strategy background paper noted that speech pathology is self-regulated by Speech Pathology Australia and 'there is no national standardised data set on the supply of speech pathologists'.[207]

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205 Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, Speech Pathology Australia, *Committee Hansard*, Canberra, 19 August 2021, page 2.

206 Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, Speech Pathology Australia, *Committee Hansard*, Canberra, 19 August 2021, page 4.

207 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, page 19.

5.265 As with other self-regulated professions, membership of professional organisations is not mandatory. Speech Pathology Australia noted that while membership is required in order 'to receive payments through various funding programs such as the NDIS, MBS, DVA [Department of Veterans' Affairs] and private health insurance', those working in the public sector are not required to do so. Speech Pathology Australia estimated this amounts to approximately 20 per cent of the workforce.[208]

5.266 Speech Pathology Australia outlined work underway to overcome a lack of accurate workforce data and enable strategic workforce planning:

> Speech Pathology Australia will be undertaking a specific Workforce Analysis Project to capture and understand the speech pathology workforce and to understand the future needs of the profession and community. The Workforce Analysis Project will aptly provide a detailed profile of the supply, demand and distribution of the profession, including locations, context and factors related to shortages in services and influences in recruitment and retention.
>
> The project aims to create Australia's first interactive geospatial map of the speech pathology profession. This map will enable a comparison of speech pathology ratios by geographic area and population demand, determined by a range of factors, including age groups, socio-economic status and health determinants. The outcomes of this project will provide invaluable data to inform Speech Pathology Australia's capacity to develop strategies to address the needs of the community.[209]

Committee comment

5.267 The Committee commends Speech Pathology Australia's efforts to capture and analyse accurate workforce data. This type of project should be replicated across all self-regulated allied health professional bodies to support workforce coordination.

5.268 The Committee has made further commentary on the need for data collection, monitoring and evaluation, and research to support policy decisions in Chapter 7.

Committee comment on allied health professionals

5.269 Despite best efforts, we have not been able to meaningfully reduce the incidence of mental ill health or number of suicides, and demand for

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208 Speech Pathology Australia, *Submission 229*, page 1.

209 Speech Pathology Australia, *Submission 229*, page 1.

services continues to outstrip supply. It is important that every opportunity is explored to produce a variety of interventions that can provide support and hope to Australians enduring mental illness or suicidal ideation.

5.270 The allied health workforce is trained, developed and able to complement more traditional mental health supports. These services need to be further integrated into multidisciplinary mental health teams and be provided as options by GPs to patients as valuable components of mental health plans.

5.271 In order to increase integration of allied health professionals into the mental health workforce, there needs to be promotion of the roles and the referral pathways for each of the allied health professions, both for members of the public and other health professionals.

5.272 However, the Committee is concerned that while the sector is looking at innovative and integrative options to strengthen and diversify the mental health workforce, there are significant variations on education and training standards, governance and regulatory requirements.

5.273 Those seeking support for mental health problems need to be sure that the professional providing services is appropriately qualified, engaging in professional development and supervised in a manner that ensures safety and protections.

Recommendation 21

5.274 The Committee recommends that the Australian Government strengthen the frameworks for allied health professions to be fully integrated into the mental health workforce, including by:

- **reviewing the regulation and oversight of allied health professions that contribute to the mental health workforce, and specifically the need to establish national boards supported by the Australian Health Practitioner Regulation Agency where they do not currently exist**

- **providing funding or incentives to increase the availability of discipline-specific supervision to expand the number of places for allied health professionals wanting to specialise in mental health**

- **recognising the full spectrum of allied health professionals, including physiotherapists, exercise physiologists and Dietitians, and their contribution to the mental health workforce as allied health**

professionals in the final National Mental Health Workforce Strategy and subsequent implementation plans

- **developing and implementing a strategy to promote the mental health related interventions that allied health professionals can offer. This should include information targeted at both consumers and other health professionals.**

Crisis support – volunteers

5.275 Volunteers are an integral part of the mental health workforce, often providing the first point of contact on helplines or providing support in community-based mental health services. VolunteeringACT noted that many community services rely heavily on the volunteer workforce, and as a result there is a critical need to invest in volunteering to ensure mental health services reliant on volunteers can meet increasing demand.[210]

5.276 While noting the lack of official data, Volunteering Australia provided a number of estimates that put the number of volunteers in the health or welfare sector at over 680,000 volunteers.[211] Organisations utilising volunteers include:

- Lifeline Australia, whose last annual report indicated it had a 10,000 strong volunteer workforce, which supported around a million calls over the course of a year.[212]
- MATES in Construction, which advised that its program is ‘supported by over 20,000 trained volunteers on the ground in workplaces across the country’.[213]

5.277 Highlighting the substantial contribution to society and the economy, Volunteering Australia pointed out that ‘volunteers and volunteering contribute to every government portfolio, except perhaps for Defence, but there is no whole-of-government strategy to volunteering’.[214]

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210 VolunteeringACT, *Submission 123*, page 4.

211 Volunteering Australia, *Submission 133*, page 7.

212 Lifeline Australia, *Lifeline Annual Report 2019-2020*, pages 4, 7.

213 MATES in Construction, *Submission 164*, page 1.

214 Mr Mark Pearce, Chief Executive Officer, Volunteering Australia, *Committee Hansard*, Canberra, 17 June 2021, pages 15-16.

5.278 Despite the importance and number of volunteers in the mental health workforce, neither the National Mental Health Workforce Strategy consultation draft nor draft background paper has included reference to volunteers.[215]

5.279 The Productivity Commission Report made a number of references to volunteers, including a section on the benefits of volunteering,[216] but this did not lead to any recommendations. Volunteering Australia identified this as a 'critical gap' in the Productivity Commission's Report recommendations:

> [There was] no reference to the role of volunteering in mental health prevention or recovery, nor the role of volunteers in the mental health workforce. We urge that this is addressed in the implementation process.[217]

5.280 Volunteering Australia called for volunteering and the role of volunteers to be made explicit in the implementation of recommendations coming out of recent reports and strategies, and for the voices of volunteers and organisations utilising volunteers to be at the table:

> Volunteering does not just happen. It requires leadership, investment and strategic oversight. The role of volunteering in supporting mental health and suicide prevention needs to be highlighted, supported and be an integral part of the implementation process.[218]

5.281 Similarly, Lifeline Australia submitted that 'the value of the volunteer mental health workforce, and considerations of their role, training, and standards should be included in the development of any comprehensive mental health workforce strategy'.[219]

5.282 In terms of the training and development of volunteer crisis supporters, Wesley Mission emphasised that it is not them as training counsellors or clinicians for the Lifeline services it operates. Wesley Mission noted that the training and ongoing professional development was comprehensive and meets accreditation standards set by Lifeline Australia:

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215 Department of Health, 'National Mental Health Workforce Strategy – Consultation Draft', *ACIL Allen*, August 2021; Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021.

216 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, page 391.

217 Volunteering Australia, *Submission 133*, page 2.

218 Volunteering Australia, *Submission 133*, page 2.

219 Lifeline Australia, *Submission 52*, page [8].

> … we require volunteers to do call-coaching sessions with our qualified clinicians. We have PACFA-qualified and TAE- [Training and Education] qualified crisis support supervisors who do call coaching. Also, once a volunteer has reached a certain amount of volunteer hours in the system, we ensure that volunteers are engaging in what we call group supervision, which is a space to do that reflective practice linking one's personal experiences on the calls with that of their peers and looking at different techniques to be able to attend to the helpseekers' needs.[220]

5.283 Lifeline Australia advised that in addition to the training, there were clear processes in place for support when volunteers are on-shift and for escalation pathways:

> … while we're on shift we always have ready access to a supervisor who can listen in and support us in the calls if we're experiencing something we may not have experienced before …
>
> If our crisis supporters identify there's immediate danger, we have quite detailed and practical procedures in place where we connect with emergency services. That's a critical part of the training for our team...[221]

Committee comment

5.284 The Committee expresses its thanks to all those who volunteer their time to help others in times of need, and acknowledges that many who volunteer do so because they have at some point been impacted by mental illness, suicide or other life challenges.

5.285 Volunteers are giving, and in return, they must be recognised not only by the organisation they work for, but also within the structures that underpin the mental health and suicide prevention workforce. This means having volunteers and those who employ them represented on national mental health workforce taskforces, and in the strategies and implementation plans being developed.

5.286 Lifeline Australia and its service delivery partners have done a lot of work to ensure a high standard of training and development, consistency across centres and a safe work environment for its volunteers. This provides a

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220 Mr James Bell, Group Manager, Wesley Mission, *Committee Hansard*, Canberra, 29 July 2021, page 18.

221 Mr Robert Sams, Executive Director, Lifeline Direct Services, Lifeline Australia, *Committee Hansard*, Canberra, 29 July 2021, pages 15.

sound model that could be leveraged when considering the development of the lived experience (peer) workforce.

Recommendation 22

5.287 The Committee recommends that the Australian Government formally acknowledge the value of the volunteer mental health workforce, with consideration of its role, training, and standards included in the final National Mental Health Workforce Strategy and subsequent implementation plans.

Lived experience (peer) workers

5.288 The concept of lived experience (peer) workers is not new but peer workers have recently received increasing recognition for the important contribution that they can make as part of the mental health workforce. batyr's youth ambassador, Bella Cini, shared her story with the Committee:

> I think the role of the peer worker is one of the most valuable roles within the mental health sector and is something that we definitely need to be emphasising a little bit more. Through personal experience working with young people in a peer support role, I found it to be so effective in helping that person move along in their journey and helping them receive and reach out for the help that they need ... I've been sharing my experience for four years in the peer work programs. I can be with kids for a couple of hours, but the amount of students that you talk to who are feeling so empowered and understood, and who feel like they can relate to you and what you're saying, proves to me that that peer work works and is effective and is really helping young people come to terms with what they're going through.[222]

5.289 The National Mental Health Consumer and Carer Forum (NMHCCF) outlined the critical role of peer workers 'in the transformational changes necessary to develop recovery-oriented mental health services and systems':

> Employing peer workers in the mental health system resets the balance of power and significantly advances greater equity, rights, and justice.[223]

5.290 Overwhelmingly, witnesses expressed support for growing the peer workforce:

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222 Bella Cini, National Advisory Group Member and Board Member, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 24.

223 Mrs Hayley Solich, Carer Co-Chair, National Mental Health Consumer and Carer Forum (NMHCCF), *Committee Hansard*, Canberra, 5 August 2021, page 13.

- headspace – 'lived experience needs to be embedded at the forefront of change through structure, policy and practice … Mental health and suicide prevention services and supports will only work if they harness the expertise of users, and the experiences of people improve'.[224]
- Mental Health Carers NSW – 'the value of peer workers for carers is enormous ... we need to provide support for carers by people who understand what it is to support someone with a mental health issue and the difficulty that that presents and who do not have the stigmatising attitudes'.[225]
- National Mental Health Consumer Alliance – 'surveys have shone a light on how important peer support work actually is—just to have someone who is a role model or who people can talk to'.[226]
- Professor Brin Grenyer – 'People with lived experience give people with personality disorders a different message of hope and encouragement than they can get from health practitioners'.[227]

5.291 Included in the National Suicide Prevention Adviser's recommendation for all governments to integrate lived experience knowledge and leadership, was a priority action that 'all governments commit adequate funding and implement support structures to build the lived experience workforce, including the lived experience peer workforce'.[228]

5.292 While structures and governance arrangements for the peer workforce are still being developed, the Royal Flying Doctor Service (RFDS) encouraged taking a risk managed approach:

> … we often assess the risk of what we're doing, but we often don't compare it to the risk of not doing anything. I think that's important too. I'm not suggesting for a moment that anyone gets careless, but the risk of us not

224 Ms Amelia Walters, headspace Board Youth Advisor, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 25.

225 Mr Jonathan Harms, Chief Executive Officer, Mental Health Carers NSW, *Committee Hansard*, Canberra, 5 August 2021, page 4.

226 Ms Irene Gallagher, Foundation Member, National Mental Health Consumer Alliance, *Committee Hansard*, Canberra, 5 August 2021, page 10.

227 Professor Brin Grenyer, Professor of Psychology, University of Wollongong and Director, Project Air Strategy for Personality Disorders, *Committee Hansard*, Canberra, 19 August 2021, page 11.

228 National Suicide Prevention Adviser Final Advice, *Executive Summary*, December 2020, page 6.

> delivering services and not taking every opportunity to recruit folks from the local communities also presents risks to us.[229]

5.293 SANE Australia posed a range of questions that it considered need answering 'if we want to see a really modern integrated collaborative workforce':

> … what does that look like? And critically, how do these roles intersect in a collaborative way, in an equal way with clinical roles? I think that's some of the area of opportunity for development of training courses, research and innovation but also of opportunities to encourage new people to think about these as possible career pathways.[230]

5.294 The Western Australian Association for Mental Health (WAAMH) suggested that the peer role is complementary, and that a stronger emphasis on a well-supported integrated peer workforce might reduce distress for those presenting and ease pressures on the responding clinical workforces.[231]

5.295 Determining the scope of peer workers and the intersection with clinical roles was raised by Carers ACT, noting that from a carer perspective, peer workers 'provide a reduction in isolation and sense of feeling alone in their caring role' but do not replace the need for engagement with the clinical workforce:

> … what carers need most is understanding of diagnosis, understanding of treatment, skill and education in the provision of that treatment and the ability to know how to act and react in an effective manner when they're providing the bulk of the care. And the carers we represent would say that a peer workforce doesn't provide that and that only a clinical workforce would provide that degree of education and expertise.[232]

5.296 With a focus on integrating lived experience, Brisbane South PHN has introduced its implementation framework, which runs from co-design right through to co-production and co-evaluation:

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229 Mr Frank Quinlan, Federation Executive Director, Royal Flying Doctor Service of Australia (RFDS), *Committee Hansard*, Canberra, 17 June 2021, page 9.

230 Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 29.

231 Ms Taryn Harvey, Chief Executive Officer, Western Australian Association for Mental Health (WAAMH), *Committee Hansard*, Canberra, 19 July 2021, page 2.

232 Ms Lisa Kelly, Chief Executive Officer, Carers ACT, *Committee Hansard*, Canberra, 5 August 2021, page 4.

> … we have a lived experience coordinator who is working between metro south mental health service and PHN. We are very lucky to have him, and he is supporting us to implement our lived experience advisory panel and a lived experience taskforce that will then ensure that lived experience is lived, essentially, throughout our entire implementation framework.[233]

Representative professional association

5.297 The draft National Mental Health Workforce Strategy background paper indicated that the peer workforce had 'the largest relative gap in mental health workforce supply', and while still an emerging workforce, is expected to grow as recognition of its value increases.[234] To support growth of the peer workforce, there has been a resounding call in recent reports and by a range of organisations for the establishment of a national association of peer workers.[235]

5.298 NMHCCF strongly supported the professional association recommended in the Productivity Commission Report, outlining its view of the associations role:

> Such a professional association would develop peer worker role delineation, develop and implement peer supervision pathways, support data collection at both national and jurisdictional levels, and develop and deliver training programs to other members of the mental health workforce. The availability of existing programs, such as nationally recognised training programs, and the peer workforce guidelines, which are soon to be released by the National Mental Health Commission, will support the activities of the professional association.[236]

5.299 Lived Experience Australia (LEA) drew attention to its report 'Towards Professionalisation', which was the product of an 18-month national scoping project for the establishment of a member-based organisation for the peer

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233 Mrs Jennifer Newbould, Director, Mental Health, Suicide Prevention, Alcohol and Other Drugs, Brisbane South PHN, *Committee Hansard*, Canberra, 21 July 2021, page 6.

234 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, pages 16-17.

235 See, for instance: Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, Action 16.5, page 75; Royal Commission into Victoria's Mental Health System, *Final Report: Summary and Recommendations*, February 2021, page 66; Mental Health Victoria, *Submission 144*, page 6.

236 Mrs Hayley Solich, Carer Co-Chair, NMHCCF, *Committee Hansard*, Canberra, 5 August 2021, page 13.

workforce. The report noted that there are established policy commitments in all states and territories, but a national association is needed to increase understanding and provide role clarity for organisations and 'enable access to resources, specialised training, supervision and communities of practice to support professionalisation of the peer workforce'.[237]

5.300 However, both LEA and NMHCCF remained concerned about the Productivity Commission Report proposal to provide one-off seed funding. NMHCCF called for a longer term investment:

> Without the financial commitment for the establishment of a peer workforce professional association, with guaranteed funding for at least the first five years of operations, it is possible that the funded training opportunities may not achieve the desired outcome.[238]

5.301 Mental Health Victoria suggested that rather than additional government funding, once established, the professional association could be funded through member and organisation fees.[239]

5.302 The Australian Government's National Mental Health and Suicide Prevention Plan indicated that 'the Government will work with mental health stakeholders to investigate and co-design future national peak body arrangements to ensure a greater role for lived experience, through the 2021-22 Budget'.[240]

Training and support

5.303 WAAMH predicted a rise in demand for peer and community sector workforces once reforms are implemented, and noted that:

> Focused attention and investment are needed to identify, train and support these workforces to meet this demand and provide quality services. Lived experience workforces will also need supportive and enabling structures to

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[237] Lived Experience Australia (LEA), *Submission 106*, page 13. See also: Private Mental Health Consumer Carer Network (Australia) Ltd, *Towards Professionalisation – Final Report*, 15 January 2019, page 16.

[238] LEA, *Submission 106*, page 13; Mrs Hayley Solich, Carer Co-Chair, NMHCCF, *Committee Hansard*, Canberra, 5 August 2021, page 13.

[239] Mental Health Victoria, *Submission 144*, page [6].

[240] Australian Government, *Prevention Compassion Care - National Mental Health and Suicide Prevention Plan*, 11 May 2021, page 30.

> shift cultures within services and allow this workforce to reach their potential and drive systemic change.[241]

5.304 The Australian Government provided '$3.1 million to sponsor up to 390 peer workers to undertake vocational training' in the 2021-22 Budget.[242]

5.305 The draft National Mental Health Workforce Strategy background paper noted that while there is not currently a mandatory qualification for peer workers, there is 'a nationally recognised Certificate IV in Mental Health Peer Work'.[243]

5.306 The Productivity Commission Report questioned the benefit of requiring a minimum standard of qualifications for peer workers, and on this basis did not make any specific recommendations about the regulation, training or qualifications for peer workers. The Productivity Commission referred the Committee to its report commentary:

> The unique value of peer workers is that they bring to bear their lived experience of mental ill-health and recovery, rather than qualifications through education (2021, p. 731).[244]

5.307 However, for those that are looking to develop a career as a peer worker, headspace suggested that there needs to be thought given to 'how young professionals or lived experience professionals can progress in their career'. headspace noted that this may include different qualification offerings, but would require allies prepared to champion these kinds of roles within the broader mental health workforce.[245]

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241 WAAMH, *Submission 173*, page [7].

242 NMHC, *2021-22 Federal Budget: Initiatives for the mental health and suicide prevention workforce*, www.mentalhealthcommission.gov.au/getmedia/5672c984-3471-4428-8c22-330d5d9e0c03/2021-2022-Federal-Budget-mental-health-workforce-information-sheet.pdf, viewed 24 September 2021.

243 Department of Health, 'National Mental Health Workforce Strategy - Background Paper (Draft)', *ACIL Allen*, August 2021, page 15.

244 Productivity Commission, *Answer to Question on Notice*, page 1.

245 Ms Amelia Walters, headspace Board Youth Advisor, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 29.

5.308 WAAMH noted that the existing peer work qualification, implemented by the vocational training sector providing certificate III and IV level skills, is 'fairly well established'.[246]

5.309 SANE Australia suggested developing broader academy style approaches to the lived experience workforce beyond the certificate IV. SANE Australia advised that this 'would require structural investment in research and development and should be led by lived experience'.[247]

5.310 To help those wishing to go beyond being a peer worker, SANE Australia endorsed the recommendation of the Royal Commission into Victoria's Mental Health System to establish a lived-experience-led agency. SANE Australia suggested that the intention would be 'to set it up as a registered training organisation to support people with lived experience to develop, design and lead their own organisations'.[248]

5.311 AASW highlighted that 'many highly qualified mental health practitioners also have lived experience, on which they draw in their professional work', but in doing so are able to differentiate which aspects are appropriate to share:

> … that task itself is something that requires professional education and supervision.[249]

5.312 ReachOut recognised the need to ensure training and safe practices are in place for those people with lived experience who are providing support for others:

> That extends all the way through to things like making sure we've got debriefs, clinical supervision of the peer workers themselves, as much as we are thinking about the experience of the young people accessing the service.[250]

5.313 Youth Insearch outlined the criteria it has stipulated for those wanting to become youth leaders, and the protections that have been put in place. In

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246 Ms Taryn Harvey, Chief Executive Officer, WAAMH, *Committee Hansard,* Canberra, 19 July 2021, page 5.

247 Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, pages 25-26.

248 Ms Grace McCoy, Head of Partnerships and Lived Experience, SANE Australia, *Committee Hansard,* Canberra, 26 July 2021, page 29.

249 AASW, *Submission 111*, page 9.

250 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard,* Canberra, 28 July 2021, page 14.

addition to attending a number of its workshops, prospective peer workers need to demonstrate 'that they have the capacity or that they have begun to work on their issues':

> We are very aware and concerned about the risk of having a youth, peer-led workforce, and for that reason we have ongoing training for them as well—monthly training that they attend. They have constant support by staff members. They are never in a situation where they are on their own working with young people. They're always surrounded by supports that are available to them at any time.[251]

5.314 LEA also raised the important role of reciprocal training, where views of those with lived experience are able to be incorporated into training products for the wider mental health workforce:

> Lived Experience Australia has developed 5 online educational models comprising the views of consumers, a carer, a GP, and a psychiatrist. LEA has acquired CPD points from the Royal Australian and New Zealand College of Psychiatrists and the Australian College of Mental Health Nurses. To cement these learnings into clinical practice LEA has targeted psychiatry trainees and now provides an annual award titled: 'Best practice in consumer and carer inclusion' for those who undertake the training and submit a reflective piece about how their learnings have changed their clinical practice.[252]

Enabling the peer workforce into practice in the community

5.315 While noting that ongoing funding continues to present challenges, RFDS provided a working example on how it partnered with Lifeline Australia to upskill local communities and develop peer workers, supporting mental health in rural and remote settings:

> It's a non-clinical peer advocate program where we've identified leaders in the community around far west New South Wales. It's a pastoral focused program; they're graziers living on cattle stations and they have a lived experience with mental health. We employ them and train them and provide mental health support to them in their role. They can receive phone calls from their neighbours and peers, they will speak at local community events, they will visit people on properties, they're essentially contactable 24/7 as peer advocates and they will help link people in. It's not a service for everyone, but it's on the ground and local; it's a linkage pathway, I suppose. One of those champions has indicated she's about to enrol in the cert IV peer mental health

251 Mrs Leanne Hall, Clinical Lead, Youth Insearch, *Committee Hansard,* Canberra, 28 July 2021, pages 37-38.

252 LEA, *Submission 106*, page 13.

> program, so she's identified wanting to do more training and become more qualified, I suppose, to deliver more services herself.
>
> … The champions, as we call them, have monthly education sessions with each other and with various members of our clinical staff. They have one-on-one debriefs or reflective practice with a trained mental health professional, and that's at least monthly or as needed. Through Lifeline, they have a counsellor for their own mental health and wellbeing, and that's also monthly or as needed ... There's an interview process and a panel that have to endorse this community member to become a champion. They're not obligated to stay if at any time they don't feel comfortable.[253]

Committee comment

5.316 To realise the full potential of the emerging lived experience (peer) workforce, help people navigate complex mental health systems and provide support and reassurance throughout the process, there needs to be some degree of professionalisation.

5.317 While the Committee acknowledges the Productivity Commission's view on the unique nature of the lived experience (peer) workforce, it differs on the need for regulation, training or qualifications.

5.318 In order to protect the lived experience (peer) workers and the people they seek to assist, there must be a minimum level of structured induction and training. This is to ensure that prospective workers have ongoing supports and understand how to safely integrate their experience into the role.

5.319 The Committee is of the view that professionalisation will reduce sector stigma and support recognition across the mental health workforce and community, helping lived experience (peer) workers to be better integrated into multidisciplinary care and other team settings.

5.320 Noting the amount of work that has already been done by state and territory governments and NGOs, the Committee supports the establishment of a lived experience office, similar to that recommended in the Royal Commission in Victoria's Mental Health System. This should sit within the Department of Health portfolio and could leverage the administrative structures in place as for the National Suicide Prevention Office.

5.321 The lived experience office should be tasked with bringing together best-practice lived experience (peer) workforce practices from each of the states

253 Ms Vanessa Latham, Manager, Mental Health Services, RFDS, *Committee Hansard*, Canberra, 17 June 2021, pages 8-9.

and territories, and engage with stakeholders to develop a nationally consistent set of guidelines for lived experience (peer) workers. The office should also consider the practicalities around a national registration system and whether this should be facilitated by government or a professional association, and establish a monitoring and evaluation framework to support a safe and thriving lived experience (peer) workers sector.

5.322 The Committee also supports the establishment of a national professional association for lived experience (peer) workers, which could:

- contribute to defining the role and scope of lived experience (peer) workers, and constructing a recognisable identity for the workforce
- promote the development and integration of lived experience (peer) workers as part of the mental health and suicide prevention and aftercare workforce
- provide education and training, professional development, certification, supervision and debriefing mechanisms to support a safe and effective workforce
- engage with non-lived experience (peer) workers to develop training packages that help to reduce stigma, discrimination and increase understanding of the value of lived experience (peer) work
- consolidate information on different programs, products, practices, and policies across the lived experience (peer) sector, and provide advice to government on what is and is not working.

Recommendation 23

5.323 The Committee recommends that the Australian Government support the development of the lived experience (peer) mental health and suicide prevention workforce by:

- **establishing a lived experience office within the Department of Health portfolio to support the growth of a safe and effective lived experience (peer) workforce, led by a National Lived Experience Officer**

- **providing seed funding for the establishment of a national professional association for lived experience (peer) workers, with additional guaranteed funding for the first five years of operations.**

Carers and family

5.324 Often unpaid and largely unrecognised, carers supporting people with mental health problems or providing suicide aftercare provide a valuable contribution to the community and reduce the burden on health systems. Tandem Carers provided insight into the role of a carer, and expectations placed upon them, following a suicide attempt, and called for carer inclusive policies:

> After a suicide attempt, for instance, it's predominantly women and families who are charged with ensuring that further attempts are prevented through suicide watch. Suicide watch is a mental health term that says nothing about the person who is doing the watching, about their ability to undertake 24/7 surveillance, about the toll this takes and about what it does to relationships. Currently there is patchy follow-up at best when someone is discharged to a family, and little consideration is given to the emotions and the economic or social circumstances of those families or carers or how isolated they are in rural or regional locations. This means that carers and families are left scrambling to do the best they can and bear the burden of guilt for poor outcomes … Without support, carers and families can quickly reach breaking point. This has a flow-on effect across the community, leading to cost blow-outs for federal, state and territory governments in health, justice, housing and homelessness.[254]

5.325 HelpingMinds highlighted a University of Queensland study, commissioned by Mind Australia, that placed the value of unpaid informal carer support work to the community in Australia at about $13.2 billion a year.[255]

5.326 Despite the important role that carers play, Mental Health Carers Australia raised concerns that 'families and carers are often left out of discussions about how to best support the person that they're caring for'.[256]

5.327 Carers, family and friends also need nationally recognised training available to empower them to provide skilled intervention. Suicide prevention training organisation, LivingWorks highlighted the need to 'skill up those around vulnerable people' through programs such as Applied Suicide Intervention Skills Training (ASIST). LivingWorks explained they need:

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254 Ms Amaya Alvarez, Lived Experience Advisor, Tandem Carers, *Committee Hansard*, Canberra, 27 August 2021, page 18.

255 Mrs Deborah Childs, Chief Executive Officer, HelpingMinds Ltd, *Committee Hansard*, Canberra, 19 July 2021, page 25.

256 Ms Katrina Armstrong, Executive Officer, Mental Health Carers Australia, *Committee Hansard*, Canberra, 5 August 2021, page 3.

> … practical abilities to be able to respond early to someone in distress through seeing the warning signs, listening with compassion, looking for turning points to live, and then onto safety plans for referral to the right service at the right time.[257]

5.328 The Productivity Commission Report considered in detail the role, support services and income support for carers and proposed actions to improve access to funding supports and income support payments, and to improve how families and carers are included by mental health services. It noted that as a priority:

> All mental health services should be required to consider family and carer needs, and their role in contributing to the recovery of individuals with mental illness …
>
> – State and Territory Governments should ensure the workforce capacity exists in each region to implement family- and carer-inclusive practices within their mental healthcare services.[258]

5.329 NMHCCF contended that the Productivity Commission Report recommendation to consider the family and carer needs and their role would not lead to any significant changes. Instead, NMHCCF advocated for the development and implementation of family and carer inclusive practices, where the carer is an equal member of the team and it is not negotiable that services link with carers.[259]

5.330 Similarly Carers Australia called for strategies that support inclusive relationships between carers and service providers, ensuring carers are treated with respect and considered as partners in care.[260]

5.331 Carers Australia noted that the introduction of the *Carer Recognition Act 2010 (Cth)* acknowledged 'the valuable social and economic contribution of carers in Australia'. However, it raised concerns that 'the last National Carers

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[257] LivingWorks Australia, *Submission 223*, pages [2], [11].

[258] Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, Action 18.1, page 868.

[259] Mrs Hayley Solich, Carer Co-Chair, NMHCCF, *Committee Hansard*, Canberra, 5 August 2021, page 12.

[260] Ms Liz Callaghan, Chief Executive Officer, Carers Australia, *Committee Hansard*, Canberra, 5 August 2021, page 1.

Strategy lapsed in 2014', and called for a new 'national carer strategy that covers all carers regardless of their situation and circumstances'.[261]

5.332 Mind Australia suggested that 'a new national carer strategy would demonstrate a real commitment to the needs of carers and ensure they are prioritised in future government policy'.[262]

Peak body representation

5.333 MHA advocated for the implementation of the Productivity Commission Report recommendations related to 'designing a person-led mental health system including but not limited to Action 22.4, the establishment of peak bodies to represent mental health consumers and carers'.[263]

5.334 There were differing opinions across carers and consumer representatives as to whether there should be combined or separate carer and consumer bodies.

5.335 Mental Health Carers NSW and the National Mental Health Consumer Alliance contended that the different perspectives and types of experiences of each group need to be represented. Mental Health Carers NSW suggested that advocating for their own role and position is 'appropriately empowering and respectful'.[264]

5.336 Supporting the separation of peaks, Carers ACT advised that 'carers report more often than anything else feeling incredibly invisible', and raised concerns that a merged body may result in further reducing the carer voice.[265]

5.337 However, NMHCCF supported the 'continued funding of a combined consumer carer and family lived experience voice', and stressed the need for a fully inclusive and diverse membership:

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261 Carers Australia, Submission 155, page 6; Ms Liz Callaghan, Chief Executive Officer, Carers Australia, *Committee Hansard*, Canberra, 5 August 2021, page 1.

262 Mind Australia Ltd, *Submission 68*, page 6.

263 MHA, *Submission 69*, page 13.

264 Mr Jonathan Harms, Chief Executive Officer, Mental Health Carers NSW, *Committee Hansard*, Canberra, 5 August 2021, page 5; Ms Irene Gallagher, Foundation Member, National Mental Health Consumer Alliance, *Committee Hansard*, Canberra, 5 August 2021, pages 7-8.

265 Ms Lisa Kelly, Chief Executive Officer, Carers ACT, *Committee Hansard*, Canberra, 5 August 2021, page 4.

> … this type of an organisation offers the opportunity for ongoing shared understanding, discussion and debate on the intersectionality of issues, and co-design opportunities that will be missed if the combined voice is not established ... We also ask that the government ensures that the combined voice has representation from all jurisdictions and diverse population groups, such as Aboriginal and Torres Strait Islanders and the culturally and linguistically diverse, and reach into the communities they represent.[266]

Caring for the carer – wellbeing and respite

5.338 Evidence indicated that carers are deprioritising their own health and participation in the paid workforce due to the demands being placed on them in the role of carer. In addition witnesses raised concerns that mental health respite carer support had been removed without a suitable replacement.[267]

5.339 Mental Health Carers Australia suggested that 'the biggest determinant of carer wellbeing is a functioning mental health system', noting a functioning system would enable carers to engage in employment and other pursuits.[268]

5.340 Tandem Carers called for consistent and accountable carer-friendly policies in the workplace to boost carers' ability to 'juggle all their responsibilities'.[269]

5.341 PACFA suggested counselling be made available for carers, providing them an opportunity to prioritise their own self-care, talk about their situation and receive support in 'a confidential and safe space'.[270]

5.342 When it comes to respite, Carers ACT explained that there is not a national standard and 'respite for mental health carers looks very different than respite for people who care for aged or disabled people':

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[266] Mr Keir Saltmarsh, Consumer Co-Chair, NMHCCF, *Committee Hansard*, Canberra, 5 August 2021, page 14.

[267] See, for instance: Mrs Deborah Childs, Chief Executive Officer, HelpingMinds Ltd, *Committee Hansard*, Canberra, 19 July 2021, page 25; Ms Kerry Hawkins, Vice Chair, Mental Health Carers Australia, *Committee Hansard*, Canberra, 5 August 2021, page 3; Mrs Hayley Solich, Carer Co-Chair, NMHCCF, *Committee Hansard*, Canberra, 5 August 2021, page 13.

[268] Ms Katrina Armstrong, Executive Officer, Mental Health Carers Australia, *Committee Hansard*, Canberra, 5 August 2021, page 3.

[269] Ms Amaya Alvarez, Lived Experience Advisor, Tandem Carers, *Committee Hansard*, Canberra, 27 August 2021, page 20.

[270] Ms Johanna de Wever, Chief Executive Officer, PACFA, *Committee Hansard*, Canberra, 13 August 2021, page 11.

> For respite to work effectively for mental health carers it needs to be flexible, it needs to be responsive and it needs to be trauma-informed. We need to set up facilities that are non-clinical and that are welcoming and inviting for people with mental health concerns to want to be at in order to get proper respite.[271]

5.343 Having trialled various different models with different communities around Western Australia, HelpingMinds highlighted high demand for its current respite program that builds in a range of supports tailored to mental health carers:

> The supports that we are evaluating at the moment are around a retreat-type approach, so it has an educational component but there is also the ability to rest and revise and build up your—resilience seems to be an overused word at the moment, but your energy levels so that you can then go back to that role. With these retreats, we actually don't need to advertise them ... It's about trying to build smart outcomes that communities can offer for themselves.[272]

Committee comment

5.344 First and foremost, the Committee wants to acknowledge all the people who have taken on the role of carer, and the family and friends who have stepped up to provide support.

5.345 In parliamentary roles, representing communities across Australia, the members of the Committee have heard the frustrations experienced by many Australians as they try to navigate the mental health or suicide aftercare system on behalf of a loved one.

5.346 There are also members of the Committee themselves who have brought their lived experience as mental health carers of family members to this inquiry.

5.347 As with lived experience (peer) workers, the Committee wants to ensure that carers have a voice at the table, and that the experience of carers is treated with respect and valued, recognising the contribution they can make to improving systems and individual outcomes. However while the Committee supports the views of carers being formally represented, based on the evidence heard the Committee was unable to reach a conclusion on whether

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271 Ms Lisa Kelly, Chief Executive Officer, Carers ACT, *Committee Hansard*, Canberra, 5 August 2021, page 4.

272 Mrs Deborah Childs, Chief Executive Officer, HelpingMinds Ltd, *Committee Hansard*, Canberra, 19 July 2021, pages 26, 28.

the representative association should be a combined carer and consumer body or a discrete carer entity.

5.348 The Committee endorses the Productivity Commission Report recommendation for all mental health services to consider family and carer needs, and their role in contributing to the recovery of individuals with mental illness.

5.349 In recognising the rights of consumers, and acknowledging that not all persons may want a carer or family member involved in their treatment, the Committee calls for the Productivity Commission's recommendation to be strengthened to require carer or family inclusive practices only where the carer or family member has guardianship responsibilities (for example parents of younger children), or the consumer has expressed a wish for the carer or family member to be involved.

5.350 To support the implementation of improved recognition and support for mental health and suicide aftercare carers, the Committee calls for a renewed national strategy for carers that explicitly recognises these unique roles, the specialist support they provide and respite requirements. This work should take into account best practice from states and territories that have current strategies.

5.351 Carers also need funded access to nationally recognised training to upskill them to provide safe, evidence-based interventions. A priority should be the development of training modules for carers (unpaid carers, family members and friends) that support carers to be suicide aware and suicide safe. Training developed on the LivingWorks ASIST type model and targeted at carers would benefit carers themselves and people living with mental health issues.

Recommendation 24

5.352 The Committee recommends that the Department of Social Services, in consultation with the Department of Health, National Mental Health Commission and National Suicide Prevention Office, develop a national carer strategy that includes:

- **details on how and when unpaid carers are to be integrated into care teams**
- **access to national standardised training for suicide awareness, risk and prevention for all carers**

- **a clear pathway for engagement with carer representative bodies.**

Recommendation 25

5.353 The Committee recommends that the Department of Social Services implement a fit-for-purpose respite care program that is flexible and includes access to educational components, counselling services and other supports to boost resilience.

Workforce wellbeing

5.354 Chapter 2 explored in detail the impacts felt across communities as a result of the COVID-19 pandemic, bushfires and other recent natural disasters. However, these crises have undoubtedly impacted Australia's health and mental health professionals who have been thrust into the spotlight and faced extraordinary levels of demand of their services.

5.355 As ReachOut noted, those working to support others have also been affected by the same factors:

> … you've seen the circumstances that are driving a lot of the service access from the community also affecting the team in a similar way. That almost amplifies the fatigue, because you're helping others through it as you, yourself, are navigating through it as well.[273]

5.356 To help its team cope, ReachOut implemented a number of adjustments, including adding resources, amending rosters to recognise the increased intensity, emphasising trauma informed training, and providing mechanisms for informal and formal debriefs.[274]

5.357 The Mountains Youth Services Team (MYST), a small NGO, experienced a massive spike in demand. In addition to structural adjustments, the team increased its focus on wellbeing, adding some light-hearted activities to counter-balance the intensity, and increased access to clinical supervision. However, MYST also recognised that additional resources would be helpful to support youth workers:

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273 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 14.

274 Mr Ashley de Silva, Chief Executive Officer, ReachOut, *Committee Hansard*, Canberra, 28 July 2021, page 14.

> Youth workers don't have the same kind of training that our counsellors have, so, when they're dealing with young people disclosing plans to suicide, even though they've done additional training in suicide prevention, just being able to have additional staff—… other counsellors that have that special crisis training—would be really helpful to take that load off. [275]

5.358 There was general consensus that stressors including waiting lists, waiting times, lack of in-patient beds and shortages of clinicians were resulting in burnout and driving health and mental health professionals to leave the sector or work elsewhere.[276]

5.359 Noting the workforce shortages, the Australasian College for Emergency Medicine said that the pressure was being felt across all staff in emergency as they try to deal with a 'supply-and-demand mismatch':

> Having to deal with those system failures that we know are contributing to poor patient care and worsening their outcome is incredibly stressful for physicians and nurses, and it is all those things that I think contribute to that level of stress and burnout.[277]

5.360 Likewise, consultant psychiatrist, Dr Emma Radford explained that 'there is a large component of burnout that comes from never feeling you meet any need and feeling that you are constantly saying no or you are constantly not able to provide something for people'. Dr Radford suggested protective factors include engagement with professional peers and supervision, and valuing your own work.[278]

5.361 NMHC advocated for strengthening 'supervision arrangements and arrangements around the care of mental health workers', and looking more broadly for ways to avoid burnout:

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275 Ms Kim Scanlon, General Manager, Mountains Youth Services Team, *Committee Hansard*, Canberra, 28 July 2021, page 29.

276 See, for instance: Dr Simon Judkins, Immediate Past President, Australasian College for Emergency Medicine, *Committee Hansard*, Canberra, 26 July 2021, page 9; Associate Professor Alessandra Radovini, La Trobe University, *Committee Hansard*, Canberra, 26 July 2021, page 37; Dr Emma Radford, Psychiatrist, Melbourne Health, *Committee Hansard*, Canberra, 26 July 2021, pages 37-38; Dr Caroline Johnson, Member, Senior Representative, RACGP, *Committee Hansard*, Canberra, 24 June 2021, page 9.

277 Dr Simon Judkins, Immediate Past President, Australasian College for Emergency Medicine, *Committee Hansard*, Canberra, 26 July 2021, page 9.

278 Dr Emma Radford, Psychiatrist, Melbourne Health, *Committee Hansard*, Canberra, 26 July 2021, pages 37-38.

> … so looking at what the appropriate structures can be and perhaps utilising things such as our telehealth measures et cetera to expand the capacity for supervision, particularly for clinicians who might be in rural or remote areas.[279]

5.362 In terms of supporting specific fields, Professor Grenyer stressed the need for those in private practice to have access to support, advice and professional development. Professor Grenyer noted that annual conferences and online training are some of the ways to connect, but that supervision remains important:

> Supervisors will say, 'I recommend you go and read something or go to one of these trainings.' That can be the turning point around practitioners getting the kinds of tips and strategies that will help keep them continuing to do good work when things get challenging and difficult.[280]

5.363 However concerns were raised about the cost of supervision, especially in private practice, where these costs would be borne either by the clinician or passed on to the consumer.[281] NMHC called for a 'conversation and investigation into funding models and funding mechanisms' that take into account the intersection with existing supervision requirements.[282]

5.364 Not all supervision is equal according to Professor Rosen, who noted that:

> It's patchy ... There are some beacons of very good supervision and mentorship. There is quite a huge wasteland between those beacons.[283]

5.365 Other suggestions to help mitigate burnout and improve wellbeing of the workforce included:

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279 Ms Christine Morgan, Chief Executive Officer, NMHC, *Committee Hansard*, Canberra, 18 March 2021, page 17.

280 Professor Brin Grenyer, Professor of Psychology, University of Wollongong and Director, Project Air Strategy for Personality Disorders, *Committee Hansard*, Canberra, 19 August 2021, pages 10-11.

281 See, for instance: Ms Christine Morgan, Chief Executive Officer, NMHC, *Committee Hansard*, Canberra, 18 March 2021, page 17; Dr Dianne Stow, President, PACFA, *Committee Hansard,* Canberra, 13 August 2021, page 8.

282 Ms Christine Morgan, Chief Executive Officer, NMHC, *Committee Hansard*, Canberra, 18 March 2021, page 17.

283 Professor Alan Rosen AO, Chair, Transforming Australia's Mental Health Service Systems, *Committee Hansard*, Canberra, 29 July 2021, page 3.

- QNMU – implementing nurse-to-patient ratios in mental health units.[284]
- RACGP – reassuring doctors that they can get help for their mental health conditions without professional censure.[285]

5.366 AMA acknowledged that the greater stigma around mental health in the medical profession, and concerns about being reported to the regulator, remain barriers to help-seeking.[286]

5.367 AMA advised that there have been some programs developed for doctors' mental health, including by Beyond Blue, the DRS4DRS system, and since COVID-19, a support portal, but noted there is more to be done:

> … particularly, as you said, in that more preventative space, including things like debriefing after severe events or having an opportunity, like some other mental health specialities do, for some professional supervision, where you could talk things through without it necessarily having any impact on your own health record and health and life insurance down the track and those sorts of other impacts that worry doctors, as they do other professionals.[287]

Committee comment

5.368 Health professionals have faced a sustained spike in demand for their services, including increased presentations of mental health issues and suicidal ideation. Mental health professionals have built-in pathways for supervision that provide opportunities for wellbeing check-ins. In addition and as noted above, a national workforce institute for mental health could be tasked with:

- examining strategies to reduce burnout
- development of supervision pathways for other health professionals, who may benefit from the introduction of a process to facilitate regular debriefings with mental health professionals.

5.369 In addition to normalising help-seeking, these actions could also help health professionals build their mental health skills and gain valuable second opinions on clinical judgements.

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284 Mr Allan Shepherd, Professional Officer, Team Leader, QNMU, *Committee Hansard*, Canberra, 21 July 2021, page 11.

285 Dr Caroline Johnson, Member, Senior Representative, RACGP, *Committee Hansard*, Canberra, 24 June 2021, page 9.

286 Dr Omar Khorshid, President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 40.

287 Dr Danielle McMullen, NSW President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 40.

6. Funding

6.1 The Australian Government's 2021-22 Budget made the largest Commonwealth mental health investment to date, allocating $2.3 billion to the National Mental Health and Suicide Prevention Plan.

6.2 States and territories have also made a series of record breaking investments in mental health and wellbeing. For example:

- Responding to the Royal Commission into Victoria's Mental Health System, the Victorian Government invested $3.8 billion to 'transform the state's mental health and wellbeing system'.[1]
- The New South Wales (NSW) Government allocated $10.9 billion over the next four years across the state to support mental health and wellbeing.[2]
- Western Australia provided '$1.114 billion in 2021-22 to the Mental Health Commission to boost mental health, alcohol and other drug services'.[3]

6.3 These substantial investments across Australia reinforce the need to ensure that funding arrangements for mental health services, including through the Medicare Benefits Schedule (MBS) and Primary Health Networks (PHNs), are structured in a way that supports safe, high quality and effective care in

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1 Victorian Government, '2021-22 Victorian State Budget Mental Health Highlights', www.vic.gov.au/2021-22-victorian-state-budget-mental-health-highlights, viewed 5 October 2021.

2 The Hon Bronnie Taylor MLC, New South Wales (NSW) Minister for Mental Health, 'Record $10.9 billion spend in mental health services', Media Release, 22 June 2021.

3 The Hon Mark McGowan MLA, Premier of Western Australia (WA) and the Hon Stephen Dawson MLC, WA Minister for Mental Health, 'Massive boost for mental health in 2021-22 State Budget', Media Release, 9 September 2021.

line with the qualifications of practitioners and needs of consumers across whole of population.

6.4 This chapter first reviews the Commonwealth, state and territory funding coordination and reform priorities, and then examines the role of PHNs, the MBS and other non-government organisations (NGOs) providing services. Finally, the chapter considers implementation priorities.

The National Agreement and Commonwealth-state and territory funding coordination

6.5 On 11 December 2020, the Prime Minister announced that the National Federation Reform Council (NFRC) had agreed to the development of a new National Agreement on Mental Health and Suicide Prevention (National Agreement):

> The NFRC agreed to collaborate on systemic, whole-of-governments reform to deliver a comprehensive, coordinated, consumer-focussed and compassionate mental health and suicide prevention system to benefit all Australians. This will be achieved through a new National Agreement on Mental Health and Suicide Prevention to be negotiated through the Health National Cabinet Reform Committee by the end of November 2021.[4]

Defining roles and responsibilities

6.6 Mental Health Australia's (MHA) submission recommended that:

- The Australian, state, and territory governments should clarify funding roles and responsibilities through the National Agreement on Mental Health and Suicide Prevention, currently being developed.[5]
- The Australian, state, and territory governments should ensure lines of funding for mental health are clear and transparent enough to enable consumer-focussed accountability.[6]

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4 The Hon Scott Morrison MP, Prime Minister, 'National Federation Reform Council Statement', Media Statement, 11 December 2020.

5 Mental Health Australia (MHA), *Submission 69*, page 20. See also: Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 2; Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 24.

6 MHA, *Submission 69*, page 20.

6.7 Appearing before the Committee, headspace called for the National Agreement to incorporate a whole-of-life, whole-of-government and whole-of-community approach that positions mental health and suicide prevention as everyone's responsibility:

> This needs to be cross-portfolio, cross-jurisdictional and not confined to mental health. It needs to be accountable to first ministers and incorporate clear roles and responsibilities across all levels of government. It also calls for a whole-of-sector effort in collaboration that's incentivised and supported by governments.[7]

6.8 The Black Dog Institute contended that successful negotiation of the National Agreement would be critical in resolving jurisdictional fragmentation, and reinforced the importance of leadership and cross-portfolio engagement:

> … mental health goes well beyond the healthcare system—the role of education and of social support in mental health. Our view is consistent with Mental Health Australia's advice that, even if health ministers are going to be tasked with that, there needs to be a mechanism through which health ministers can request … other ministerial portfolios to document that activity, and that there is oversight of that.[8]

6.9 Any reform to funding responsibilities requires an appreciation of the types of services delivered by Commonwealth and state and territory governments, and their respective intensities and costs. The Australian Institute of Health and Welfare explained:

> … if you look at spending, there's a lot more spending on the state and territory services because they're more intensive services. Often, if somebody stays in hospital for several days or in residential mental health, the costs are a lot higher than the MBS data. In terms of sheer numbers, there are more people using MBS mental health services than the state and territory services.[9]

6.10 headspace identified the National Agreement as the starting place for effective reform to the mental health sector, noting that:

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7 Ms Carolyn Nikoloski, Chief Strategy Officer, Beyond Blue, *Committee Hansard*, Canberra, 26 July 2021, page 25.

8 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 3.

9 Mr Matthew James, Deputy Chief Executive Officer, Australian Institute of Health and Welfare, *Committee Hansard*, Canberra, 6 August 2021, page 15.

> The disparity between a state system and a federal system or a primary care system, if they're not connected in a policy sense, in a funding sense, plays out on the ground … Shared systems, shared electronic records and a real consumer focus has to be at the forefront of any reform, and that starts with this very challenge that's before this committee and governments around having an agreed position on who is responsible for what.[10]

6.11 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) also recommended 'that any Commonwealth funding work very closely with the state based services':

> I say that because, if we create more and more doors for accessing services, it confuses the person who needs to access that service … That's where I think the integration of Commonwealth and state based services is very important. We should not be rolling out services that do not interface with other existing services correctly. An example is headspace. There are headspaces that work very well because they work in connection with a state based service and there are headspaces that are not working in connection with the state based services … They work less better than the other ones.[11]

6.12 Concerns were raised about the lack of consultation with peak bodies and service providers during the National Agreement development process. The Western Australian Association for Mental Health (WAAMH) stated:

> We had a chance to make a submission to Mental Health Australia, who are the peak non-government body for mental health at a national level. They asked for submissions from their members, of which we are one, with the advice to us that Mental Health Australia are not represented on the expert advisory committee overseeing the development of the agreement and that they hadn't been asked to undertake any consultation with the sector in relation to its content … According to Mental Health Australia, that was not something that anyone had actually instigated; that was something that they had to instigate themselves. In the spirit of getting perspectives from the entire sector, I'd say that's maybe something to take back and consider about how we actually get genuine input from different parts of the mental health sector and the community around these processes and make them easy to understand and easy to engage with.[12]

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10 Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 31.

11 Associate Professor Vinay Lakra, President, Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Committee Hansard*, Canberra, 6 August 2021, page 11.

12 Dr Elizabeth Connor, Senior Policy Officer, Western Australian Association for Mental Health (WAAMH), *Committee Hansard*, Canberra, 19 July 2021, page 4.

Committee comment

6.13 Noting that the development of the National Agreement should be almost finalised, the Committee hopes that it clearly outlines the specific funding responsibilities, governance structures and reporting requirements of the Commonwealth, states and territories. This will be fundamental for resolving current service and workforce gaps, and the fragmentation of the sector's systems.

6.14 Recognising the significant impact that the National Agreement will have on the mental health sector, the Committee calls for the Australian Government to include stakeholder consultation in any future funding negotiations.

Primary Health Networks

6.15 Australia's 31 PHNs are independent organisations that operate as regional commissioning bodies, working to streamline health services and coordinate care.[13]

6.16 In early 2017 the Department of Health commissioned an evaluation of PHN's, the Primary Health Network Mental Health Reform Lead Site Project, which was conducted by the University of Melbourne. It was established to provide the Department of Health with an evidence base on effective approaches to planning, integration and delivery of mental health services. In December 2020 this report was completed, but is not publicly available.[14]

6.17 The Productivity Commission Inquiry Report on Mental Health (Productivity Commission Report) recommended reform to funding arrangements with PHNs to support efficient and equitable service provision:

- The Australian Government Department of Health should reform the way that it allocates funding to PHNs (or RCAs [regional commissioning authorities]) to support greater regional equity and remove incentives to engage in cost shifting.[15]

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13 Department of Health, 'Primary Health Networks', www.health.gov.au/initiatives-and-programs/phn, viewed 28 September 2021.

14 Department of Health, *Answer to Question on Notice*, 18 March 2021, page [3].

15 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, Action 23.5, page 82.

6.18 The Productivity Commission Report also recommended the Department of Health provide guidance on the evidence base behind interventions and require PHNs to demonstrate evidence-based service delivery.[16]

Coordinated, joint regional approaches

6.19 Various witnesses highlighted the importance and the need for coordinated, joint regional approaches to commissioning mental health and suicide prevention services.[17] Professor Ian Hickie from the University of Sydney's Brain and Mind Centre stated:

> The inequity tends to grow under systems that are not well structured and in which the agreements between the Commonwealth, the states and, I must say, increasingly the non-government sector are poorly coordinated.
>
> I am therefore a strong advocate of regionalisation—that these things can be regionally organised. I was a strong advocate on the Mental Health Commission for PHNs taking that role on behalf of the Commonwealth, but they cannot act in isolation. Regional planning requires cooperation between the federally funded services, organised through the PHN, state-run services and the non-government sector. It also requires strong action by the Commonwealth with regard to supporting the private health sector to be a productive member of this discussion.[18]

6.20 MATES in Construction explained that through PHN support and regional coordination, it has been able to effectively address service gaps, trial its services in broader-community approaches, and reach more diverse regional areas.[19]

6.21 WAAMH suggested that as a peak body it had the capacity to support workforce planning objectives, but requires clarity from governments and

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16 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, Action 23.6, page 82.

17 See, for instance: Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, pages 44-45; Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 30; Mr Paul Martin, Mental Health Working Group, PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 7.

18 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 30.

19 Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, pages 44-45.

PHNs on what it should be planning for, and what the regional priorities are:[20]

> I think one of the things that's also important … is taking into account that whatever's going to be done at a national level, replicated in states and territories, really needs to be done in a way that can take account of the local infrastructure and state funded service systems that are already in existence. Again, that's one of the reasons why we had a strong preference for the notion of regional commissioning that the Productivity Commission spoke to.[21]

6.22 The PHN Cooperative referred to the Productivity Commission Report findings that identified a 'lack of system integration across the mental health system', and 'the challenge of the blame game, or cost shifting between funders'. The Cooperative argued that:

> … the reality is that the Commonwealth is going to continue to fund primary care, and the states are going to continue to fund hospital care. While those two things are continuing, they both need to work together to address mental health issues … So it's by PHNs and LHNs [Local Health Networks] working together that we can understand the needs of communities, plan and commission services.[22]

6.23 Healthy North Coast highlighted its work around developing a joint regional approach to address duplication of investment in certain areas and funded programs that had not been delivering on outcomes:

> At its pinnacle—and I think it's got a long way to go around that—we started to make investment decisions at a portfolio level, and saying, 'Actually, we're investing all of this money here like we always have, but if we shifted investment focused on outcomes we could probably get much better outcomes for our region.' But those things can't be done unless you're working collectively together towards a joint set of goals. Importantly, you really need to understand not only what you invest but the outcomes of what you invest.[23]

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20 Ms Taryn Harvey, Chief Executive Officer, WAAMH, *Committee Hansard*, Canberra, 19 July 2021, page 3.

21 Ms Taryn Harvey, Chief Executive Officer, WAAMH, *Committee Hansard*, Canberra, 19 July 2021, page 3.

22 Mr Paul Martin, Mental Health Working Group, PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 7.

23 Ms Julie Sturgess, Chief Executive Officer, Healthy North Coast (North Coast Primary Health Network), PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, pages 9-10.

6.24 Brisbane North PHN noted the benefits of a health alliance with the Local Health Network (LHN), explaining that the alliance provides a mutual space for strategic work in joint planning and co-commissioning of services:[24]

> … where PHNs are really well positioned is to have an understanding of the service profile across our particular region and how consumers might access that. From our perspective we have a mental health service navigator line that really is consumer facing. It can also support our GPs [general practitioners] and other primary healthcare providers to think about what services are in the community that can meet people's needs and how people might navigate to those.[25]

6.25 The Productivity Commission Report recommended reform to PHN funding arrangements to support efficient and equitable service provision. To achieve this, the report recommended that governments strengthen the cooperation between PHNs and LHNs by requiring comprehensive joint regional planning. It recommended that:

- The National Mental Health Commission should independently monitor and report on compliance by PHNs and LHNs against their commitments. (Action 23.1)[26]

6.26 Action 23.4 of the Productivity Commission Report recommended federal support for the state and territory governments that choose to establish regional commissioning authorities (RCAs) to administer mental health funding as an alternative to PHN-LHN groupings.[27]

6.27 The Brisbane South PHN and Metro South Addictions and Mental Health Services (MSAMHS) submission identified concerns with this recommendation in the Productivity Commission Report. The submission argued that while not all PHN-LHN relationships are as collaborative as the Brisbane South PHN-MSAMHS relationship, federal and state governments might erase all progress achieved over the last five years by moving to a new commissioning model. It contended that:

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24 Ms Libby Dunstan, Chief Executive Officer, Brisbane North PHN, *Committee Hansard*, Canberra, 21 July 2021, pages 1-2.

25 Ms Libby Dunstan, Chief Executive Officer, Brisbane North PHN, *Committee Hansard*, Canberra, 21 July 2021, pages 4.

26 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 202, page 82.

27 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, page 82.

> We would support strengthened guidelines/requirements for, and oversight of, the PHN-LHN working relationship but see the creation of new commissioning agencies or bodies as a duplication of resources and effort.[28]

6.28 Appearing before the Committee, Brisbane South PHN further explained this concern:

> Systems change takes time, and the systems and our communities can't afford another reset in the system. I don't think that there is a single agency that can be the panacea, and any new iteration would need to integrate into the broader health and social systems, just as we're doing, and will have the disadvantage of needing to gain trust from stakeholders that this next solution will stick.[29]

6.29 Wesley Mission also expressed concern with the suggestion of changing the regional commissioning model, noting that:

> The reason why we recommended continuing to build the PHN capability is that there are significant inroads made in terms of the relationship of trust between community members and the commissioning authority … There's obviously quite a lot of workforce capability that's been developed there.[30]

Multidisciplinary care

6.30 Various reports and witnesses have raised the importance of investing in multidisciplinary models of service delivery outside of the MBS, to give the Australian population access to holistic healthcare and remove the current siloing approach that causes discipline friction.[31]

6.31 The PHN Cooperative contended that current funding models lead to the siloing of professions and do not effectively accommodate individuals who present with other concurring health challenges, co-morbidities, or life situation concerns:

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[28] Brisbane South PHN and Metro South Addictions and Mental Health Services, *Submission 218*, page 1.

[29] Mrs Jennifer Newbould, Director, Mental Health, Suicide Prevention, Alcohol and Other Drugs, Brisbane South PHN, *Committee Hansard*, Canberra, 21 July 2021, pages 2-3.

[30] Mr James Bell, Group Manager, Wesley Mission, *Committee Hansard*, Canberra, 29 July 2021, page 19.

[31] See, for instance: Mr Philip Armstrong, Chief Executive Officer, Australian Counselling Association (ACA), *Committee Hansard*, Canberra, 21 July 2021, page 22; Mrs Leanne Hall, Clinical Lead, Youth Insearch, *Committee Hansard*, Canberra, 28 July 2021, page 37; Professor Alan Rosen AO, Chair, Transforming Australia's Mental Health Service Systems, *Committee Hansard*, Canberra, 29 July 2021, page 5.

> So PHNs receive funding to fund psychology. We receive funding for mental health nursing. So we receive these little pots of money each with their own guidelines attached to them, which are about funding professions. But what we don't get is a pot of money that's about funding the services that people need. What people say they want and need is often a multidisciplinary integrated service.[32]

6.32 Similarly, Professor Alan Rosen from Transforming Australia's Mental Health Service Systems argued that:

> The dual disorder is in the services, not in the service users. In fact, it's not just dual; it can be up to a quintuple whammy that includes mental health problems, drug and alcohol, forensic, alienation of youth and all the social determinant factors such as poverty. That's just a simplified version.[33]

6.33 The Women's Mental Health Service at the Royal Women's Hospital highlighted the success of its multidisciplinary approach within its delivery of perinatal care, improving patient navigation of the public healthcare system:

> … the Royal Women's Hospital recently established an innovative approach called the social model of health, which combines mental health, sexual violence and trauma counselling, social work, housing, and alcohol and drug services for our most vulnerable. The social model of health is underpinned by a strong multidisciplinary team approach based on close clinical collaboration, providing perinatal women, in particular, with greater integration and continuity of care as they journey through the inpatient, outpatient, antenatal and postnatal aspects of their care, which can be extremely fragmenting. Such a multidisciplinary team approach also allows for enhanced capacity building and cross-fertilisation of ideas amongst clinician[s].[34]

6.34 However, the Committee heard that successful multidisciplinary teams require reliable funding and adequate staffing. Exercise and Sports Science Australia (ESSA) noted that exercise physiologists (EPs) are often based in

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32 Mr Paul Martin, Mental Health Working Group, PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 8; Adjunct Associate Professor Learne Durrington, Chief Executive Officer, WA Primary Health Alliance and Chair, National PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 8.

33 Professor Alan Rosen AO, Chair, Transforming Australia's Mental Health Service Systems, *Committee Hansard*, Canberra, 29 July 2021, page 5.

34 Professor Marie-Paule Austin, Head, Women's Mental Health Service, Royal Women's Hospital, *Committee Hansard*, Canberra, 27 August 2021, page 23.

community facilities or hospitals and are unreliably funded through a combination of compensable schemes or state PHNs:

> … in terms of hospital models of care there are some really great examples. For example, in Brisbane it's located in the community care unit, our Coorparoo residential service, and they predominantly treat those who are suffering with schizophrenia … So it's delivered by a multidisciplinary team which includes a dietitian, and the programs are led by the psychiatrist there. Unfortunately their EP is funded inconsistently, so they have to reapply for their funding.[35]

6.35 Likewise, Professor Perminder Sachdev contended that multidisciplinary approaches to service delivery effectively support the complex treatment of eating disorders, but are often not sustainably funded:

> The best treatment is offered by a unit that specialises in eating disorders, because you need dietitians, social workers, psychologists, psychiatrists and general physicians working together, and only a specialised unit can offer that kind of treatment. We have very limited, specialised units for eating disorders, especially in the public sector. There are a few in the private sector, but there are very few in the public sector.[36]

6.36 The Black Dog Institute raised concerns in relation to the staffing of multidisciplinary centres:

> There's no point opening up a new multidisciplinary centre if the only way to staff that is to pull mental health professionals out of other services, and we've certainly seen that before where new centres and initiatives have been opened.[37]

Referral and connectivity

6.37 According to SANE Australia, in order to develop an integrated systems approach to reform there needs to be thought given to the level of investment actually required for NGOs in the mental health sector, in

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35 Dr Caroline Robertson, Senior Strategic Adviser, Exercise and Sports Science Australia (ESSA), *Committee Hansard*, Canberra, 21 July 2021, pages 49-50.

36 Professor Perminder Sachdev, *Committee Hansard*, Canberra, 29 July 2021, page 13.

37 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 2.

addition to other social services, to improve connection-building and data sharing.[38]

6.38 The Mountains Youth Services Team (MYST) advised that its relationship-based, 'warm referral' model was improving connectivity with other community services. The model includes 'drop-in' workers from drug and alcohol and accommodation services to build relationships and support consumer transfer between services.[39]

6.39 Appearing before the Committee, the Queensland Nurses and Midwives' Union (QNMU) discussed the benefits of the discontinued mental health nurse incentive program. The federal program funded providers to engage credentialed mental health nurses to deliver coordinated clinical mental health care in the community.[40] QNMU identified that:

> Unfortunately this funding arrangement has ceased, with the primary health networks now given a flexible funding pool which means mental health services are commissioned to local providers, which are not necessarily provided by mental health nurses or mental health-trained health practitioners.[41]

Regional commissioning flexibility and funding cycles

Funding flexibility

6.40 Various contributors to the inquiry identified concerns with tight constraints on funding and an inability to respond or adapt to the significant increases in demand as a result of the COVID-19 pandemic and recent natural disasters.[42]

6.41 Noting systemic affordability issues within the mental health sector, Mind Australia stated:

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38 Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 26.

39 Ms Kim Scanlon, General Manager, Mountains Youth Services Team (MYST), *Committee Hansard*, Canberra, 28 July 2021, pages 27-28.

40 Ms Kathleen Veach, Assistant Secretary, Queensland Nurses and Midwives' Union (QNMU), *Committee Hansard*, Canberra, 21 July 2021, pages 7-8.

41 Ms Kathleen Veach, Assistant Secretary, QNMU, *Committee Hansard*, Canberra, 21 July 2021, pages 7-8.

42 Mrs Nicola Ballenden, Executive Director, Research, Advocacy and Policy Development, Mind Australia Ltd, *Committee Hansard*, Canberra, 26 July 2021, page 22; Ms Kim Scanlon, General Manager, MYST, *Committee Hansard*, Canberra, 28 July 2021, pages 28-29.

> Our workforce, on the whole, is probably less expensive than a clinical workforce, but all of our services are funded directly by government, so there's not a lot of give for us in what we can do if we're not specifically contracted to do that … Our capacity to solve the affordability issue is constrained by the ways in which services are commissioned.[43]

6.42 Brisbane North PHN argued that through the development of regional plans it is able to improve community accessibility and affordability issues. These plans provide the priorities of commissioning decisions and identify service gaps, but it argued that the capacity for implementation is currently limited by PHN budgets.[44]

6.43 Surge funding for capacity building over time, and as community demands increase, is becoming increasingly important. MYST contended that the inflexibility of funding contracts provided to community organisations has restricted options to expand to meet demand and presentation complexity. MYST identified that:

> … because of the crisis [COVID-19 pandemic] we have a contract with our state funders for five years, but it's the same amount of funding from years 1 to 5, and we're seeing this huge increase, and no additional resources. It would be really helpful to have a few additional counsellors who have clinical training in crisis to help us through this gap.[45]

6.44 Appearing before the Committee, yourtown highlighted the benefits of not needing to depend on government or PHN funding, and not being constrained by granular funding agreement clauses:

> … we are able to redesign our theories and change to engage with them [different client demographics] to understand their needs and preferences, develop new program logics for our programs and bring in staff with the relevant skills needed to address their needs. So our lesson learnt has been that you have to be quite flexible and responsive to do this and you have to be agile to the changing needs of your clients, and they do change over time.

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43 Mrs Nicola Ballenden, Executive Director, Research, Advocacy and Policy Development, Mind Australia Ltd, *Committee Hansard*, Canberra, 26 July 2021, page 22.

44 Ms Libby Dunstan, Chief Executive Officer, Brisbane North PHN, *Committee Hansard*, Canberra, 21 July 2021, page 3.

45 Ms Kim Scanlon, General Manager, MYST, *Committee Hansard*, Canberra, 28 July 2021, pages 28-29.

> Particularly with COVID we have had very different cohorts of people coming into our services with very different needs that we haven't anticipated.[46]

6.45 The Consumers Health Forum of Australia and the Royal Flying Doctor Service (RFDS) also stressed the importance of flexibility within regional commissioning structures, including funding arrangements, to support effective regional commissioning, service planning, and to ensure that service profiles can be properly integrated into the community.[47]

6.46 The Committee heard that one of the key benefits of regional commissioning of mental health and suicide prevention services is the capacity for PHNs to commission to meet the unique demand profiles of their communities and take steps towards resolving service gaps. SANE Australia proposed that this required some degree of flexibility in regional commissioning and funding:

> … we've heard support from the Productivity Commission and the royal commission for regionally based commissioning … it's about getting the state and territory governments and the Commonwealth to fund in a way that leads to system cohesion while retaining that local flexibility through the regional commissioning.[48]

6.47 The Brisbane North PHN and Metro North Hospital and Health Service (HHS) submission noted:

> A flexible funding pool at the regional level, made up of state and federal funds, would facilitate better co-commissioning and reduce administrative burdens on providers. This integrated approach to the health system, at the regional level, is the best way to drive system improvements and achieve health outcomes for local communities.[49]

6.48 The Metro South HHS indicated that flexible COVID-19 response funding enabled the HHS to support place-based, local decisions:

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46 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 45.

47 Ms Leanne Wells, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, Canberra, 5 August 2021, page 10; Ms Lauren Gale, Director, Policy and Programs, Royal Flying Doctor Service of Australia (RFDS), *Committee Hansard*, Canberra, 17 June 2021, page 10.

48 Ms Grace McCoy, Head of Partnerships and Lived Experience, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 30.

49 Brisbane North PHN and Metro North Hospital and Health Service (HHS), *Submission 73*, page 5.

> In discussion with the PHN and in discussion with local communities we had three areas that we wanted to work on, and one of the things we did really well I think is PHN leveraging the HHS. We've implemented dialectical behavioural therapy training [DBT] for the whole sector, so our staff at the HHS are training up GPs, NGOs and our own staff to allow the confidence to deliver some DBT, with the aim of increasing the resilience of our community.[50]

6.49 The Metro North HHS admitted that the highly-targeted nature of PHN budgets acts as a significant commissioning restriction, largely limiting the implementation of regional commissioning plans:

> … it's a little bit arbitrary to have these decisions about joint commissioning because, as I say, most, 99 per cent, of the funding is targeted to a specific program such as headspace or Way Back. Effectively the Commonwealth and the state make a decision that they are going to give money for a specific program, so it is in some ways a waste of time having a regional plan if no one is prepared to give us funding to actually do something about it.[51]

6.50 This was further explained by Metro North HHS:

> For example, in the budget that the PHN gets there's money for headspace, there are a whole range of $2 million blocks of money, and basically there is very little discretionary funding. In the new money coming from the Commonwealth, the largest bucket of money is the Head to Health programs. Again that's not going to give us a lot of ability to deliver areas of planning that we see as important. So I would, if I were saying something to the federal government and the opposition, the need for non-targeted funding. Unless you give us that, we're not going to be able to roll out our plans.[52]

Funding cycles

6.51 Short government funding cycles and PHN contracts and the flow-on impacts that they have on proper co-design, the stability and sustainability

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[50] Mr Kieran Kinsella, Executive Director, Addiction and Mental Health Services, Metro South HHS, *Committee Hansard*, Canberra, 21 July 2021, page 4.

[51] Professor Brett Emmerson AM, Executive Director, Mental Health, Metro North HHS, *Committee Hansard*, Canberra, 21 July 2021, page 5.

[52] Professor Brett Emmerson AM, Executive Director, Mental Health, Metro North HHS, *Committee Hansard*, Canberra, 21 July 2021, page 3.

of service delivery, and the recruitment and retainment of mental health professionals within NGOs were raised as areas of concern.[53]

6.52 While noting that extending the funding cycle would require a change in approach to how governments and PHNs embed accountability and monitoring mechanisms within commissioned services, RFDS explained it was not ‘talking about removing accountability’:

> … I am saying we should not use the retendering of services and programs as our fundamental accountability mechanism, because there are others. We can sit down, as we do each year, with the Commonwealth and we can assess our progress against a set of KPIs [key performance indicators] … That process can be an ongoing process over many, many years. It doesn't require this arbitrary cut-off of saying, 'In order to test efficiencies, we're going to go back to the market.’[54]

6.53 The Aboriginal Health and Medical Research Council of NSW (AHMRC) highlighted the impact of truncated funding cycles on being able to demonstrate service impact, and complete an effective evaluation of services. The Council advocated for a transition from 12 month contract terms to three to five year contract terms, noting this resolution could solve workforce attraction issues as well as the current lack of outcome data collection.[55]

6.54 Appearing before the Committee, Lifeline Australia also emphasised the importance of longer-term funding cycles, noting particularly their impact on its workforce:

> I think absolutely the longer the term, the better. Of course, like many other organisations, whether they be private, commercial, not for profit or profit for purpose, I guess it's allowing for longer-term planning and staff engagement, particularly for our members who run a lot of community based services. It's

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53 See, for instance: Mr Frank Quinlan, Federation Executive Director, RFDS, *Committee Hansard*, Canberra, 17 June 2021, page 8; Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 2; Ms Taryn Harvey, Chief Executive Officer, WAAMH, *Committee Hansard*, Canberra, 19 July 2021, page 3; Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 28; Mind Australia Ltd, *Submission 68.1*, page [3].

54 Mr Frank Quinlan, Federation Executive Director, RFDS, *Committee Hansard*, Canberra, 17 June 2021, page 8.

55 Dr Peter Malouf, Executive Director of Operations, Aboriginal Health and Medical Research Council of NSW (AHMRC), *Committee Hansard*, Canberra, 29 July 2021, page 8; AHMRC, *Submission 88*, page [5].

> very difficult to keep staff engaged, let alone volunteers we were talking about before, when it's a year-on-year contract scenario.[56]

6.55 SANE Australia similarly noted the role that funding insecurity has on recruitment and an NGO's capacity to attract mental health professionals:

> People might spend a bit of time in an NGO, but it's quite common for them to then to head to a state or Commonwealth government funded position. We can't offer the same length of permanency with funding contracts that are only two to three years in length.[57]

6.56 Beyond Blue advised that a three-year minimum contract length is critical for NGOs to meet community demands and for sector reforms to be effective in meeting their objectives.[58]

6.57 Witness comments align with findings of earlier reports. Action 17.1 of the Productivity Commission Report recommended the extension of minimum contract terms to improve the availability of psychosocial supports:

> As contracts come up for renewal, commissioning agencies should extend the length of the funding cycle for psychosocial supports from a one-year term to a minimum of five years. Commissioning agencies should ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle.[59]

6.58 Recommendation 3 of the Report of the PHN Advisory Panel on Mental Health (PHN Advisory Panel report) – which was formed to develop advice to the Minister for Health – similarly recommended this extension of minimum contract terms to PHN contracts:

> As a matter of priority, provide PHNs with contract certainty (5 years) to allow more considered and timely planning, workforce development, and more appropriate commissioning cycles.

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56 Mr Robert Sams, Executive Director, Lifeline Direct Services, Lifeline Australia, *Committee Hansard*, Canberra, 29 July 2021, page 16.

57 Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 28.

58 Ms Carolyn Nikoloski, Chief Strategy Officer, Beyond Blue, *Committee Hansard*, Canberra, 26 July 2021, page 29.

59 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, page 76.

> Provisions should include a mandatory 12 month notice period if PHNs will be discontinued in order to avoid 'end of contract' uncertainty, which invariably affects service stability.[60]

Reviewing the Primary Health Network-model, its commissioned services and national standards

6.59 Various stakeholders have called for a review of PHN commissioning focusses, as they can introduce unnecessary complexity into the commissioning of national programs and fragment evidence-based practice.[61]

6.60 StandBy petitioned for a continuation of its single funding agreement with the Commonwealth in light of the National Agreement, identifying, before the Committee, several concerns with a proposed PHN-commissioned arrangement:

> StandBy, with the national expansion that we have been funded to deliver over the last several months, have developed a comprehensive national architecture which ensures that there is consistency, uniformity and fidelity across the country, no matter where you live, to the evidence based StandBy model that we base all of our services on. We're concerned that that will be lost through separate commissioning processes around the country in each Primary Health Network.[62]

6.61 StandBy also raised general concerns with requiring national programs – like Beyond Blue's postvention program (The Way Back program) – to be commissioned across 31 PHNs, identifying that:

> … it creates inefficiency due to excessive commissioning activities, inconsistencies in approaches across PHNs, and fragmentation of the national coordination StandBy has developed.[63]

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60 PHN Advisory Panel on Mental Health, *Report of the PHN Advisory Panel on Mental Health*, September 2018, page 14.

61 See, for instance, Orygen, *Submission 127*, page 9; Professor Brett Emmerson AM, Executive Director, Mental Health, Metro North HHS, *Committee Hansard*, Canberra, 21 July 2021, page 3; Dr Louise Flynn, General Manager, Jesuit Social Services, *Committee Hansard*, Canberra, 28 July 2021, page 43.

62 Mr Stephen Scott, Partnerships Manager, StandBy Support After Suicide, *Committee Hansard*, Canberra, 21 July 2021, page 40.

63 Ms Karen Phillips, General Manager, StandBy Support After Suicide, *Committee Hansard*, Canberra, 21 July 2021, page 38.

6.62 This criticism of the PHN model as it applied to mental health was reinforced by Professor Patrick McGorry, appearing before the Committee on behalf of Orygen. Professor McGorry labelled the approach as being 'deeply flawed', due to an inability to guarantee standards of care with a devolved commissioning structure.[64] Professor McGorry contended that:

> There is an argument for local provision of services. I've said it's more like an 80-20 rule, 20 percent variation. But, basically, the needs of people around the country are very similar, and services have to be based on the best available evidence and team based care. We have those models, but PHNs have currently got the ability to mess with them, and many of them actually have … We need to … have a much more centrally commissioned mental health system. I note that New Zealand has been taking that step in recent months, to recentralise the commissioning of mental health care and health care more generally. That's not to say there isn't a role for PHNs, but it certainly can't be the role, in my view, that they've currently got.[65]

6.63 These criticisms are not new. In 2018, the PHN Advisory Panel report identified some of these issues, recommending that government, in consultation with PHNs, review the types of services and activities that would be more efficiently and effectively managed nationally, rather than by PHNs individually.[66]

6.64 Further, the PHN Advisory Panel report recognised the need to manage regional disparities in evidence-based care, recommending that government:

> Commission the development and implementation of minimum standards for evidence-based practice which include guidelines for trialling new service models. This could foster and support the important role of PHNs to develop innovative service models and ensure that clinical risks are managed.[67]

6.65 Contrary to the evidence heard from stakeholders during the inquiry, Action 23.6 of the Productivity Commission Report recommended more funding control for PHNs. The reform would permit PHNs to redirect funding

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64 Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 25.

65 Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 25-26.

66 PHN Advisory Panel on Mental Health, *Report of the PHN Advisory Panel on Mental Health*, September 2018, page 15.

67 PHN Advisory Panel on Mental Health, *Report of the PHN Advisory Panel on Mental Health*, September 2018, page 15.

hypothecated to particular providers to alternative services, where they are not meeting the service needs identified in regional plans.[68]

6.66 Orygen's submission raised significant concerns with Action 23.6:

> Orygen strongly disagrees with this recommended action. In our feedback to the draft report, Orygen stated that this approach ignored and contradicted the evidence base and global scale-up of youth early psychosis programs and models of care and would put the future of these programs at considerable risk. As a result, there would be a gradual erosion and fragmentation of these models, replacing them with disparate elements of service provision and components of care being delivered by different providers. This would leave young people and their families with the impossible task of negotiating services, exacerbate service and geographic gaps and deliver an inconsistent quality of care.[69]

6.67 Jesuit Social Services highlighted issues from having fragmented funding sources, including increased administrative complexity, workloads and costs, as well as onerous reporting obligations:

> … dealing with four funding bodies is very bureaucratic. We're funded across much of Victoria. We used to be funded directly from the Commonwealth. Now we are funded by four. In the first year of the primary health networks I was doing two reports. The next year I was doing 22 reports. There are different reporting regimes and different templates. There are budgets, activity work plans, reporting and financial acquittals for four funding bodies now, rather than one. That is actually the challenge. A lot more time has needed to go into that administration. It would even be better if there was some uniformity in terms of the reporting and the templates et cetera, but there isn't. They're each developing their own identity, which probably has its own strengths. But, for a service provider, it has challenges.[70]

6.68 Jesuit Social Services further outlined that as its budget amount for management expenses is a fixed percentage (10 per cent), any broader administration, evaluation or management outside of that funding threshold simply does not happen.[71]

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[68] Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 82.

[69] Orygen, *Submission 127*, page 9.

[70] Dr Louise Flynn, General Manager, Jesuit Social Services, *Committee Hansard*, Canberra, 28 July 2021, page 43.

[71] Dr Louise Flynn, General Manager, Jesuit Social Services, *Committee Hansard*, Canberra, 28 July 2021, page 43.

6.69 The Pharmacy Guild of Australia called for clearer lines of organisation in PHN's commissioning, stating that the devolved funding structure has created disparate levels of commissioning quality, and that it is unclear where some of the funding that is directed at mental health goes. The Guild further outlined that:

> Without picking on PHNs, some pharmacies have a good relationship in a PHN, but there would be pharmacists in other PHNs that could not tell you what they do. It's unclear where a lot of the funding and channelling through PHNs goes. I think there has been a bit of streamlining into some of the GP related professions in PHNs. It's marginalised some of the pharmacies in primary care and also in the allied health space as well.[72]

Committee comment

6.70 While many examples of collegial PHN-LHN relations and effective alliances were provided to the Committee, it is clear that this is not the case for every jurisdiction. Collaborative efforts between PHNs and LHNs are required to achieve desirable regional outcomes.

6.71 Effective oversight is essential for enabling a degree of PHN funding flexibility, while also reducing regional outcome disparities and ensuring proper commissioning activity.

6.72 The Committee recognises the importance of oversight, and supports both stakeholder recommendations and Action 23.1 of the Productivity Commission Report, for the National Mental Health Commission (NMHC) to take on oversight responsibilities of PHN-LHN collaboration.

Recommendation 26

6.73 The Committee recommends that the Australian Government provide legislative authority to strengthen the independence of the National Mental Health Commission, with a designated task being to monitor and report on compliance by Primary Health Networks and Local Health Networks against their commitments.

6.74 The importance of regional commissioning flexibility links directly with regional services being able to immediately respond to regional needs, as

72 Mr David Heffernan, National Vice-President and NSW Branch President, Pharmacy Guild of Australia, *Committee Hansard*, Canberra, 19 August 2021, page 22.

they change with demographics and the impacts of national and natural disasters.

6.75 PHNs can be supported to effectively complete this work through the development of flexible funding pools to ensure the effective implementation of regional plans.

6.76 However, the Committee is concerned that too much flexibility in commissioning may be detrimental, leading to quality and evidence-based inconsistencies between regions, so these funding pools must have reporting and approval requirements.

Recommendation 27

6.77 The Committee recommends that the Australian Government review the commissioning constraints on Primary Health Networks to ensure that the implementation of regional plans providing for regional mental health and suicide prevention services can reasonably be delivered.

6.78 The relationships between contract length and sustainable service delivery, the capacity for evaluation and reporting, service quality, and workforce attraction, are interconnected. Therefore, there is an identifiable need to improve the minimum contract length for mental health and suicide prevention services.

6.79 A transition to longer contract lengths should see the addition of equivalent longer term reporting and accountability measures factored into funding agreements to improve data collection and outcome evaluation.

Recommendation 28

6.80 The Committee recommends that, in line with stakeholder and the Productivity Commission Report recommendations, the Australian Government:

- **fund Primary Health Networks (PHNs) for mental health and suicide prevention services on five year cycles**
- **transition mental health and suicide prevention services provided by non-government organisations to five year funding contracts**
- **require PHNs to commission mental health and suicide prevention services on five year contracts**

- **strengthen long- and short-term outcome reporting requirements to enable continuous service evaluation in response to increasing the length of contracts and funding cycles.**

6.81 The Committee does not support Action 23.4 of the Productivity Commission Report that suggests the consideration of new commissioning models, noting the threat that this poses to another system reset.

6.82 Nationally coordinated and delivered services with high levels of national standardisation and shared evidence bases, like the Way Back Support, StandBy and headspace services, should retain their singular contract arrangements with the Commonwealth to avoid discrepancies in the delivery of care, and to avoid unnecessary complexity in service commissioning.

6.83 Therefore, the Committee supports Recommendation 16 of the Report of the PHN Advisory Panel on Mental Health for a review of the decision to devolve commissioning for previously nationally-coordinated, single contract services.

Recommendation 29

6.84 The Committee recommends that the Australian Government review the types of mental health and suicide prevention services that would be better delivered nationally, noting the importance of having strong national standards of care, quality, and evidence-based practice in service delivery, as well as reducing the burdens of unnecessary commissioning complexity.

The Medicare Benefits Schedule and the Better Access initiative

6.85 The MBS is a listing of the Medicare services subsidised by the Australian Government, and the Better Access initiative gives Medicare rebates to improve access to mental health professionals and care.[73]

[73] Department of Health, 'Better Access initiative', www.health.gov.au/initiatives-and-programs/better-access-initiative, viewed 30 September 2021; Department of Health, 'MBS Online', www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home, viewed 30 September 2021.

6.86 The Department of Health has commissioned the University of Melbourne to evaluate the Better Access initiative. The University of Melbourne will partner with the University of Queensland, Deakin University, the Australian National University, LaTrobe University, Monash University and NovoPsych to complete the evaluation. The evaluation will start in August 2021 and it is expected to be completed in June 2022.[74]

Reform to address access barriers

6.87 Various stakeholders identified a range of barriers that have limited individual access to mental health and suicide prevention services that are funded through the MBS rebate system.[75]

6.88 Affordability of services was an identified barrier to care, with NMHC contending that:

> Probably one of the most challenging realities for people in Australia is the significant gap payment that is associated with any MBS rebate. I don't believe there's a simplistic answer to that in the form of just changing the payments. I think much deeper analysis is required. That certainly affects affordability.[76]

6.89 The Australian Counselling Association (ACA) referenced the Productivity Commission Report findings, evidencing that:

> Essentially, there is a mismatch between the provision of mental health services under the Better Access initiative, which goes disproportionately to higher-income areas, and mental health problems, which occur disproportionately in lower socioeconomic and regional and rural areas.[77]

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74 Department of Health, *Answer to Question on Notice*, 18 March 2021; Department of Health, 'Better Access Evaluation', www.health.gov.au/better-access-evaluation, viewed 1 October 2021.

75 See, for instance: Ms Christine Morgan, Chief Executive Officer, National Mental Health Commission (NMHC), *Committee Hansard*, Canberra, 18 March 2021, page 15; Australian Psychological Society (APS), *Submission 140*, page 11; Mr Philip Armstrong, Chief Executive Officer, ACA, *Committee Hansard*, Canberra, 21 July 2021, page 18; Mrs Anita Hobson-Powell, Chief Executive Officer, ESSA, *Committee Hansard*, Canberra, 21 July 2021, pages 49-50; Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, Speech Pathology Australia (SPA), *Committee Hansard*, Canberra, 19 August 2021, page 2; Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 21.

76 Ms Christine Morgan, Chief Executive Officer, NMHC, *Committee Hansard*, Canberra, 18 March 2021, page 15.

77 Mr Philip Armstrong, Chief Executive Officer, ACA, *Committee Hansard*, Canberra, 21 July 2021, page 18.

6.90 Affordability and access issues were raised in the Australian Psychological Society's (APS) submission, recommending the government introduce bulk-billing incentives for consumers facing financial hardship, and incentivise telehealth service provision in rural, regional and remote locations.[78]

6.91 APS further elaborated on these concerns, contending that:

> Currently within the medical streams of the MBS there are actually systems that allow for bulk-billing incentives. That would mean that those who are low socioeconomic and can't necessarily afford gap payments are supported within the system broadly across all those who can provide service within the MBS. They're supported by bulk-billing incentives to allow them to afford that gap and provide it to those in need. It allows for a connection between the group that is most vulnerable and in need and the capacity of the system to provide that service. The second element of it is rural incentive programs. We know that that works very well within the medical sphere to actually allow for the delivery of services in those locations and to encourage and incentivise them. Currently those types of things have not been applied within the current MBS system to do with mental health. I think that that would be a huge change that would actually increase access.[79]

6.92 MBS reform for increasing access to allied health professionals was raised by ESSA, Dietitians Australia and Speech Pathology Australia (SPA), who identified that a lack of MBS items prevents exercise and sports scientists, accredited practicing dietitians and speech pathologists from privately treating individuals and groups with mental health disorders, unless via chronic disease management plans.[80]

6.93 Dietitians Australia also argued that:

> … only five visits per year are Medicare rebatable for those on chronic disease management plans, and these visits are shared amongst 14 different allied health professions. This allowance is vastly inadequate to provide meaningful treatment outcomes.[81]

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78 APS, *Submission 140*, page 11.

79 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 3.

80 Mrs Anita Hobson-Powell, Chief Executive Officer, ESSA, *Committee Hansard*, Canberra, 21 July 2021, pages 49-50; Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 21; Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, SPA, *Committee Hansard*, Canberra, 19 August 2021, page 2.

81 Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 21.

The two-tier MBS rebate system

6.94 Currently the MBS system for accessing psychologists is provided through two rebate tiers (the two-tier system). It maintains a higher rebate for psychologists with clinical endorsement and a lower rebate for registered psychologists, including psychologists with qualifications in the other endorsed areas. For example, a session of psychological assessment or therapy of at least 50 minutes would see:

- Clinical psychologists claim under MBS item 80010 with the service valued by Medicare at $152.40, this carries an 85 per cent benefit so the MBS rebate available is $129.55.[82]
- All other registered psychologists claim under MBS item 80110 with the service valued by Medicare at $103.80, this carries an 85 per cent benefit so the MBS rebate available is $88.25.[83]

6.95 The Australian Association for Psychologists Inc (AAPi), argued that there should be a raised, one-tier, $150 rebate for clients of all registered psychologists, identifying that:

> … the current system, which has psychologists and clinical psychologists on two different rebate levels, is financially affecting the public, consumers, and making services unaffordable for many.[84]

6.96 AAPi calculated that, given the significant costs for registration, insurance, professional development, supervision, equipment and administration required, the hourly income of a registered psychologist seeing five or six bulk-billing clients per day is approximately $23 per hour. This reiterates that the capacity for psychologists to bulk-bill services without an increase in rebate or additional financial support is low.[85]

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82 Department of Health, 'Medicare Benefits Schedule – Note MN.6.1', www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=MN.6.1&qt=noteID&criteria=80100, viewed 1 October 2021.

83 Department of Health, 'Medicare Benefits Schedule – Note MN.7.1', www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=MN.7.1&qt=noteID&criteria=80100, viewed 1 October 2021.

84 Mrs Amanda Curran, Chief Services Officer, Australian Association of Psychologists Inc (AAPi), *Committee Hansard*, Canberra, 21 July 2021, page 13.

85 Ms Karen Donnelly, Vice-President, Psychologist, AAPi, *Committee Hansard*, Canberra, 21 July 2021, page 17.

6.97 AAPi also identified that having a two-tier system has led to professional discrimination across the MBS, employment opportunities, scope of practice and funding. AAPi further contended that:

> We see this played out in places like Centrelink, where you need a report from a clinical psychologist to open up a disability support application. We're restricting consumers with a disability to the 30 per cent of psychologists who have clinical endorsement. Rather than allowing them to see someone who might have been treating them for five years to try to overcome their disability and get back into the workforce, we're asking people to go and see a clinical psychologist or psychiatrist for a few sessions and get a report for Centrelink. We see this is as inappropriate, and the best evidence would come from someone who's actively been trying to support them to overcome their issues.[86]

6.98 Dr Catriona Davis-McCabe argued that despite having advanced training and competencies in psychological therapy, counselling psychologists and other psychologists with areas of practice endorsement have been restricted by the Better Access initiative to provide focused psychological strategies and offer a lower rebate to clients. Dr Davis-McCabe recommended that:

> … whilst the public absolutely needs access to clinical psychology, all areas of practice endorsement have a role in the delivery of advanced mental health services to the community. There needs to be a broadening of the higher rebates within Better Access to include areas of practice endorsement who do work with complex mental health.[87]

6.99 This perspective was supported by APS:

> The APS's position has always been that a broader range of psychologists than those with clinical endorsement, particularly those who have additional training and expertise, should be recognised and included within the higher rebate. Adding other areas of practice endorsement to that higher tier would ensure that the public could have access to the expertise of the full diversity.[88]

6.100 Conversely, the Australian Clinical Psychology Association's (ACPA) submission argued that clinical psychologists have high levels of expertise in mental health and that the rebate discrepancy was justified by clinician outcomes. ACPA supported its position with evidence from an American

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86 Mrs Amanda Curran, Chief Services Officer, AAPi, *Committee Hansard*, Canberra, 21 July 2021, page 14.

87 Dr Catriona Davis-McCabe, *Committee Hansard*, Canberra, 19 August 2021, page 12.

88 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 3.

journal article published in 1995 by David M Stein and Michael J Lambert. According to ACPA, the research shows that practitioners with credentials have improved mental health outcomes.[89] ACPA's submission also contended that:

> Paramount to effective service delivery is protection of the public through recognition of accredited training and allocation of expertise to the right level of intervention for patient needs, supported by the regulatory framework under which we work and upon which the National Law (2009) is founded. Compelling research evidence shows that experience alone does not make practitioners better therapists (e.g., Blow et al., 2016; Goldberg et al., 2016).[90]

6.101 Responding to a question by the Committee, the Department of Health explained that the two-tier rebate system for clinical psychologists and registered psychologists under the MBS was initially implemented on advice from the psychology profession, as referenced in the 2011 final report of the Commonwealth Parliament's Senate Community Affairs Reference Committee's Inquiry into Commonwealth Funding and Administration of Mental Health Services.[91]

6.102 In 2012, the then government advised, in response to the Senate report, that it was committed to ensuring that patients have access to the most appropriate practitioners with relevant competencies. It stated that:

> The issue of the two-tier Medicare rebate for psychologists under the Better Access program reflects the international benchmarks regarding qualifications, skills and experience in delivering psychological therapy services.[92]

6.103 The Department of Health further submitted that:

> The Medicare Benefits Schedule (MBS) recognises different types of practitioner training in setting schedule fees. For example, medical practitioners working in general practice can also claim different rebate amounts for preparing a mental health treatment plan for treatment through the Better Access to Psychiatrists, Psychologists and General Practitioners

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89 Australian Clinical Psychology Association (ACPA), *Submission 130*, page 4.

90 ACPA, *Submission 130*, page 4.

91 Department of Health, *Submission 41.1*, page [1].

92 The Hon Mark Butler MP, Minister for Mental Health and Ageing, Minister for Social Inclusion, and Minister Assisting the Prime Minister on Mental Health Reform, *Australian Government Response to Recommendations from the Inquiry into Commonwealth Funding and Administration of Mental Health Services Report*, page 6.

> through the MBS initiative (Better Access) according to whether or not they have completed accredited mental health skills training.[93]

6.104 APS identified that at present there are not any Australian studies available that compare the outcomes between psychologists with clinical endorsement and other psychologists. It further noted a lack of any outcome data collected on psychologists, recommending:

> … the inclusion of outcome measures to get at some of the data. That certainly would be of interest when we're doing a mental health system change.[94]

6.105 NMHC's submission affirmed a lack of outcome collection and outcome-based policy on mental health-related MBS decisions, outlining that:

> The Commission shares concerns raised in reform reviews, including the Productivity Commission Inquiry and Victorian Royal Commission, that the availability of MBS items for psychology and psychiatry is not clearly linked to evidence on their outcomes, effectiveness, and successful 'dosage' of treatment.[95]

6.106 Further discussion on the importance of data collection to support decision making is included in Chapter 7.

The 10 session cap

6.107 In response to the increased rates of mental health problems as a result of COVID-19, the Australian Government doubled the number of MBS-rebated psychological therapy sessions from 10 to 20 for eligible patients. Many stakeholders recommended this increase be permanently available under the MBS.[96] AAPi outlined that:

> It's also our position that more sessions need to be allowed under the MBS. We've seen that recommended across so many different inquiries. The review of the MBS, the Productivity Commission—they have all recommended that session numbers be increased. If we actually treat people with the amount of

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93 Department of Health, *Submission 41.1*, page [1].

94 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 3.

95 NMHC, *Submission 9*, page 11.

96 See, for instance: Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, pages 3, 5; Mrs Amanda Curran, Chief Services Officer, AAPi, *Committee Hansard*, Canberra, 21 July 2021, page 13; Dr Tracie O'Keefe, Co-Founder, SAGE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 3.

> treatment they need then they won't be presenting back year after year, needing more access to the system and remaining unwell.[97]

6.108 This was further supported by APS , which also noted that the existing limit was not evidence-based:

> The 10-session model does not allow for the delivery of evidence based care so those with higher needs are able to access curative treatment and therefore exit the system. We know that some people need 10 but also that there are others who need 20 and, for a small but really important few, up to 40 sessions in a year. We would never, ever cut access to evidence based levels of medication or cancer care the way that we do for mental health care.[98]

6.109 APS explained how this session cap has translated into conflicting service delivery objectives:

> I have to say, practising on the ground is one of the hardest things when I am trying to pace out sessions and see people once a month or when you're dealing with a child case and you want to consult the parent and none of that is allowable within the system. I can't see a strong reason for it. The data presented within some of the MBS forums has very clearly shown that the funding decision around it seems to be at conflict with what is actually in the best interests of the patient. Not everyone needs all of those sessions, absolutely, but, for those that do, creating an artificial limitation within the system is not the best idea.[99]

6.110 SAGE Australia referred to the 10 session cap as a 'sticking plaster approach' to mental health and suicidality treatment.[100]

6.111 The ACA suggested that some individuals may transfer to counsellors because there is no gap fee, a consistent price and the capacity to see a mental health professional without the restriction of 10 or 20 sessions.[101]

6.112 Professor Brin Grenyer advised that for individuals with complex disorders, such as personality disorders, there are access issues caused by having a

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97 Mrs Amanda Curran, Chief Services Officer, AAPi, *Committee Hansard*, Canberra, 21 July 2021, page 13.

98 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, pages 1-2.

99 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 5.

100 Dr Tracie O'Keefe, Co-Founder, SAGE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 3.

101 Mr Philip Armstrong, Chief Executive Officer, ACA, *Committee Hansard*, Canberra, 21 July 2021, page 21.

limit of 10 MBS-rebated sessions and reliance on MBS-funded mental health professionals:[102]

> The No. 1 complaint of people with personality disorders is getting access to trained and skilled practitioners. Unfortunately, state funded health services and community mental health services can only go so far with programs … for this particular disorder, we need 40 sessions a year and that 10 sessions or even 20 sessions are a challenge. For lots of the patients that we consult, it's now August and they've run out of sessions, so they're facing quite a few challenging months without their psychologist.[103]

6.113 APS raised concerns about the requirement in mental health plans to complete a rebate review by returning to the general practitioner (GP) at session six, as well as session 10, suggesting these act as a friction point and result in treatment drop out.[104] APS's submission recommended 'changing the requirement for GP reviews from six sessions to ten sessions':

> Psychologists are experts in the assessment, diagnosis and treatment of mental health disorders, and are able to determine the needs of their patients and make appropriate recommendations to referring GPs. Reviews after six sessions are often administrative, rather than clinically necessary, and place an additional financial burden on the MBS and are a misuse of GP's time.[105]

6.114 Metro North HHS observed that despite the Commonwealth's pandemic response doubling the number of sessions available through the MBS, access to private providers actually became worse during COVID-19:

> … whilst it is good if you've got those 20 sessions, [it] effectively halved the access for people, because the number of psychologists, for example, hasn't gone up. We will have waits in our health service, whether it is in the public system or the private system, of six to nine months unless you are very acute, so there is a whole systemic issue of availability and access. It is just not there.[106]

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102 Professor Brin Grenyer, *Committee Hansard*, Canberra, 19 August 2021, page 10.

103 Professor Brin Grenyer, *Committee Hansard*, Canberra, 19 August 2021, page 10.

104 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 5.

105 APS, *Submission 140*, page 11.

106 Professor Brett Emmerson AM, Executive Director, Mental Health, Metro North HHS, *Committee Hansard*, Canberra, 21 July 2021, page 4.

6.115 This was reiterated by Brisbane South PHN and headspace.[107] headspace explained that:

> Perhaps one of the unintended consequences has been that—we were talking about the same supply of the workforce—one person having 15 to 20 sessions means that you're spending less time seeing those who come into the system, so it's a double-edged sword in some ways. It's a hard one because it was absolutely the right decision to extend the sessions, but the supply of the workforce means that people who are now coming into the services may not have access to the same numbers of workforce who are able to see new clients.[108]

Better Access for counsellors and psychotherapists

6.116 Chapter 5 discussed the training and regulatory requirements for mental health professionals, and noted that counsellor and psychotherapist are not legally regulated titles in Australia. Appearing before the Committee, the ACA noted that despite counsellors and psychotherapists being tertiary qualified and accredited, the services that they deliver are not recognised under the MBS. The ACA recommended:

> … that an item number be either added to the Better Access scheme at the tier 1 rate or created outside the Better Access scheme within MBS for counsellors to deliver psychological therapies independently from Better Access.[109]

6.117 This recommendation was supported by the Psychotherapy and Counselling Federation of Australia, who argued that if qualified counsellors were given Medicare item numbers, the profession would be able to greater support the mental health of the Australian community, workforce shortages and telehealth delivered care:[110]

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107 Mrs Jennifer Newbould, Director, Mental Health, Suicide Prevention, Alcohol and Other Drugs, Brisbane South PHN, *Committee Hansard*, Canberra, 21 July 2021, page 4; Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 32.

108 Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 32.

109 Mr Philip Armstrong, Chief Executive Officer, ACA, *Committee Hansard*, Canberra, 21 July 2021, page 18.

110 Dr Dianne Stow, President, Psychotherapy and Counselling Federation of Australia, *Committee Hansard*, Canberra, 13 August 2021, page 12.

> … before Better Access in Australia, GPs would refer to counsellors or refer to psychotherapists. Since Better Access for our psychologist colleagues, that suddenly equals mental health, and counsellors and psychotherapists, albeit equivalent parallel training, seem to have been kind of left off the list. But, internationally, counsellors are standing alongside psychologists. Psychotherapists internationally are standing alongside psychologists.[111]

6.118 The ACA contended that a large proportion of its members had indicated that they would look at bulk-billing were they to be given Medicare rebates, particularly in low socio-economic regions.[112]

6.119 The capacity for accredited counsellors to increase the access for at-risk populations to supportive mental health care was also recognised. SAGE Australia outlined that equipping the 14,000 qualified counsellors and psychotherapists in Australia with MBS numbers would contribute to the scaffolding approach required to support sex and/or gender diverse (SGD) mental health.[113] SAGE Australia's submission further contended that:

> This will allow for greater immediate early intervention for suicide prevention in sex and/or gender diverse groups of people. Members of those registers who are from SGD groups can create quicker and greater rapport with those clients, offering faster suicide prevention.[114]

Reform to general practitioners and general practice

6.120 In response to concerns that mental health treatments plans prepared by GPs were being completed to a low standard, the Royal Australian College of General Practitioners (RACGP) argued the issue stems from the low remuneration value of their completion. RACGP identified that the remuneration is approximately half that of a chronic disease management plan, providing a low incentive given the work involved in assessment and treatment planning.[115]

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111 Dr Dianne Stow, President, Psychotherapy and Counselling Federation of Australia, *Committee Hansard*, Canberra, 13 August 2021, page 8.

112 Mr Philip Armstrong, Chief Executive Officer, ACA, *Committee Hansard*, Canberra, 21 July 2021, page 20.

113 Dr Tracie O'Keefe, Co-Founder, SAGE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 3.

114 SAGE Australia, *Submission 3*, pages 6-7.

115 Dr Caroline Johnson, Member, Senior Representative, Royal Australian College of General Practitioners (RACGP), *Committee Hansard*, Canberra, 24 June 2021, pages 7-8.

6.121 This was also recognised by the Australian Medical Association (AMA), which recommended that:

> … government should also think about the fact that mental health consultations with GPs are actually funded at a lower level than physical health consultations of a similar complexity. That seems rather difficult to understand, if you acknowledge the burden of disease that is present in mental health …[116]

6.122 To improve patient rebates to support mental health care, and coordination of mental health and physical healthcare by GPs, RACGP recommended within its pre-Budget submission 2021-22 an improvement to MBS funding, outlining that:

> As a first step, patient rebates for mental health care and physical healthcare should be aligned … For example, unlike general consultation items, there is currently no unrestricted item for patients to spend more than 40 minutes with their GP discussing their mental health.[117]

6.123 Another factor identified as hampering quality mental health treatment by GPs is that Medicare does not permit multiple treatment items to be used on the same day. As a result, GPs are either required to complete the work with no remuneration or request that the patient return on another day:[118]

> This is because, understandably, the government is trying to exclude inappropriate use of Medicare. But what they inadvertently do is disadvantage doctors who are trying to do the right thing. They design a system to protect against misuse but, in so doing, punish doctors who are trying really hard to meet a group of very vulnerable patients who otherwise would not get the care.[119]

6.124 Appearing before the Committee, AMA explained the ramifications of a model that is primarily funded for episodic care:

> In fact, the funding mechanism directs GPs to frequent low-complexity care as being more financially rewarding and therefore more sustainable for a bulk-billing practice than dealing with patients with various chronic diseases,

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116 Dr Omar Khorshid, President, Australian Medical Association (AMA), *Committee Hansard*, Canberra, 6 August 2021, page 35.

117 RACGP, *Pre-Budget Submission 2021-22*, page 5.

118 Dr Caroline Johnson, Member, Senior Representative, RACGP, *Committee Hansard*, Canberra, 24 June 2021, page 8.

119 Dr Caroline Johnson, Member, Senior Representative, RACGP, *Committee Hansard*, Canberra, 24 June 2021, page 8.

> including, of course, mental health. So we need to work a way for our system to change—to actually support GPs, both financially but also in all the other ways that have just been described, to actually deliver the care the patient needs, rather than what the system wants to pay.[120]

6.125 RACGP identified that while there is an opportunity to expand mental health services with GPs delivering focused psychological strategies, the structure of Medicare funding does not support this. RACGP explained that GP delivery of focussed psychological strategies cuts into the 10 counselling sessions available to patients via the Better Access initiative with other providers:

> This is actually counter-intuitive, in terms of the stepped care model. The stepped care model is meant to be that the GP offers some more simple interventions—lower intensity things like the ones I just described—and then has the option of referring patients on to more intense psychological interventions if the patient isn't making progress … So, most of us who are trained in this are reluctant to use the item numbers, even though we're trained to do so and even though it seems, on paper, that there's an incentive to do this training.[121]

Reform to funding for case conferencing and multidisciplinary approaches

6.126 APS recognised the importance of an integrated approach to mental health care, noting that current limitations within the Better Access program have resulted in mental health remaining the poor cousin of physical health:

> We would like to ensure telehealth, digital and online services, as well as multidisciplinary case conferencing, are integrated within the system. The current one-size-fits-all approach is hugely problematic.[122]

6.127 The Committee heard the capacity to effectively and sustainably implement multidisciplinary teams is strongly tied to how funding mechanisms incentivise multidisciplinary approaches and case conferencing. NMHC identified this, stating that:

> The MBS rebate system, whilst it will rebate different disciplines and whilst it will rebate where there has been case conferencing, that is purely at the

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120 Dr Omar Khorshid, President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 40.

121 Dr Caroline Johnson, Member, Senior Representative, RACGP, *Committee Hansard*, Canberra, 24 June 2021, page 7.

122 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, pages 1-2.

> election of those professions who may be claiming those rebates. Multidisciplinary approaches—coordinated, integrated approaches—shouldn't be optional. They actually need to be a core component of how services are delivered. Unless you have a funding mechanism which requires that, you are not really matching your funding mechanism to what you are fundamentally trying to do in terms of your service delivery.[123]

6.128 Similarly, the Back Dog Institute argued that the Australian mental health system does not support multidisciplinary approaches:

> We know from international studies that works, but the Australian system incentivises away from that style of collaborative care … For psychiatrists and clinical psychologists, the incentive is really to keep seeing patients they already have rather than to take on new patients and to genuinely share the care with GPs.[124]

6.129 The Black Dog Institute advised that it has been developing a model of collaborative care that would suit the Australian system, which has just begun its pilot. However, the same funding concerns remain:

> … the reality is that's not going to be able to be used at scale without changes to the way in which MBS numbers work, so I think one of the solutions is going to have to be to look at the MBS numbers and to have new numbers that encourage collaborative care.[125]

6.130 The Consumers Health Forum of Australia were of the view that general practices should be funded to fully manage and coordinate mental health care, by being able to offer, negotiate and manage consumer movement between lower- and higher-level treatment options.[126]

6.131 RANZCP asserted that the MBS could assist in the connection of multidisciplinary practices and virtual care. RANZCP stated that:

> If you were establishing a private practice, there would be incentives available to you if you had other professionals come and work with you. I think that is something worth exploring. I think it is possible to have substantial

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123 Ms Christine Morgan, Chief Executive Officer, NMHC, *Committee Hansard*, Canberra, 18 March 2021, page 15.

124 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 2.

125 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 2.

126 Ms Leanne Wells, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, Canberra, 5 August 2021, page 6.

> opportunities for new as well as existing practices, to say, 'If you have another professional work with you, there are some incentives available to you.' This will encourage that.
>
> The other thing that needs to happen is virtual multidisciplinary care, allowing reimbursement for case conferences and discussions between those professionals who provide that multidisciplinary care for the person who is at the higher end of complexity and challenges that they are experiencing. We refer to multidisciplinary care. There are a lot of people who would benefit from seeing their professionals and having regular communication with their professionals, but there are some who need to go to that next level for a truly integrated multidisciplinary care.[127]

6.132 APS argued that it is difficult for mental health professionals to work in a multidisciplinary manner for the benefit of a patient when there is no system support:

> That's particularly problematic for child and family cases, where you really want to work with the system around a child to get the kind of change that you'd like to see. At present, our MBS system doesn't support proper consultation. I think that's integral to getting a system that works together, to get the best outcome for the patient.[128]

6.133 SPA highlighted that most clinicians are willing to take part in case consultations, but the current lack of funding through the MBS for mental health treatment case conferencing is a barrier.[129]

6.134 The Pharmaceutical Society of Australia advised that:

> There's a positive recommendation from the MBS Review Taskforce to incorporate pharmacists as allied healthcare professionals who could be reimbursed through MBS for their involvement in mental health care. The Better Access program excludes pharmacist participation in a funded manner within case conferencing. One recommendation would be to make sure that pharmacists' participation and their legitimised role within the case conference are more recognised.[130]

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127 Associate Professor Vinay Lakra, President, RANZCP, *Committee Hansard*, Canberra, 6 August 2021, pages 11-12.

128 Ms Tamara Cavenett, President, APS, *Committee Hansard*, Canberra, 6 August 2021, page 4.

129 Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health, SPA, *Committee Hansard*, Canberra, 19 August 2021, page 2.

130 Ms Hannah Loller, Senior Project Pharmacist, Pharmaceutical Society of Australia, *Committee Hansard*, Canberra, 19 August 2021, page 22.

6.135 The National Mental Health Consumer and Carer Forum (NMHCCF) recommended dedicated MBS items for all health professionals to engage families and carers in case conferencing:

> … currently there is no financial incentive, I would say, for the inclusion of family members in discussions, even around the planning of treatment. So, for there to be an incentive for the inclusion of family members, even to have those meetings without the consumer present to obtain the family perspective, currently there is no mechanism for that to happen. So, as a family member, you are at the will of the clinicians to engage with you.[131]

6.136 The Independent Private Psychiatrists Group's submission queried specifically who the multidisciplinary team model should include, arguing for further clarification of the key participants, and how often a multidisciplinary focus should be embedded in ongoing treatment.[132]

6.137 The Independent Private Psychiatrists Group suggested a flexible model of multidisciplinary collaboration with investment in a strong clinical governance structure, and psychiatrists to lead the complex treatment with clear handover points. The Group further outlined that:

> At an appropriate stage in treatment, the ongoing care would be handed over to another team member, who could be the GP, a mental health nurse, a psychologist, or other allied health worker - but with ongoing input via consultations for the consumer, with the psychiatrist. At times, two or three members of the multidisciplinary team may be actively consulting with the consumer. But mostly, the consumer would see just one team member predominantly. These teams would be bound together with local ties of trust from working with each other over time, and by regular consumer focused team meetings, but on a less frequent schedule than in institutional teams.[133]

Committee comment

6.138 There are significant concerns about the trend outlined within various reports that the lowest access to MBS item numbers also correlates with the lowest socio-economic demographics. The Committee recognises that this is at odds with the purpose of the MBS system in supporting broad access to health services.

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131 Mrs Hayley Solich, Carer Co-Chair, National Mental Health Consumer and Carer Forum (NMHCCF), *Committee Hansard*, Canberra, 5 August 2021, page 15.

132 Independent Private Psychiatrists Group, *Submission 84*, page [7].

133 Independent Private Psychiatrists Group, *Submission 84,* page [7].

6.139 APS's recommendation to expand bulk billing incentives, like those available to rural and remote working GPs, to support individuals experiencing financial hardship was particularly persuasive.

6.140 The Committee agrees with NMHC that coordinated, integrated approaches need to be the standard rather than be optional, and need to be core to multidisciplinary service delivery. In addition to identifying and promoting best practice for digital services, the MBS should support the use of these tools by all professionals involved in treatment. Chapter 4 refers to the importance of integrating digital services to support coordinated care.

6.141 The Committee is also concerned by the lack of patient outcome data and outcome evaluation for psychologists, psychiatrists and GPs in the delivery of mental health care, to guide policy decision-making and MBS rebate amounts. The lack of any recent Australian study proving an outcome disparity, and thus justifying the rebate distinction between clinical psychologists and other psychologists, is a concern.

6.142 While acknowledging the call for counsellors and psychotherapists to be recognised under the MBS, the Committee considers there is a need to address the regulatory framework in which these professions operate before making any additional recommendations in this regard. See the discussion on regulation in Chapter 5.

6.143 The current annual cap on MBS-funded sessions with a psychologist does not support the effective delivery of evidence-based care for complex presentations. This can prevent individuals from receiving sufficient treatment and instead see them exit the system. This increases long-term costs for the individual, for the sector and for governments.

6.144 The current cap also results in drop-outs by requiring excessive GP review of patients, impacting the delivery of treatment by psychologists, and reducing the quality of treatment for complex mental illnesses. Reform should ensure treatment is patient-oriented, with the number of sessions to be determined by a mental health professional, such as a GP, psychologist or psychiatrist in the interests of the patient's health.

6.145 The Committee calls for a change to the GP referral system for psychological services to match that of other health professionals, with a 12 month referral. This should be supported by digital services to track patient outcomes and reduce the need for patient/ GP review sessions. This will improve patient outcomes, communication between referrer and referee, and efficiency and reduce administrative burden. This will also prevent interruptions to treatment, and reduce the risk of the patients dropping out.

Recommendation 30

6.146 The Committee recommends that the Australian Government's evaluation of Better Access, and reform of the system, focus specifically on:

- **the viability of bulk-billing incentives available to general practitioners (GPs) being similarly made available to mental health practitioners for the treatment of mental illness, where there are patient affordability constraints**
- **the two-tier system impacts on treatment access, appropriateness and affordability of psychological care**
- **including psychologists with other areas of endorsement (non-clinical endorsement) on the higher rebate tier, noting that this will increase access to specialists, address non-clinical endorsement disincentives and support the diversity of the psychological workforce**
- **the value of extending the annual cap on psychologist sessions, to ensure evidence-based delivery of care for complex presentations to increase affordability for people experiencing serious and/or complex mental illness**
- **the GP referral system for psychological services, including a valid 12 month referral:**
  - **utilising digital services for treatment to track patient outcomes**
  - **with a limit of two GP review sessions – an initial Better Access assessment/ referral and another after session 10 (to assess if another 10 sessions with the current provider is appropriate).**

6.147 The Committee supports the recommendation within RACGP's pre-Budget 2021-22 submission, for mental health care rebates to be equated with the rebates for physical health, and recommends that rebates for mental health treatment plans be valued at the same rate that chronic disease treatment plans are.

Recommendation 31

6.148 The Committee recommends that the Australian Government reform the Medicare Benefits Schedule to ensure that the completion of mental

health treatment plans and consultations by general practitioners for the management of mental illnesses have the same rebate value as chronic disease management plans and physical health consultations.

6.149 In September 2021, it was announced that MBS items 10955, 10957, 10959, 82001, 82002 and 82003 will be added to the MBS, in accordance with the *Health Insurance Legislation Amendment (Section 3C General Medical Services – Allied Health Case Conference) Determination 2021*. Available from 1 November 2021, these items will provide rebates for allied health participation in chronic disease management and autism, pervasive developmental disorder and disability case conferences.[134]

6.150 The Committee commends the Australian Government's decision to expand case conferencing MBS items for allied health professionals to chronic disease management and autism, pervasive developmental disorder and disability case conferences.

Recommendation 32

6.151 The Committee recommends that the Australian Government add Medicare Benefits Schedule items to support case conferencing in the treatment of mental illness for:

- **allied health professional attendance, for example psychologists, pharmacists, social workers, occupational therapists, exercise physiologists, and speech pathologists**
- **health professional attendance, for example general practitioners, mental health nurses, and psychiatrists**
- **mental health professionals to support the attendance of carers and families.**

134 Department of Health, 'About the MBS – November 2021 News' www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/news-211101, viewed 1 October 2021.

Community and culturally-based services and programs

6.152 The importance of sufficiently funding community and culturally-centred initiatives and organisations, particularly for at-risk communities, was raised by various stakeholders.[135]

6.153 Appearing before the Committee, the Australian Rural Health Education Network recommended that governments invest in the social infrastructure of rural and remote communities:

> While people will often present to their GP in the first instance, it's the local sporting clubs, the other community facilities or the strength of the school where often they will find support or advice which may connect them or may assist them to support themselves during a period where they may not entirely be well.[136]

6.154 RFDS raised concerns about gaps in commissioning pathways for community and cultural initiatives, where the portfolio of responsibility is not clearly defined. This was identified within the context of RFDS' Guiding Rural Outback Wellbeing (GROW) program:

> Is it an education program? Is it an economic development program? Is it a social connectedness program? Is it a mental health program? Is it something else? That's the great strength; it's also the great weakness because, when you look to fund a program like that, who's going to fund it? Is it really education or are they going to say it's mental—I think that those integrated programs on the ground are probably some of the most productive and some of the most challenging in terms of ongoing funding.[137]

6.155 There was broad agreement amongst stakeholders on the importance of funding public community services and grassroots NGOs in supporting

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135 See, for instance: Dr Tracie O'Keefe, Co-Founder, SAGE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 4; Ms Emma Taylor, Mental Health and Wellbeing Clinical Manager, Western Sydney University, *Committee Hansard*, Canberra, 28 July 2021, page 33; Ms Joanne Hutchinson, National Director, Australian Rural Health Education Network, *Committee Hansard*, Canberra, 17 June 2021, page 3; Mr Frank Quinlan, Federation Executive Director, RFDS, *Committee Hansard*, Canberra, 17 June 2021, page 10.

136 Ms Joanne Hutchinson, National Director, Australian Rural Health Education Network, *Committee Hansard*, Canberra, 17 June 2021, pages 3-4.

137 Mr Frank Quinlan, Federation Executive Director, RFDS, *Committee Hansard*, Canberra, 17 June 2021, page 10.

multidisciplinary, evidence-based, and ongoing mental health care in a way that private MBS services cannot.[138] According to WAAMH:

> The focus of all levels of government is very much on current implementation of clinically based supports. The need for community based supports around providing recovery is really the area that we think needs to be given attention in new areas of reform. Evidence on this is very clear that we need new funding to be injected in this. It's not possible for us to remove funding from other parts of the system, because of the levels of crisis that are currently presenting.[139]

6.156 Professor Sachdev affirmed the importance of appropriately investing in community services, noting that people who have been hospitalised for mental illness are often discharged quickly and hospitals are not structured to deliver ongoing care in the community.[140]

6.157 Appearing before the Committee, MYST outlined the impacts that COVID-19 has had on the capacity of grassroots organisations to meet the increased demand within the constraints of funding:

> The young people we provide support to have been experiencing an increase in suicidal ideation since the pandemic began. Sixty-two per cent of our individual clients had suicidal ideation in 2019, which increased to 92 per cent in 2020. We have also seen an increase in young people contacting our service—on average, seven new referrals a week. Worryingly, given MYST's resourcing levels, we are having to turn young people away. This, coupled with the increase in suicidal ideation, may have significant impacts for our local community.[141]

Culturally and linguistically diverse community organisations

6.158 Despite higher vulnerability, culturally and linguistically diverse (CALD) communities can be supported to improve mental health and suicide

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138 See, for instance, Ms Amy Young, Head, Mental Health Evidence Base Improvement Unit, Australian Institute of Health and Welfare, *Committee Hansard*, Canberra, 6 August 2021, page 15; Australian Patients Association, *Submission 39*, page 2; Ms Taryn Harvey, Chief Executive Officer, WAAMH, *Committee Hansard*, Canberra, 19 July 2021, pages 1-2; Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, page 44.

139 Ms Taryn Harvey, Chief Executive Officer, WAAMH, *Committee Hansard*, Canberra, 19 July 2021, pages 1-2.

140 Professor Perminder Sachdev, *Committee Hansard*, Canberra, 29 July 2021, page 11.

141 Ms Kim Scanlon, General Manager, MYST, *Committee Hansard*, Canberra, 28 July 2021, page 26.

prevention through funded community solutions and organisations, and by investing in programs for cultural engagement.

6.159 Within the 2021-22 Budget, the Australian Government announced a $16.9 million investment in mental health early intervention supports and preventative measures for migrants and multicultural communities, and initiatives to improve the cultural competence of the broader health workforce:

> This includes continued funding in 2021-22 for the Program of Assistance for Survivors of Torture and Trauma, and support for Mental Health Australia to promote mental health among culturally and linguistically diverse (CALD) communities.[142]

6.160 To address mental health barriers like stigma, the Centre for Multicultural Youth (CMY) explained that the Australian Government can best support CALD communities by directing funding to local literacy programs and 'empower the local organisations and the community members and work alongside them' to reach desired outcomes.[143]

6.161 CMY's submission identified the importance of a culturally-responsive local mental health system with staff professional development and transcultural approaches, a multicultural workforce, interpreter services, and engagement with young people, families and communities from multicultural backgrounds that they trust.[144]

6.162 NMHCCF's submission highlighted a lack of workforce and funding support for CALD community carer organisations, identifying that:

> Some of the Community Managed Organisations (CMOs) employ a few bilingual workers to work with some high number CaLD populations but they are barely able to address the issues. In some Local Health Districts/Local Health Networks with more than 40% of their populations from CaLD backgrounds covering several hundred languages and cultures – the service provision unfortunately doesn't reflect that.[145]

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142 Department of Health, *Budget 2021-22, Prioritising Mental Health and Suicide Prevention (Pillar 4) – Supporting vulnerable Australians*, 11 May 2021, pages [1-2].

143 Mr Tyson Tuala, Youth Worker - Le Mana (Empower) Pasifika Youth Project, Centre for Multicultural Youth (CMY), *Committee Hansard*, Canberra, 6 August 2021, page 32; Ms Willow Kellock, Senior Policy Advisor, Centre for Multicultural Youth, *Committee Hansard*, Canberra, 6 August 2021, page 31.

144 CMY, *Submission 146*, page 4.

145 NMHCCF, *Submission 71.1*, page 2.

6.163 NMHCCF's submission recommended that government fund Local Health Districts to provision services to train and coordinate multi-lingual or multicultural carers, who can be shared state-wide between Local Health Districts to maximise talent and address demand.[146]

6.164 In its submission, CMY recommended that government:

- Promote the mental health and wellbeing of young people from refugee and migrant backgrounds through significant investment in accessible sports, recreation, arts, youth support, leadership development and employment – opportunities that strengthen young people's connections, social capital, ability to access support, and increase a sense of belonging.
- Invest in co-designed youth suicide prevention programs that specifically target communities from migrant and refugee backgrounds.
- Resource recurrent, co-designed mental health literacy programs with young people and communities from migrant and refugee backgrounds to reduce stigma and promote help seeking.[147]

LGBTIQ+ and SGD community organisations

6.165 SAGE Australia highlighted community funding as a key component of the 'scaffolding approach' required to improve mental health and suicidality rates within the SGD community. It noted that:

> It has been the community support that has helped people, so the government needs to give money to community groups to help people with depression and suicidation.[148]

6.166 LGBTIQ+ Health Australia argued that continued investment into large-scale, generalist mental health services has meant that community-controlled LGBTIQ+ health organisations that desperately need investment to meet current demand and expand are struggling.[149] LGBTIQ+ Health stated:

> Now I've often said previously that you can judge our health by the health of our community-controlled organisations, and they're not in good health … So at the structural level I suppose what I'm wanting to get across is that we need a really cohesive process where we can see national investment. I mean, we

146 NMHCCF, *Submission 71.1*, page 3.

147 CMY, *Submission 146*, pages 5-6.

148 Dr Tracie O'Keefe, Co-Founder, SAGE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 4.

149 Ms Nicky Bath, Chief Executive Officer, LGBTIQ+ Health Australia, *Committee Hansard*, Canberra, 26 July 2021, page 2.

> don't get peak funding; we have a bid in at the moment, as do all those other organisations that are seeking that precious funding, but we need jurisdictional joined-up approaches so that we can see our organisations flourish across the country, because only when these organisations flourish will our communities flourish.[150]

6.167 Similarly, SAGE Australia noted the importance of providing grants and funding to community groups in conjunction with mainstream services, to avoid the reality of social ostracism and build local supports for SGD individuals who are suffering from suicidal ideation:

> The danger zone when somebody is suicidal is 28 days after the first incident, when the brain begins to repattern itself. They need daily support for those 28 days, and only small local community groups can do that.[151]

6.168 The Trans Health Research Group explained that the mental health needs of the transgender community are not being met by mainstream services, with most relying on LGBTIQ+ organisations that cannot keep up with this demand. The Trans Health Research Group stressed an urgent need to expand and consider novel approaches for co-designed services:[152]

> … our vision and I think that of most people would be that trans people can turn up to their local GP or any psychologist or any mainstream service to access care, and ideally, trans people would be in a society where they can live, work, rent a house and go to the supermarket without any fear of discrimination or abuse. But we're not there yet, and so because we're not there yet, right now it's the community-controlled organisations that can work to prevent suicide and improve mental health and provide that peer support where people can go and get help and they know they'll be understood and be included and feel safe.[153]

6.169 Mind Australia in its submission explained that a lack of funding led to the closure of its Mind Equality Centre, a specialist counselling and support service, established to address the disproportionately high rates of mental

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150 Ms Nicky Bath, Chief Executive Officer, LGBTIQ+ Health Australia, *Committee Hansard*, Canberra, 26 July 2021, page 4.

151 Dr Tracie O'Keefe, Co-Founder, SAGE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 5.

152 Sav Zwickl, Researcher, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 1.

153 Dr Ada Cheung, Senior Research Fellow and Head, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 5.

illness in LGBTIQ+ communities and the lack of specialist mental health support for LGBTIQ+ people in Victoria:

> The Equality Centre was funded almost entirely by Mind. Demand for the centre (approximately 95%) came from the general community through mental health treatment plans funded through the Medicare Benefits Schedule (MBS). However, 85% of clients were not able to afford the gap payment.
>
> In August 2020, the operations of the Equality Centre ceased. This was due to a lack of government and other external funding, coupled with the complexity and vulnerability of the people accessing the service, making the model unsustainable.[154]

6.170 However, Mind Australia continues to operate Mind Equality services through the delivery of an aftercare program, funded by the North Western Melbourne PHN. The results of the aftercare program pilot evaluation (March 2020 - December 2020) showed the success of the program and the gap it could fill in the mental health system.[155]

6.171 Despite this, Mind Australia confirmed that the aftercare program is subject to the same funding uncertainty as many other mental health services.[156]

Aboriginal Community Controlled Health Organisations

6.172 The Kimberley Aboriginal Law and Cultural Centre (KALACC) underscored the criticality of funding culture within Aboriginal communities, identifying a need for long-term, sustainable funding and sufficient investment.[157]

6.173 KALACC explained:

> That's the biggest challenge for our communities. This is why we continue to have these gaps, I reckon, because, when you have good practice you have to keep it going, but they say, 'We're termed for only three years …' whereas they could continue programs that have benefit and could evaluate them to keep them up to date with the latest information, but do it in the cultural

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154 Mind Australia Ltd, *Submission 68.1*, page [2].

155 Mind Australia Ltd, *Submission 68.1*, page [2-3].

156 Mind Australia Ltd, *Submission 68.1*, page [3].

157 Ms Erica Spry, Executive Board Member, Kimberley Aboriginal Law and Cultural Centre (KALACC), *Committee Hansard*, Canberra, 27 August 2021, page 12.

> context, including the elders and the young people, because that's the healing component coming in.[158]

6.174 KALACC also highlighted the importance of having appropriately funded cultural programs that connect to community directly in a co-design approach, noting the profound impact of the Yiriman Project for offending juveniles:

> They took them out on camps, 10-day camps, and these young people that attended never reoffended. We all go back and say that we had a lot of gaps in program delivery. In my term of coming on KALACC, I've had some of the elders say, 'Well, if you didn't stop the funding then, we wouldn't have what we have now, where crime has just totally escalated and they're much harder to have to work with.' To me this two-year funding isn't enough. I would say have five-year funding and then do evaluations on it and then continue to build on that best practice to go forward.[159]

6.175 In its evidence, KALACC outlined that there is significant evidence identifying Aboriginal suicidality as a cultural issue not a health issue, referencing a number of publications including:

- *Culture wounds require cultural medicines*, written by Professor Michael J Chandler in 2012
- *Learnings from the message stick* report, published by the Western Australian Parliament's Standing Committee on Health and Education in November 2016
- *My life, my lead* report, published by the Department of Health in December 2017
- *Country can't hear English*, written by Kerry Arabena in June 2020
- *Culture is key*, published by the Lowitja Institute in early 2021.[160]

6.176 KALACC acknowledged that despite this evidence-base, there are still no commissioning pathways for services in the social and cultural determinants of health. KALACC stated that:

> 'If we are serious about reducing the suicide rate, we need to get serious about investing in language programs, we need to get serious about investing in

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158 Ms Erica Spry, Executive Board Member, KALACC, *Committee Hansard*, Canberra, 27 August 2021, page 14.

159 Ms Erica Spry, Executive Board Member, KALACC, *Committee Hansard*, Canberra, 27 August 2021, page 12.

160 Mr Wesley Morris, Coordinator, KALACC, *Committee Hansard*, Canberra, 19 July 2021, pages 15, 17.

ceremony, we need to get serious about investing in Aboriginal empowerment of their own culture.' We don't want to turn this phenomenon of suicide. This is not a health issue. This is a cultural issue.[161]

6.177 AHMRC identified that in response to growing antenatal depression presentations within its member services, it has been building social and emotional wellbeing strategies and additional programs to support parents in health and culture. AHMRC highlighted that:

> … the issue for us is that we don't get extra funding for those programs. Our services utilise their own self-generated income to develop these community based programs that are targeted for young women.[162]

6.178 Similarly, the National Aboriginal Community Controlled Health Organisation (NACCHO) stated that mental health, and social and emotional wellbeing funding is poorly coordinated and sits within different federal departments. NACCHO recommended:

> … social and emotional wellbeing funding be moved to the Commonwealth Department of Health from the National Indigenous Australians Agency to ensure a more integrated approach to funding proposals.[163]

6.179 Further, Gayaa Dhuwi (Proud Spirit) Australia argued the importance of Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system, including for funding arrangements, in order to achieve the highest attainable standard of care.[164] Gayaa Dhuwi recommended:

> Implementing *The Gayaa Dhuwi (Proud Spirit) Declaration* in all departments and importantly the Health Department and PHN service contracts/schedules, with KPIs that ensure Aboriginal and Torres Strait Islander people have access to clinical and cultural responses - the 'best of both worlds'.[165]

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161 Mr Wesley Morris, Coordinator, KALACC, *Committee Hansard*, Canberra, 19 July 2021, page 17.

162 Dr Peter Malouf, Executive Director of Operations, AHMRC, *Committee Hansard*, Canberra, 29 July 2021, page 8.

163 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (NACCHO), *Committee Hansard*, Canberra, 12 August 2021, page 10.

164 Gayaa Dhuwi (Proud Spirit) Australia, *Submission 180*, pages [11-14].

165 Gayaa Dhuwi (Proud Spirit) Australia, *Submission 180*, page [13].

6.180 The Royal Commission into Victoria's Mental Health System acknowledged the need to support Aboriginal social and emotional wellbeing and recommended that the Victorian Government:

1. build on the interim report's recommendation 4 to support Aboriginal social and emotional wellbeing, and resource the Social and Emotional Wellbeing Centre to establish two co-designed healing centres.
2. resource Infant, Child and Youth Area Mental Health and Wellbeing Services to support Aboriginal community-controlled health organisations by providing primary consultation, secondary consultation and shared care.
3. resource Aboriginal community-controlled health organisations to commission the delivery of culturally appropriate, family-oriented, social and emotional wellbeing services for children and young people.
4. resource the Victorian Aboriginal Community Controlled Health Organisation, in partnership with an Infant, Child and Youth Area Mental Health and Wellbeing Service, to design and establish a culturally appropriate, family-oriented service for infants and children who require intensive social and emotional wellbeing supports.[166]

6.181 The Australian Government announced in the 2021-22 Budget, a $79 million investment to address the devastating and disproportionate impact of suicide and ill-mental health on Aboriginal and Torres Strait Islander Australians. Key initiatives include funding for aftercare, regional suicide prevention networks, suicide prevention leadership, the Gayaa Dhuwi-Lifeline crisis line, and sector reviews, under a renewed Indigenous-led National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.[167]

6.182 Appearing before the Committee, NACCHO acknowledged the Australian Government funding for Aboriginal and Torres Strait Islander suicide prevention and after-care services in the 2021-22 Budget. However, NACCHO noted that:

> … there is no funding set aside for Aboriginal and Torres Strait Islander-specific prevention and early intervention services. NACCHO must play a lead role in identifying how this funding, as well as programs and services,

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166 Royal Commission into Victoria's Mental Health System, *Final Report: Summary and Recommendations,* February 2021, Recommendation 33, page 70.

167 Department of Health, *Budget 2021-22, Prioritising Mental Health and Suicide Prevention (Pillar 4) – Supporting vulnerable Australians*, 11 May 2021, page [1].

> will be rolled out across the country to ensure culturally competent access for Aboriginal and Torres Strait Islander people.[168]

6.183 In addition, NACCHO identified that social and emotional wellbeing teams within Aboriginal Community Controlled Health Organisations (ACCHOs) struggle to attract adequate and sustained funding, which results in individuals missing critical early interventions. NACCHO argued that often this progresses to individuals requiring more complex treatment, generally within hospital settings, resulting in worse health outcomes and increased costs to governments.[169]

6.184 In its submission NACCHO further argued that an integrated funding approach to Aboriginal mental health, suicide prevention, and social and emotional wellbeing would be beneficial for:

- minimising staff costs and duplication
- streamlining reporting and decreasing the reporting burden for ACCHOs
- better coordination and integration of health and community services
- maximising funding for service delivery.[170]

6.185 AHMRC explained that funding services through ACCHOs allows support services to be tailored to the needs of each community and reduces the disjointed care pathway:

> A great example of this is the adequately governed project of the Building on Resilience initiative funded by the New South Wales government, in which activities are delivered directly to Aboriginal community controlled services, who create their own community controlled suicide prevention projects. There is a strong evidence base to indicate that Aboriginal communities respond better to suicide prevention activities that incorporate culture as a critical component.[171]

168 Ms Patricia Turner, Chief Executive Officer, NACCHO, *Committee Hansard*, Canberra, 12 August 2021, page 8.

169 Ms Patricia Turner, Chief Executive Officer, NACCHO, *Committee Hansard*, Canberra, 12 August 2021, page 8.

170 NACCHO, *Submission 216.1*, page [2].

171 Dr Peter Malouf, Executive Director of Operations, AHMRC, *Committee Hansard*, Canberra, 29 July 2021, page 6.

Committee comment

6.186 The Committee commends the Australia Government for the 2021-22 Budget's investment in the mental health and suicide prevention services of Australia's CALD and Aboriginal and Torres Strait Islander communities.

6.187 LGBTIQ+ and SGD communities face significant mental health and suicide disparities when compared to the general population, and there is an apparent incapacity for mainstream services to meet this demand.

6.188 The Committee is concerned by the closures of, and the lack of funding given to, LGBTIQ+ and SGD community-controlled organisations who currently struggle with funding instability and competitive tendering processes against large mainstream services.

Recommendation 33

6.189 The Committee recommends that the Australian Government direct specific funding for LGBTIQ+ and sex and/or gender diverse community-controlled health services, community groups and programs to provide mental health and suicide prevention services that meet community needs.

6.190 The importance of culture and cultural community programs to Aboriginal and Torres Strait Islander communities are significant factors that underwrite Aboriginal and Torres Strait Islander mental and physical health.

6.191 The Committee is particularly concerned by continued investment in mental and suicide prevention health that does not appropriately factor in the social and emotional wellbeing or cultural needs of Aboriginal and Torres Strait Islander communities.

6.192 This is undoubtedly leading to variable returns on investment, and there is a clear gap in the commissioning model that does not sufficiently fund culture-oriented community programs.

Recommendation 34

6.193 The Committee recommends that the Australian Government formalise commissioning pathways for Aboriginal cultural programs, noting the significant relationship between cultural connectedness and Aboriginal mental health, suicide prevention, and social and emotional wellbeing.

6.194 The Committee commends the Australian Government for its $79 million investment into Aboriginal mental health and suicide prevention within the 2021-22 Budget.

6.195 The Committee supports the 'best of both worlds' approach for providing clinical and cultural responses, and calls for the Australian Government to further invest in Aboriginal and Torres Strait Islander leadership within the mental health system through fully implementing the Gayaa Dhuwi (Proud Spirit) Declaration.

6.196 Proactive investment in early interventions for Aboriginal communities plays a significant role in maintaining Aboriginal health, and in reducing hospitalisations and health system costs.

6.197 Therefore, the Committee supports government action to address the funding gaps in Aboriginal mental illness prevention, early intervention, and social and emotional wellbeing programs through ACCHOs.

6.198 The Committee also supports the recommendation within NACCHO's submission that:

> Funding for Aboriginal and Torres Strait Islander mental health and suicide prevention services should be redirected from Primary Health Networks (PHNs) to Aboriginal Community Controlled Health Organisations (ACCHOs).[172]

6.199 Further, the mental health, suicide prevention, and social and emotional wellbeing funding portfolios need to be integrated within ACCHOs to improve coordination, and minimise costs and duplication.

Recommendation 35

6.200 The Committee recommends that the Australian Government:

- **consolidate its funding portfolios to Aboriginal Community Controlled Health Organisations (ACCHOs) within the Department of Health for Aboriginal mental health, suicide prevention, and social and emotional wellbeing**

- **ensure that Commonwealth funding for Aboriginal services is redirected from Primary Health Networks to ACCHOs, where available**

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172 NACCHO, *Submission 216*, page 3.

- **ensure funding is sufficient for the full and rapid implementation of the Gayaa Dhuwi (Proud Spirit) Declaration.**

Implementation

6.201 Appearing before the Committee, NMHC argued that:

> It's a well-known maxim that you can have very well developed theories, processes, strategies et cetera but they are only as good as the implementation of them … we certainly will be proposing that this should be included in the national agreement between the states and territories and the Commonwealth. But it is something we need to put on the table: what mechanisms are needed, how do we ensure that the implementation process is recognised, resourced and reported, and are there measurable consequences if things are not being implemented?[173]

6.202 Additionally, stakeholders have identified the importance and urgency in the Australian Government implementing the recommendations identified and repeated through the significant history of government reports, parliamentary inquiries, research papers and evaluations.[174] The Salvation Army outlined that:

> … we'd like to stress that we need action, but, more importantly, we need action now. Across our services, particularly in the emergency relief space, we're seeing an increase and a heightening of behaviours that would indicate a mental health concern. We are preparing for it to get a lot worse before it gets better.[175]

6.203 MHA's submission recommended that the Australian Government should prioritise:

- The development of an implementation plan for the PC Report's [Productivity Commission Report] recommendations including any gaps

173 Ms Christine Morgan, Chief Executive Officer, NMHC, *Committee Hansard*, Canberra, 18 March 2021, page 16.

174 See, for instance, Professor Perminder Sachdev, *Committee Hansard*, Canberra, 29 July 2021, page 10; Mr Simon Tatz, General Manager, Policy and Government Relations, Australian Physiotherapy Association, *Committee Hansard*, Canberra, 26 July 2021, page 17; Ms Jennifer Kirkaldy, General Manager, Policy and Advocacy, The Salvation Army Australia, *Committee Hansard*, Canberra, 28 July 2021, page 39.

175 Ms Jennifer Kirkaldy, General Manager, Policy and Advocacy, The Salvation Army Australia, *Committee Hansard*, Canberra, 28 July 2021, page 39.

identified in the other reviews and well informed by mental health consumers, carers, and the broader sector.

- The provision of an accompanying budgetary plan that identifies the key components of the future mental health system, clarifies which level/s of government will be responsible for delivering each of the components, and articulates the Australian, state and territory governments' commitments to fund these recommendations over a number of funding cycles.
- Immediate investment to fund the PC Report recommendations that can be implemented immediately, and to ensure continuity of funding for the psychosocial service sector.[176]

6.204 MHA welcomed the funding announced for mental health and suicide prevention in the Australian Government's 2021-22 Budget and acknowledgment that this was the 'first instalment of their response to the PC Report'. While noting that implementation details were still to be released, MHA stated:

> It is imperative that they engage consumers and carers early in the design and delivery of these new services and that there is broader sector engagement to ensure service integration and to inform appropriate accountability and evaluation processes.[177]

6.205 Other stakeholders called for any investment in mental health and suicide prevention to be coupled with long-term funding plans, outcomes and activity, to ensure that investments make a difference and support the continuity and sustainability of services.[178]

6.206 Similarly, Gayaa Dhuwi (Proud Spirit) Australia advised that:

> Implementing the system-wide reform process proposed in the three policies, comprehensively and with a long-term commitment, would begin to address the targets and outcomes of the National Agreement on Closing the Gap and all the critical, longstanding disparities listed in the Indigenous health performance framework, including the rate of suicide for all Indigenous Australians being twice that of the general population and that Aboriginal and

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176 MHA, *Submission 69*, page 6.

177 MHA, '2021 Federal Budget Summary', 11 May 2021, mhaustralia.org/general/2021-federal-budget-summary, viewed 8 October 2021.

178 See, for instance: Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, pages 1-2; Ms Amelia Walters, headspace Board Youth Advisor, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 25; Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 25.

> Torres Strait Islander people are 2.5 times more likely than non-Aboriginal and Torres Strait Islander people to have high to very high levels of psychological distress.[179]

6.207 Beyond Blue suggested that the implementation of reform that has been recommended to the government needs to be approached differently, on an iterative basis:

> This is a really big and complex reform agenda and it's not possible to do everything at once, so for many measures, government should embrace iterative design and a 'try, test and learn' approach where it makes sense to do so. This way new ideas and solutions can be incubated and proven in stages rather than being delayed by overinvestment in the design phases that are not informed in real-time by results, user feedback and analysis.[180]

6.208 Stakeholders also identified that there is an immediate capacity for government to ensure mental health and suicide prevention policies are implemented by embedding them through all ongoing government procurement processes. MATES in Construction argued that while there is progress within workplace health and safety policies, incorporating suicide prevention and mental health outcomes within contracts:

> … would actually drive best practice across diverse settings and would be a relatively low-cost way for government to be able to make significant impacts. That's something we've already seen. We've been part of having that happen in some parts of our industry and we've seen the benefits it has actually delivered.[181]

6.209 Similarly, Ms Christine Morgan, the National Suicide Prevention Adviser to the Prime Minister, argued that procurement is also a strong lever for government to ensure 'lived experience' representation within the creation and delivery of services:

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179 Mr Thomas Brideson, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, Canberra, 24 June 2021, page 2.

180 Ms Carolyn Nikoloski, Chief Strategy Officer, Beyond Blue, *Committee Hansard*, Canberra, 26 July 2021, page 25.

181 Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, page 42.

> … [it] is really calling it out to say, 'Please don't go into a contract unless the organisation that you're giving this to has demonstrated experience in engaging with lived experience.' It's that simple. Don't experiment with it.[182]

Committee comment

6.210 The need to begin action on the implementation of the ideas within the major reports cannot be understated, and the Australian Government has already begun aspects of the needed reform.

6.211 Despite this, the Committee has also recognised a real sense of urgency for the successful delivery of an improved mental health and suicide prevention system at the grassroots, and developing stakeholder fatigue.

6.212 Clearly, implementation needs to have a whole-of-government approach and accountability, and the evidence across the inquiry has identified a number of immediately actionable recommendations that would deliver this result with immediate impact.

6.213 In the implementation of system reform, one of these whole-of-government levers the Australian Government has to enact system change is the terms of federal contracts in service commissioning and procurement.

Recommendation 36

6.214 The Committee recommends that the Australian Government ensure:

- **under the Commonwealth Procurement Rules it is a condition for participation that any potential supplier demonstrate minimum standards of mental health support and care in their workplace**

- **mental health and suicide prevention service commissioning activity requires services to reasonably demonstrate the inclusion of lived experience in service design and delivery.**

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182 Ms Christine Morgan, National Suicide Prevention Adviser to the Prime Minister, *Committee Hansard*, Canberra, 13 May 2021, page 6.

7. Building the evidence base

Data, monitoring and evaluation, and research

7.1 As discussed previously in this report, mental health and suicide prevention are complex areas. Effective mental health and suicide prevention responses require robust data to identify need; monitoring and evaluation to ensure programs and interventions are achieving anticipated outcomes; and ongoing research that draws on both Australian and international experience and directions.

7.2 The Productivity Commission Inquiry Report on Mental Health (Productivity Commission Report) included advice that it had 'experienced significant data and informational limitations' and noted 'there is no policy framework to guide monitoring, evaluation and research in mental health and related sectors'. Responding to this, it recommended actions to 'drive continuous improvement and promote accountability', including requiring 'that government support data collection and use, transparent monitoring and reporting, program evaluations and practical research'.[1]

7.3 In response to this, the Australian Government allocated $117.2 million over the next four years 'for capturing data to evaluate and measure programs, to ensure that mental health reforms have been effective at improving outcomes'. The 2021-22 Budget also provided for an additional $7.3 million for the National Mental Health Commission (NMHC) to bolster the Commission's capacity to monitor and report on the mental health system

[1] Productivity Commission, *Productivity Commission Inquiry Report on Mental Health,* No 95, 30 June 2020, page 1,184.

and lead consultation with people who have experience with the system as well as their families and carers'.[2]

7.4 During the course of the inquiry, the Committee heard evidence about the existing knowledge base that underpins mental health and suicide prevention, and how this is impacting on capability to harness emerging evidence-based approaches to ensure effective early detection, diagnosis, treatment and recovery.

7.5 This chapter examines first some general issues in the collection and substance of data on mental health in Australia. It then examines in more detail data relating to suicide, self-harm, and suicidality reporting.

7.6 The chapter moves to discuss monitoring and evaluation of programs and interventions, along with services themselves, with a focus on outcomes. It closes by looking at how research can support best-practice approaches to treating mental illness and preventing suicide.

Data

7.7 The treatment of mental illness in Australia relies on data, specifically data that is timely, comprehensive, consistent, and comparable across jurisdictions. Without robust data, governments are constrained in their ability to understand the population requiring assistance and supports, plan service delivery, ensure an appropriately qualified workforce, allocate resources, and assess outcomes to drive continuous improvement.

Harmonisation and linkage

7.8 Previous reports in the mental health sector have highlighted the need to harmonise data standards and datasets.[3] This same point was emphasised in evidence to the inquiry. The Committee heard the incomparability of existing datasets was one barrier to effective service planning and delivery.

7.9 Some of the incompatibility of datasets can be attributed to the often patchwork field of funding bodies for program delivery. Data and reporting requirements often depend on the particular funding and contractual

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2 Australian Government, 'Budget 2021-22: Guaranteeing the Essential Services, Mental Health – Measurement of progress' May 2021, budget.gov.au/2021-22/content/essentials.htm#two, viewed 5 October 2021.

3 See, for instance: Primary Health Networks (PHNs) Advisory Panel on Mental Health, *Report on Progress of Mental Health Reform Being Implemented Through PHNs*, September 2018, page 15.

arrangements, making consistency difficult. The Primary Health Network (PHN) Cooperative provided an example of the inconsistency:

> … there is not equivalence in the minimum data or the data that's collected across different programs. With the PHN program, for example, the minimum data set has 88 items in it … But, you can compare that to Better Access [Better Access to Mental Health Care initiative], where no data is collected about Better Access. But Better Access is many times the monetary value of the psychological services that the PHN funds.[4]

7.10 Service delivery organisations are challenged by this state of affairs. The Royal Flying Doctor Service (RFDS) stated, 'we struggle with the challenge of datasets changing and datasets being different for different funded programs'.[5] RFDS explained:

> We've got so many different contracts and different funding requirements. For some we do submit data straight into the Primary Mental Health Care Minimum Data Set, and also for drug and alcohol via a NADAbase, but it depends on who funds them as to what data they need or where.[6]

7.11 As a potential solution, RFDS called for the collection of a small number of agreed and well-articulated data points as part of a national database.[7]

7.12 Having a common minimum data set, according to the PHN Cooperative, would allow the sector to look at:

> … what's happening for people, whether they engage with mental health or community services or hospital services, private, public, NGO [non-government organisation]. We need that common minimum data set not a whole series of different data sets, because then we can't compare, nor can we even begin to track, what happens to people as they move across the system as their needs change.[8]

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4 Mr Paul Martin, Mental Health Working Group, PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 9.

5 Mr Frank Quinlan, Federation Executive Director, Royal Flying Doctor Service of Australia (RFDS), *Committee Hansard*, Canberra, 17 June 2021, page 12.

6 Ms Vanessa Latham, Manager, Mental Health Services, RFDS, *Committee Hansard*, Canberra, 17 June 2021, page 12.

7 Mr Frank Quinlan, Federation Executive Director, RFDS, *Committee Hansard*, Canberra, 17 June 2021, page 12.

8 Mr Paul Martin, Mental Health Working Group, PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 9.

7.13 This general point was supported by the Royal Australian and New Zealand College of Psychiatrists, which suggested the creation of a nationally consistent data system underpinned by clinical registries. The College stated such a data system would 'help us get that information in a timely manner and then make those policy changes so that we don't need another inquiry'.[9]

7.14 One aspect of harmonisation would be standardisation that would allow for comparisons across programs and jurisdictions. While the Commonwealth maintains the Primary Mental Health Care Minimum Data Set, the Committee was told the dataset does not allow for a solid overview of outcomes that are standardised to allow for comparison. The WA Primary Health Alliance stated standardisation would allow comparisons of regional and urban settings, amongst other matters and would drive improvements in service delivery and planning.[10]

7.15 Gaining the ability to link standardised data sets—for instance by linking Commonwealth and state and territory data—would give better insights into mental health and suicide prevention. The Australian Institute of Health and Welfare (AIHW) explained:

> Traditionally when we've reported on services, we tend to report on them in isolation. What's really interesting is the crossover in how many people use, for example, Medicare and subsidised mental health services that are also using state and territory mental health services and the intensity of that use over time. I think where we'll make gains in understanding the mental health system are in following people and pathways through the system.[11]

7.16 The value of linkage, supported by strong technology, was also identified by the Australian Medical Association (AMA):

> If we can move to a health system that has good data and is well connected, that would be a starting point to then be able to use technology to assist there and say, actually we can look at all the psychologists or psychiatrists in the country and see the bell curve of how many sessions are needed before discharge and how many people end up in hospital and what the suicide rate

9 Associate Professor Vinay Lakra, President, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, Canberra, 6 August 2021, page 12.

10 Adjunct Associate Professor Learne Durrington, Chief Executive Officer, WA Primary Health Alliance and Chair, National PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, pages 8-9.

11 Mr Matthew James, Deputy Chief Executive Officer, Australian Institute of Health and Welfare (AIHW), *Committee Hansard*, Canberra, 6 August 2021, page 14.

> is. You could get all sorts of metrics if you had really good data, but we just don't …[12]

Data gaps and their consequences

7.17 The Committee heard treatment of mental health and suicide prevention requires not only consistent and comparable data, it also requires robust data across population groups and service delivery to ensure funding is best allocated to areas of need and maximises positive outcomes.

Population gaps

7.18 Gaps in existing data mean there is insufficient information on the mental health support needs of some populations. In effect, the Committee was told these populations are invisible, significantly impacting the level of support received by some sections of Australian society.[13] LGBTIQ+ Health Australia urged change, stating, 'Our communities remain on the back foot when compared to the broader community, as the data renders us invisible'.[14]

7.19 This was supported by research from AIHW, which identified a number of gaps in the data for national reporting purposes, including in the following areas: Aboriginal and Torres Strait Islander peoples; culturally and linguistically diverse people; lesbian, gay, bisexual, transgender and intersex (LGBTI) people; people with experience of suicide; refugees; and victims of traumatic crime.[15]

7.20 Without data, evidence-based resource allocation and service planning is difficult. This was highlighted by the Centre for Multicultural Youth, which told the Committee:

> … we need to significantly improve the cultural responsiveness and accountability of the mental health service system to make sure it's accessible,

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12 Dr Omar Khorshid, President, Australian Medical Association (AMA), *Committee Hansard*, Canberra, 6 August 2021, page 42.

13 Ms Willow Kellock, Senior Policy Advisor, Centre for Multicultural Youth, *Committee Hansard*, Canberra, 6 August 2021, page 31.

14 Ms Nicky Bath, Chief Executive Officer, LGBTIQ+ Health Australia, *Committee Hansard*, Canberra, 26 July 2021, page 2.

15 AIHW, *Submission 80*, page 11. See also: Sav Zwickl, Researcher, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 1.

> inclusive and proactive in meeting the needs of all young people and families in our community. A critical part of this is improved data collection.[16]

7.21 The Trans Health Research Group at the University of Melbourne supported the need for more data on specific populations, 'research in trans health and suicide prevention must be prioritised to reduce the health disparity and measure the success of targeted interventions to reduce suicide'.[17]

7.22 Unless data is collected, the Committee heard that populations who may already experience significant health disparities cannot benefit from existing programs. LGBTIQ+ Health Australia stated it is only when the Australian Bureau of Statistics (ABS) *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020* is 'embedded into all health and social services minimum datasets, including in coroners data, that we will be able to benefit from responses such as the National Suicide and Self-harm Monitoring System'.[18]

7.23 Similar issues were highlighted in other areas with consequences for service delivery. The Australian Rural Health Education Network highlighted the difficulty in getting data concerning rural and remote health and called for:

> Investments in data collection strategies that particularly support workforce planning for the spectrum of health professionals that might be needed, understanding levels of unmet need and also working cross-jurisdictionally—working with state and territory governments—to coordinate planning …[19]

Service provision gaps

7.24 In addition to gaps in data on certain populations, more generally there are gaps in data on service provision. According to AIHW, the mental health-related Medicare Benefits Schedule (MBS) items are the only source of

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16 Ms Willow Kellock, Senior Policy Advisor, Centre for Multicultural Youth, *Committee Hansard*, Canberra, 6 August 2021, page 31. See also: Ms Nicky Bath, Chief Executive Officer, LGBTIQ+ Health Australia, *Committee Hansard*, Canberra, 26 July 2021, page 4; Dr Addie Wootten, Chief Executive Officer, Smiling Mind, *Committee Hansard*, Canberra, 26 July 2021, page 23.

17 Sav Zwickl, Researcher, Trans Health Research Group, University of Melbourne, *Committee Hansard*, Canberra, 26 July 2021, page 1.

18 Collection of accurate data, according to LGBTIQ+ Australia, is not sufficient. It needs to be underpinned by a national commitment to the coordination of investment and outcomes for LGBTIQ+ communities. Ms Nicky Bath, Chief Executive Officer, LGBTIQ+ Health Australia, *Committee Hansard*, Canberra, 26 July 2021, page 2.

19 Ms Joanne Hutchinson, National Director, Australian Rural Health Education Network, *Committee Hansard*, Canberra, 17 June 2021, page 5.

national data on mental health-related services provided by general practitioners (GPs). However, GPs do not bill all mental health-related encounters using mental health-specific MBS items. This leads to an underestimation of total mental health-related GP activity—believed by the Royal Australian College of General Practitioners to be one of the top three reasons a patient will visit their GP.[20]

7.25 Furthermore, data from emergency departments, according to AIHW, 'isn't particularly detailed in terms of occurrence'.[21] At the current time, data on the activities of PHNs, collected under the Department of Health's Primary Mental Health Care Minimum Data Set, is not yet available for reporting.[22]

7.26 Added to this, according to AIHW, there is currently no nationally consistent data on the workforce, or the activities of mental health non-government organisations (NGOs). This has an impact on policy, practice, and planning of activities. This data is particularly important as NGOs play a significant role in providing non-clinical mental health-related services to people living with mental illness, their families and carers.[23]

7.27 Where data is collected from the non-government sector, however, its value in informing policy decisions is not clear. Existing data collection in the NGO sector was described by the Queensland Mental Health Commissioner as somewhat problematic:

> … it is not as systematic as the public system and the same tools aren't used by the NGOs, so it's hard to get a sense of some of the outcomes and achievements through non-government social support.[24]

7.28 A further consequence of inconsistent data collection, according to Prevention United, is that it is hard to understand how health funding for mental health and suicide prevention is spent. This makes developing an

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20 AIHW, *Submission 80*, page 11.

21 Mr Matthew James, Deputy Chief Executive Officer, AIHW, *Committee Hansard*, Canberra, 6 August 2021, page 14.

22 AIHW, *Submission 80*, page 11.

23 AIHW, *Submission 80*, pages 11, 17. See also: Mental Health Australia, *Submission 69*, page 17; Mr Matthew James, Deputy Chief Executive Officer, AIHW, *Committee Hansard*, Canberra, 6 August 2021, page 14.

24 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 4.

infrastructure for investment in promotion, prevention and wellbeing – distinct from other forms of the mental health system – difficult.[25]

Gathering and compiling data

7.29 The Committee heard that agreeing on a standardised and comparable data framework and data collection itself is not straightforward—specialist knowledge is required, alongside the recognition the questions asked shape the responses received. Absent a deep understanding of these complexities, data can be misinterpreted in ways that have the potential to affect service delivery. This is particularly the case in seeking standardised data on outcomes.

7.30 While calling for the collection of outcomes-based data, AMA cautioned:

> The biggest challenge there is making sure you ask the right questions, because collecting the wrong data can have unintended consequences. For example, say you were collecting suicide rates. That's a very concrete outcome. We know very little about what contributes to suicide, so that may not be an accurate reflection of someone's quality of care. If you were looking at hospitalisation rates, you may falsely presume that someone who had high hospitalisation rates was performing poorly when actually their patient base tended to be of a condition that quite frequently needs hospitalisation.
>
> While I understand the sentiment of wanting data-driven care, and it's an emerging field across all specialities in medicine, if we are to head in that direction there needs to be significant consultation with all stakeholders, including our profession, to make sure that it's done gradually and sensitively.[26]

Suicide, self-harm and suicidality reporting

7.31 The importance of accessible, accurate and timely data for suicide prevention was emphasised by many witnesses during the inquiry. However, it is not only information on suicide that is required—witnesses called for a single repository for data on suicides, attempted suicides, and

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[25] Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, page 20.

[26] Dr Danielle McMullen, NSW President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 42.

presentations to hospital to facilitate the coordination of information and ultimately drive improvements in outcomes.[27]

7.32 AIHW stated a key national goal should be suicide registries in each state and territory to provide timely data.[28]

7.33 The National Suicide Prevention Adviser to the Prime Minister, Ms Christine Morgan, advised that while these registers exist in most states and territories and there is a commitment from the remaining jurisdictions to establish the registers, this should be accelerated.[29]

7.34 Queensland established the first suicide register—a partnership between the Queensland Government, led by the Queensland Mental Health Commission, the Coroners Court and the Australian Institute for Suicide Research and Prevention at Griffith University. With this register, researchers follow trends and examine the data to develop deeper insights over time and share the data with government agencies.[30]

7.35 According to Ms Morgan, the registers 'have made a significant difference, to being able to say, "This is a probable suicide that's happening," and being able to respond'. Ms Morgan also indicated that data on deaths is not sufficient and suggested national surveys are required to understand the spectrum of ideation, self-harm and attempts, and experiences in different priority population groups. This would require agreement on a standard definition of what constitutes a suicide attempt.[31]

7.36 The Black Dog Institute similarly called for ambition in a national register that would provide timely and comprehensive information on suicide to inform treatment interventions:

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27 See, for instance: Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, pages 4-5; Mr Christopher Stone, Acting Director, Policy and Government Relation, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 11.

28 Mr Matthew James, Deputy Chief Executive Officer, AIHW, *Committee Hansard*, Canberra, 6 August 2021, page 17.

29 Ms Christine Morgan, National Suicide Prevention Adviser to the Prime Minister, *Committee Hansard*, Canberra, 13 May 2021, page 6.

30 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, pages 3-4.

31 Ms Christine Morgan, National Suicide Prevention Adviser to the Prime Minister, *Committee Hansard*, Canberra, 13 May 2021, page 6.

> The key problem at the moment is that the data around suicide and self-harm takes a while to come together, and so some of the timeliness of those responses is lost. It's also complex because you don't just want to know about suicide; you want to know about attempted suicides, about presentations to hospital where people have made suicide attempts. At the moment, that data is all held by different people. In those trial sites, we have demonstrated how you can bring it together in a timely way, but what really needs to happen is that needs to be happening at a national level and there needs to be a single place that it's pulled together and where it is reported.[32]

7.37 In some cases where data is collected, it is not always available to those who deliver services. The National Aboriginal Community Controlled Health Organisation (NACCHO) told the Committee that in many state jurisdictions, police collate information on self-harm – this is an early sign someone is in a distressed mental health state. Unfortunately, this information is not readily available across the country.[33]

7.38 NACCHO highlighted an arrangement in the Kimberly between the Western Australian police and the Kimberley Aboriginal Medical Services in Broome where self-harm information for the region is shared with the medical services through a formal multi-organisational regional forum. NACCHO suggested consideration be given to an expansion of this arrangement—under a formalised arrangement, where information would be shared in each jurisdiction with the NACCHO affiliate. This would allow organisations to respond quickly to incidents of self-harm.[34]

7.39 StandBy similarly expressed concern about the link between data and service response. However, the organisation suggested that data sharing needs to be coupled with systematised or automated notification systems linked to postvention services. However, currently there are only patchy and unsystematic arrangements in local areas and in some states.[35]

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32 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, pages 4-5. See also: Mr Christopher Stone, Acting Director, Policy and Government Relation, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 11.

33 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (NACCHO), *Committee Hansard*, Canberra, 12 August 2021, page 9.

34 Ms Patricia Turner, Chief Executive Officer, NACCHO, *Committee Hansard*, Canberra, 12 August 2021, page 9.

35 Mr Stephen Scott, Partnerships Manager, StandBy Support After Suicide, *Committee Hansard*, Canberra, 21 July 2021, page 39.

Committee comment

7.40 The Committee acknowledges resourcing to address mental health and suicide prevention cannot be effectively allocated absent robust data on the level of need in the community and the outcomes achieved by interventions. The deficiencies in data highlighted during the course of the inquiry show how effective planning and service delivery are potentially hampered.

7.41 This is particularly the case with some vulnerable populations whose mental health needs remain poorly understood. The Committee acknowledges that data makes communities visible so their needs may be met. The Committee supports the recommendation put forward by LGBTIQ+ Health Australia that the ABS *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020* be embedded into all minimum datasets.[36] Accordingly, the Committee makes the following recommendation to this effect.

Recommendation 37

7.42 The Committee recommends that the Australian Bureau of Statistics *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020* be embedded into all health and social services minimum datasets, including coroners' data and Census data.

7.43 The Committee acknowledges that there is a significant amount of data on mental health and suicide prevention. However, the fact much of this data is not standardised or comparable undercuts the purpose of collecting it and its value in informing service delivery.

7.44 The Committee would like to see AIHW convene a working group to establish a national data collection framework for data on mental health and suicide prevention. This should be undertaken in collaboration with Commonwealth, state and territory authorities, researchers, clinicians, and service delivery organisations, and consult people with lived experience.

7.45 This is an ambitious project as it would involve an assessment of how existing data repositories can be incorporated, and agreement on technical issues and issues that cannot necessarily be measured in one way, such as what constitutes a positive outcome.

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36 Ms Nicky Bath, Chief Executive Officer, LGBTIQ+ Health Australia, *Committee Hansard*, Canberra, 26 July 2021, page 2.

7.46 A central repository of current, harmonised and comparable data should be established and broadly available for research and service delivery planning.

7.47 To ensure a comprehensive repository, agencies that fund mental health and suicide prevention interventions should incorporate harmonised data reporting requirements into service delivery contracts.

7.48 Such a repository would align with recommendations of other inquiries, such as the recent Productivity Commission Report that recommended, amongst other things, the Government fund regular national surveys of mental health and wellbeing, and establish a national clinical trials network.[37]

Recommendation 38

7.49 The Committee recommends that the Australian Institute of Health and Welfare convene a cross-jurisdictional working group, including Commonwealth, state and territory authorities, researchers, clinicians, and service delivery organisations, to establish a national collection framework for data on mental health and suicide prevention. The national collection framework must include:

- **a central repository of current, harmonised and comparable data from all jurisdictions which is broadly available for research and service delivery planning**
- **harmonised data reporting requirements for inclusion in service delivery contracts.**

Monitoring and evaluation

7.50 Previous reviews of mental health and suicide prevention interventions have recommended there be greater investment in collecting data on patient outcomes to ensure patients are improving as a consequence of mental health treatment—that is, determining whether interventions are achieving desired outcomes. Such data can guide improvements in services into the future.[38]

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[37] Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 83.

[38] See, for instance: Medicare Benefits Schedule Review Taskforce, *Post Consultation Report from the Mental Health Reference Group*, 2019, page 44; PHNs Advisory Panel on Mental Health, *Report on*

7.51 The Committee similarly received evidence that emphasised that there must be effective monitoring and evaluation of interventions. Investment in interventions, according to the Australian Clinical Psychology Association, must be coupled with a commitment to ensuring high quality care and evaluation of patient outcomes.[39]

7.52 Monitoring and evaluation, though, applies not only to programs but to the services that deliver these programs.

7.53 The importance of monitoring and evaluation was recognised by the Department of Health. It currently has underway evaluations for the Better Access initiative, headspace, HeadtoHelp, and the Improving Social Connectedness Pilot program.[40]

7.54 The Committee heard that while it is necessary to link desired national outcomes with evaluated services that can provide the outcomes sought, agreement on the desired outcomes at a population level is a necessary first step. According to the Brain and Mind Centre at the University of Sydney:

> … we must urgently move to decide what outcomes we're trying to achieve—not what types of activities we wish to fund—and what the supply chain is. As demand for mental health services has always greatly outstripped supply, we've never agreed about what the supply chain is across the spectrum of care from indicated prevention through to continuing care, and who is accountable for that supply chain.[41]

7.55 The Committee heard that monitoring and evaluation of outcomes is essential to ensure appropriate care is provided—whether care is provided by trained psychologists, psychiatrists or peer support workers. Mental Health Australia told the inquiry:

> … there is plenty of feedback from consumers and carers in the community who are asking for a particular type of compassionate care. I think we have a

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Progress of Mental Health Reform Being Implemented Through PHNs, September 2018, page 15; Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 83; Royal Commission into Victoria's Mental Health System, *Final Report Summary and Recommendations*, February 2021, page 101.

39 Professor Caroline Hunt, President, Australian Clinical Psychology Association, *Committee Hansard*, Canberra, 29 July 2021, page 36.

40 Department of Health, *Submission 41*, pages 10-11; Department of Health, *Answer to Question on Notice*, 18 March 2021.

41 Professor Ian Hickie, Co-Director, Health and Policy, Brain and Mind Centre, University of Sydney, *Committee Hansard*, Canberra, 19 August 2021, page 27.

> responsibility to work out how to measure impact and outcomes from whoever is providing the care, and patient-led outcome measures.[42]

Co-design

7.56 Witnesses told the Committee the incorporation of lived experience is likely to result in the design of more effective interventions because people receiving services are able to have input into the monitoring and evaluation of these services. Witnesses spoke to the Committee about the importance of co-design in Indigenous mental health. Gayaa Dhuwi (Proud Spirit) Australia told the Committee:

> If we're looking at developing services, we need to look at how we measure services and how we do that in a way that is a co-designed, Indigenous led process … It's really about having people that are directly affected by the issues, including having lived experience, involved in the processes around evaluation, reviews or whatever it might be.[43]

7.57 The Consumers Health Forum of Australia stressed the necessity of including consumers in the structures to monitor and independently report on progress and achievements:

> It's not good enough for mental health practitioners and other clinicians and services to measure their own effectiveness, or to focus solely on outcome reporting. We can't assume that their best intentions to deliver consumer centred care are necessarily always met. Consumers must be empowered through assessments, evaluations, patient experience and patient reported measures, not just about the outcomes of their treatment but about how they were treated, and have their voices heard on the experience dimension of care—how they were treated, respected and included as equal members of their care teams, whether as patients or carers.[44]

7.58 Accordingly, the Consumers Health Forum of Australia called for a 'shared truth' of the experiences of mental health systems and services by consumers and carers to drive reform.[45]

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42 Dr Leanne Beagley, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, Canberra, 3 June 2021, page 4.

43 Mr Thomas Brideson, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, Canberra, 24 June 2021, page 4.

44 Ms Leanne Wells, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, Canberra, 5 August 2021, page 6.

45 Consumers Health Forum of Australia, *Submission 60*, page 10.

Monitoring and evaluation of health services

7.59 The Committee was interested to hear about monitoring and evaluation of services themselves, and monitoring and evaluation that has a bearing on the accreditation of mental health and suicide prevention services. LivingWorks identified that the outcomes of such a process could be challenging:

> Suicide Prevention Australia have been funded by the Commonwealth government to set up quality assurance accreditation, the first in the world. We will be the first to go through with it because we have a lot of evidence … We've really welcomed it and we are going to put our programs through it. So I think that, for government and primary health networks and workplaces, having a proper accreditation process is probably the key. It will be ugly for many of us as well because we'll go, 'We're high on here but what are the other areas where we may be lower?'—but, hopefully, we will be okay.
>
> Accreditation is important because, if you want a GP or a vaccination, you are looking for some independent evaluation to say that, besides the evidence base, it has also gone through another independent test.[46]

7.60 The Gold Coast Mental Health and Specialist Services (GCMHSS) explained that the successful implementation of the Zero Suicide Framework was underpinned by a ‘data-driven, continuous quality improvement approach’ and external evaluation by ‘a number of publications, including the *British Journal of Psychiatry*’.[47]

Data for monitoring and evaluation

7.61 The Committee heard of the need for technology driven monitoring and evaluation. For instance, MindSpot stated that by using technology, it measures clinical outcomes each week. These results are reported monthly to the Department of Health, and published in peer reviewed scientific journals.[48]

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46 Mr Marc Bryant, Director, Suicide Prevention, LivingWorks Australia, *Committee Hansard*, Canberra, 13 August 2021, page 27.

47 Dr Kathryn Turner, Clinical Director, Gold Coast Mental Health and Specialist Services (GCMHSS), *Committee Hansard*, Canberra, 13 August 2021, page 13.

48 Professor Nickolai Titov, Executive Director, MindSpot, MQ Health, *Committee Hansard*, Canberra, 19 July 2021, page 22.

7.62 Another example was provided by GCMHSS which noted its data system previously had little capacity to identify who had presented with a suicide attempt:

> Our professor of psychiatry actually created a machine-learning algorithm to trawl through huge numbers of clinical records and work out who did present with a suicide attempt. They then looked back at 10 years of data for that. It's really looking at whether this suicide prevention pathway makes a difference to the time to the next event. Suicide, as an outcome, is an incredibly tricky thing to measure … We looked at that data over four years and then the three years subsequent to that. What we found was a 23 per cent reduction, whereas previously it had been escalating. Because this is the implementation of a framework within a health service, we needed to look at data compared to our health service. There are a huge number of variables that will affect the whole-of-community suicide data, but what we have said is that you should be very cautious.[49]

Committee comment

7.63 The Committee agrees with witnesses to the inquiry that effective monitoring and evaluation must occur at a program and service level, and it must involve truth sharing. However, effective monitoring and evaluation requires agreement on the outcomes sought. In this sense the challenges of monitoring and evaluation mirror some of the challenges of obtaining consistent and comparable data.

7.64 As governments allocate greater resources to addressing growing mental health concerns in the community, there must be accountability for this expenditure. The Committee agrees with the Productivity Commission Report recommendation that NMHC be given statutory authority to monitor and report on reform progress.[50] However, the Committee would like to see this recommendation expanded and considers it appropriate for government expenditure to be subject to parliamentary oversight.

7.65 While the Committee is encouraged to see the Department of Health undertaking monitoring and evaluations of some programs, it is mindful of evidence that there must be an agreement on what constitutes a desirable outcome prior to any independent monitoring or evaluation. Furthermore, it

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49 Dr Kathryn Turner, Clinical Director, GCMHSS, *Committee Hansard*, Canberra, 13 August 2021, page 16.

50 Productivity Commission, Productivity *Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 59.

is concerned evaluations are undertaken in the absence of any nationally agreed standard on data.

7.66 Reflecting the need to ensure expenditure on mental health and suicide prevention interventions is effective and that consumers are actually assisted by the supports they receive, the Committee would like to see increased independence of the officers responsible for mental health and suicide prevention.

Recommendation 39

7.67 The Committee recommends that the Australian Government develop enabling legislation to make the National Mental Health Commissioner an independent officer of the Parliament with responsibility under the legislation for monitoring and reporting on outcomes of mental health and suicide prevention initiatives.

Research

7.68 Without research there cannot be evidence-informed approaches to treatment, care and support, or effective policy development, planning and investment.[51]

7.69 Australian Government initiatives recognise the importance of research to underpin evidence-based service provision. In March 2021, $10 million from the National Health and Medical Research Council's Special Initiative in Mental Health was provided for a new research hub based at the University of Melbourne. The 'Academy of Lived Experience [ALIVE] and Co-Design Living Labs' will link research in 14 universities with the aim of delivering innovative, evidence-based mental health care.[52]

7.70 The Committee heard that research, to be of value to policy making and service provision, must be regularly conducted—this has not always occurred. According to the Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney:

> Data from the 1997 and 2007 National Survey on Mental Health and Wellbeing provided integral information about the prevalence and distribution of mental

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51 Royal Commission into Victoria's Mental Health System, *Final Report Summary and Recommendations*, February 2021, page 99.

52 The Hon Greg Hunt MP, Minister for Health, '$10 million for National Mental Health Research Centre', Media Release, 16 March 2021.

> disorders in the Australian population, which was used to inform policies around the provision of mental health services. However, there was a 14-year gap before the launch of the Intergenerational Health and Mental Health Study, which is currently underway. Funding for more regular – and ideally longitudinal – national mental health surveys would allow for important discoveries and facilitate the development of policies reflective of need.[53]

7.71 The Committee was told a key impediment to research and progress addressing mental health and suicide prevention is a lack of funding. The Black Dog Institute stated:

> At the moment the allocation of research funding that goes to mental health is nowhere near proportionate to the level of disability and suffering that mental health causes in the community. That has definitely limited our ability to make the progress we want to make.[54]

7.72 Aside from shortages in funding, there are difficulties finding professionals with a clinical background who are trained to conduct research:

> At the moment we have no viable training pathways for mental health clinicians, be they psychologists, psychiatrists or mental health nurses, to train to become researchers … In thinking of workforce, alongside what we have to do with the clinical workforce, we have to think about how we will have the next generation of clinical researchers to answer these questions moving forward. At the moment most universities are reliant on overseas trained researchers coming in to fill the gaps.[55]

7.73 The shortage is not caused by a lack of interest. Funding, according to the Black Dog Institute, plays a role:

> Our trainee doctors are all interested in research, particularly in mental health, where there are so many unanswered questions. The main barriers are that, for a clinician to come across and to get involved in researching solutions, they have to take a major pay cut compared to what they could earn if they carried on doing clinical work and accept major job insecurity in that.[56]

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53 The Matilda Centre for Research in Mental Health and Substance Use, *Submission 74*, page [2].

54 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 3.

55 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 3.

56 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 6.

7.74 While not disregarding the importance of research to establish an evidence base for mental health and suicide prevention interventions, the Committee was told there is a balance between evidence and innovation. This does not mean programs are not evidence based, but that research, monitoring and evaluation must be funded. batyr told the Committee:

> The point about the evidence base is an interesting one, because I think there's obviously a bar that should be met, in terms of an evidence base, but not at the cost of innovation and the development of new programs and innovative programs for which there might not necessarily be an evidence base straightaway but for which one needs to be built up.
>
> There's also a lot of onus, understandably, on community organisations like us, who are already resource stretched, to do that evaluative work. Within batyr, we've done a number of impact evaluations, but it takes a lot of internal expertise. It takes paying academic researchers who are able to do that work. So it takes resourcing the community sector.[57]

7.75 This view was supported by Western Sydney University, which urged that greater connections between community organisations and researchers be promoted:

> What I've been finding, working with community organisations, is that there's a bit of a lack of understanding of what good evidence is. A lot of the time amazing projects are run without having an evaluation in mind. So they come to us towards the end of the project to evaluate the project and we're like, 'Well, we need to be with you from the start so that the evaluation is embedded throughout the delivery of the intervention that you are doing in the community'.[58]

7.76 The state of knowledge in mental health and suicide prevention was acknowledged by Prevention United:

> We definitely know a fair bit about how to keep people well and prevent mental health conditions, particularly depression, anxiety, conduct disorders and oppositional defiant disorder, and even alcohol and other drug issues, though not for low prevalence disorders. That has to be said. Do we know

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57 Tom Riley, Research and Policy Manager, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 23.

58 Mrs Arianne Reis, Senior Lecturer, School of Health Science, Western Sydney University, *Committee Hansard*, Canberra, 28 July 2021, page 34.

> everything? No way. Would it help to have more investment in research? Absolutely.[59]

7.77 Emphasising the connection between research and data, the Australian Physiotherapy Association stated reforming primary care and the MBS is stymied by a lack of robust data on the physical health and wellbeing of people experiencing mental illness. This lack of data reflects historic under-investment in research.[60]

Committee comment

7.78 The Committee is aware the three issues discussed in this chapter—data, monitoring and evaluation, and research—are interdependent. Progress in agreeing to a nationally consistent data collection framework, as is recommended, is likely to have benefits for monitoring, evaluation and research. Together, these activities will grow the knowledge base for evidence-informed interventions in mental health and suicide prevention.

7.79 All three are necessary for accountability. The Committee is strongly of the view there must be accountability for the outcomes achieved through the significant public funding expenditures for mental health and suicide prevention. Therefore, greater attention must be paid to funding appropriately the collection of data, monitoring and evaluation, and research.

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59 Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, page 20.

60 Australian Physiotherapy Association, *Submission 1*, page 8.

8. Social determinants of mental health and wellbeing

Promotion, prevention and early intervention

8.1 As discussed in Chapter 7, while the sector does not know everything about mental health, it does know a fair bit about keeping people well.[1] What is known is that the social, economic, cultural and environmental conditions in which a person lives contribute to their mental health, their management of mental illness and recovery from suicide risk. Any effective mental health and suicide prevention system must provide the broader psychosocial supports, beyond clinical care, that are necessary to assist a person's recovery from mental illness.[2]

8.2 Likewise, interventions to address mental health and prevent suicide cannot be purely reactive. There must be a strong focus on mental health promotion, wellbeing and prevention.

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1 Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, page 20.

2 A note on terminology: 'Wellbeing' in this chapter is used to describe what might be considered preventative and resilience-building interventions. The Royal Commission into Victoria's Mental Health System (Victorian Royal Commission) used 'wellbeing' to describe psychosocial support services. A number of definitions can be found for wellbeing and psychosocial support services. It is the case that they cannot be neatly divided but instead might be said to exist on a continuum. Psychosocial support services are discussed separately to wellbeing supports in this chapter.

8.3 This chapter discusses first the social determinants of health and the roles of psychosocial supports in assisting people recover from mental illness. It then examines health promotion approaches that aim to provide people with the skills and resilience to support their own mental health. These may also be referred to as wellbeing approaches. The chapter closes by discussing culturally informed practice.

8.4 A key insight from submissions and evidence to the inquiry is that the treatment of mental illness and suicide prevention and aftercare must be holistic. Treatment cannot solely focus on immediate clinical needs absent consideration of broader psychosocial factors; it must be proactive to build resilience and maintain wellbeing in the population, from a young age.

Social determinants of mental health and suicide

8.5 When considering mental health interventions, the Australian Medical Association (AMA) urged 'respect for the social determinants of mental health'—a person's health and capacity to access services is shaped by the social, economic, cultural and environmental conditions in which they live.[3]

8.6 Similar views were shared by other stakeholders:

- Referring to Maslow's hierarchy of needs, SANE Australia noted that these are the types of things that 'sit around and greatly influence someone's ability to cope and even engage in mental health treatment…'[4]
- The National Mental Health Consumer and Carer Forum noted the importance of meaningful employment, education, income, housing, and physical and psychological security.[5]

8.7 StandBy drew attention to research, which highlighted that social determinants are particularly relevant to preventing suicide. The 'situational distress paradigm' developed by researchers at the University of Western Sydney challenged the conflation of mental illness and suicide by examining

3 Dr Omar Khorshid, President, Australian Medical Association (AMA), *Committee Hansard*, Canberra, 6 August 2021, page 35.

4 Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 27.

5 Mr Keir Saltmarsh, Consumer Co-Chair, National Mental Health Consumer and Carer Forum, *Committee Hansard*, Canberra, 5 August 2021, page 14.

suicide prevention in relation to a range of stressful but common life events, not through the lens of mental illness.[6]

8.8 Suicide Prevention Australia concurred:

> … fewer than half the people who die by suicide have got a mental health issue. It's the accumulation of the social determinants that often leads a person to suicidal distress. It's things such as housing, permanent employment and ensuring that they have sufficient funds to either pay for rent or put food on the table et cetera …[7]

8.9 The real causes of suicide, according to the Queensland Aboriginal and Islander Health Council, often sit outside of the health space:

> If people feel they've got a safe home, they've got a job, they've got meaning in life, they have cultural identity and community identity, they are more likely to actually look after themselves and not have dark thoughts enter their heads or have thoughts around committing suicide.[8]

8.10 Given the relevance of these broad contextual factors to mental health and suicide prevention, AMA stated:

> … we are challenged by longer-term social and cultural determinants of mental health that must be addressed by preventative policy, including education, health literacy, economic stability, employment, disability, age, cultural determinants, climate change, sexual identity and geographic location. The list is very long, but all these factors are critically important if we're going to make a lasting difference to mental health and wellbeing.[9]

8.11 Reaffirming the need for any response to take into account social determinants of mental health, AMA noted ‘there are no simple fixes … this stuff’s all linked up, and the impacts of making a mistake in one area are felt

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6 Mr Stephen Scott, Partnerships Manager, StandBy Support After Suicide, *Committee Hansard*, Canberra, 21 July 2021, page 40; Ms Karen Phillips, General Manager, StandBy Support After Suicide, *Committee Hansard*, Canberra, 21 July 2021, page 38.

7 Ms Nieves Murray, Chief Executive Officer, Suicide Prevention Australia, *Committee Hansard*, Canberra, 3 June 2021, page 11.

8 Mr Cleveland Fagan, Chief Executive Officer, Queensland Aboriginal and Islander Health Council, *Committee Hansard*, Canberra, 21 July 2021, page 31.

9 Dr Omar Khorshid, President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 35.

in another area'.[10] Significant investments, then, are required across a range of sectors not commonly associated with health.

8.12 The Queensland Mental Health Commissioner called for a whole-of-government and cross-sector focus, that goes beyond health:

> Some of our greatest potential for positive impact is building mental health and wellbeing in the settings of everyday life—that is, where people live, where they work, where they learn and where they play.[11]

Treatment and recovery from mental illness

8.13 The Committee heard from the Australian Patients Association that hospitals are not appropriate mental health interventions and called for consumer-led and co-designed models that focus more on addressing the underlying causes of mental health.[12]

8.14 In much the same way social, economic, cultural and environmental conditions contribute to a person's mental health and wellbeing, they also influence recovery from mental illness. Witnesses to the inquiry told the Committee an expansion of the psychosocial supports for people experiencing mental illness is urgently required.[13]

8.15 The Productivity Commission Inquiry Report on Mental Health (Productivity Commission Report) defined psychosocial supports as those that address 'a person's emotional, social, mental and spiritual needs [and include] a range of services to help a person manage daily activities, rebuild

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10 Dr Omar Khorshid, President, AMA, *Committee Hansard*, Canberra, 6 August 2021, page 36. See also: Mr Thomas Brideson, Chief Executive Officer, Gayaa Dhuwi (Proud Spirit) Australia, *Committee Hansard*, Canberra, 24 June 2021, page 4.

11 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 3.

12 Australian Patients Association, *Submission 39*, pages [1-3]. The importance of co-design, or involving people with lived experience was also raised by others, including: Ms Leanne Wells, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, Canberra, 5 August 2021, page 6; The Salvation Army, *Submission 79*, page 2; SANE Australia, *Submission 64*, page 2; Mind Australia Ltd, *Submission 68*, pages 4-5; National Mental Health Consumer and Carer Forum, *Submission 71*, pages 5-6; StandBy, *Submission 87*, page 3; Lived Experience Australia, *Submission 106*, page 9; Youth Insearch, *Submission 115*, page [2].

13 See, for instance: SANE Australia, *Submission 64*, page 1; Ms Rachel Green, Chief Executive Officer, SANE Australia, *Committee Hansard*, Canberra, 26 July 2021, page 25; Mental Health Coordinating Council, *Submission 202*, page 1.

and maintain connections, build social skills, participate in education and employment'.[14]

8.16 The Productivity Commission Report found that to create a person-centred mental health system, reforms would be required to ensure effective services support recovery in the community:

> Housing, employment services and services that help a person engage with and integrate back into the community, can be as, or more, important than healthcare in supporting a person's recovery.[15]

8.17 Addressing the social determinants of health as part of a mental health treatment plan may require investments in accessible housing, for instance. An example was provided by the Australian Rural Health Education Network:

> I have a client at the moment that has very significant health issues and mental health issues that are related to COVID and bushfires—a very complicated client that needs cross-sectional support. Part of her presentation is the housing crisis that we've now got in Australia, particularly for the lower-income people who are faced with this idea of being homeless for the first time in their lives. You're looking at a 62-year-old woman who, for the first time in her life, might actually become homeless. So the mental health work I am doing with her has absolutely no impact if I'm not also working on housing and working on social support.[16]

8.18 The Royal Australian College of General Practitioners suggested general practitioners (GPs) get good results in treating mental illness because they operate through a 'biopsychosocial' model that offers people social or psychological interventions. Sometimes referred to as 'social prescribing',

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14 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 25.

15 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 2. Similar findings were made by the Victorian Royal Commission. See also: Mind Australia Ltd, *Submission 68*, page 4; Ms Jennifer Kirkaldy, General Manager, Policy and Advocacy, The Salvation Army Australia, *Committee Hansard*, Canberra, 28 July 2021, pages 39, 41-42; Professor Patrick McGorry AO, Executive Director, Orygen, *Committee Hansard*, Canberra, 6 August 2021, page 29.

16 Dr Sharon Varela, Chair, Mental Health Academic Staff Network, Australian Rural Health Education Network, *Committee Hansard*, Canberra, 17 June 2021, page 5.

GPs may assist patients to obtain pensions or National Disability Insurance Scheme (NDIS) support, or help with WorkCover or employment issues.[17]

8.19 Interventions like physiotherapy, nutrition and exercise, when part of collaborative and multidisciplinary care, have been shown to assist in the treatment of mental illness,[18] as has financial counselling. The Salvation Army told the Committee:

> From what we are seeing, we've got figures from our financial counselling where people come in with a very high mental illness score and then working through and having someone who sits with them and assists them to work through their financial situation—someone who just helps them navigate the system—leads to incredible increases in their mental health.[19]

8.20 This type of approach is also described as a 'whole-of-person' approach.[20] As a recovery-based approach, psychosocial services:

> … keep people facing mental health challenges connected to their life opportunities, their capabilities, their family, their friends, their community, their education and their work. These factors play a critical role in building longer-term resilience, reducing future harm, reducing distress and reducing risk.[21]

8.21 The Committee heard family and friends are fundamental to the recovery journey of people with mental ill health and should be included, where appropriate, and supported in their caring roles.[22]

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17 Dr Caroline Johnson, Member, Senior Representative, Royal Australian College of General Practitioners, *Committee Hansard*, Canberra, 24 June 2021, page 9. See also: Ms Leanne Wells, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, Canberra, 5 August 2021, page 6.

18 Australian Physiotherapy Association, *Submission 1*, pages 6-7; Ms Tara Diversi, President, Dietitians Australia, *Committee Hansard*, Canberra, 29 July 2021, page 21; Exercise and Sports Science Australia, *Submission 90*, page 3. See Chapter 5 for additional discussion on the role of allied health professionals in mental health.

19 Ms Jennifer Kirkaldy, General Manager, Policy and Advocacy, The Salvation Army Australia, *Committee Hansard*, Canberra, 28 July 2021, page 42.

20 Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 2.

21 Ms Gill Callister, Chief Executive Officer, Mind Australia Ltd, *Committee Hansard*, Canberra, 26 July 2021, page 20.

22 Mental Health Families and Friends Tasmania, *Submission 53*, pages 1, 3; headspace National Youth Mental Health Foundation, *Submission 66*, page 6.

8.22 Psychosocial supports are often juxtaposed with clinical interventions. While witnesses to the inquiry acknowledged the role of both in addressing mental illness and suicide prevention, some perceived an emphasis on a medicalised model at the expense of community-based supports and services. The Australian Association of Social Workers called for greater funding and focus on prevention and early intervention.[23]

8.23 Whilst acknowledging the need for psychosocial supports, AMA emphasised the importance and value of 'actual medical treatment' for ongoing long-term and recurrent mental illness. AMA also supported the need for a diverse mental health system, which is available regardless of geographical location.[24]

8.24 Accompanying calls for an expansion of mental health and suicide interventions that recognise the social determinants of health and the psychosocial supports required by people to recover from mental illness were suggestions for reform to the Medicare Benefits Schedule (MBS). Suggestions provided in evidence to the Committee included covering assistance for carers under the MBS;[25] reforming the MBS to incentivise collaboration;[26] providing for permanent telehealth MBS items;[27] expanding access to psychotherapy and counselling under the MBS;[28] broadening MBS rebatable sessions with psychologists to include prevention and early intervention;[29] increasing the number of MBS sessions available for psychology consultations;[30] providing MBS subsidised access to gender reaffirming surgical interventions;[31] and including Accredited Practising Dietitians in the MBS.[32] Further discussion on the MBS and mental health is included in Chapter 6.

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23 Cindy Smith, Chief Executive Officer, Australian Association of Social Workers, *Committee Hansard*, Canberra, 6 August 2021, page 45. See also: Mental Health Community Coalition ACT Inc, *Submission 154*, page 10.

24 AMA, *Submission 81*, page 2.

25 HelpingMinds, *Submission 134*, page 8.

26 MIGA, *Submission 48*, page 2.

27 headspace National Youth Mental Health Foundation, *Submission 66*, page 5.

28 Psychotherapy and Counselling Federation of Australia, *Submission 72.1*, page 3.

29 Australian Association of Psychologists Inc (AAPi), *Submission 85*, page 12.

30 Australian Clinical Psychology Association, *Submission 130*, pages 3-4.

31 Trans Health Research Group, University of Melbourne, *Submission 120*, page 1.

32 Dietitians Australia, *Submission 148*, page 2.

8.25 Witnesses to the inquiry also called for more general reforms to funding for psychosocial support.[33] Where funding is available, yourtown suggested the funding models themselves may militate against individually tailored psychosocial supports:

> Because we have our own flexible funding because, as I mentioned earlier, we generate a significant proportion of our own income through the art unions, we respond to needs. So we look at the needs of our individual clients, and we design services to wrap around what their individual needs are. Unlike a lot of other organisations, who are fully dependent on government funding, we are not constrained by very granular funding agreement clauses.[34]

Committee comment

8.26 Evidence to the inquiry suggests clinical interventions, in the absence of broader measures to address social determinants of health, cannot resolve growing mental health concerns in Australia. As a consequence, the Committee is of the view the sixth National Mental Health and Suicide Prevention Plan must address the social determinants of mental health.[35]

8.27 As a matter of necessity, the plan must provide for psychosocial supports to be expanded and funded, outside the NDIS.[36] If it is acknowledged that a range of supports are required to assist in the recovery from mental illness, then consideration must be given to expanding not only direct funding, but the MBS itself.

8.28 Furthermore, serious consideration has to be given to expanding affordable housing and supported housing services as was highlighted by the Productivity Commission and the Royal Commission into Victoria's Mental Health System in their respective reports.[37] Stating the extent of investments

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33 See, for instance, a range of views on funding in: SANE Australia, *Submission 64*, page 1; Jesuit Social Services, *Submission 67*, page [3].

34 Ms Kathryn Mandla, Head of Advocacy and Research, yourtown, *Committee Hansard*, Canberra, 21 July 2021, page 45. The need for funding reform to incentivise collaboration was also suggested by MIGA. MIGA, *Submission 48*, Attachment 1, page 2. For comments on funding models, see also: Brisbane North PHN and Metro North Hospital and Health Service, *Submission 73*, page 5.

35 This was recommended by: Australian Association of Social Workers, *Submission 111*, page 5.

36 See, for instance: SANE Australia, *Submission 64*, page 1.

37 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 2; Royal Commission into Victoria's Mental Health System, *Final Report: Summary and Recommendations*, February 2021, page 61.

in affordable housing is not a solution to the problem. The funding that is currently committed in this area is demonstrably insufficient to meet current demand.

8.29 A failure to acknowledge the social determinants of health and to provide adequate funding for psychosocial supports means the mental health and suicide prevention system operates as a palliative. If adequate funding is not made available, then Australia will not achieve the outcomes imagined in recent reports.

Recommendation 40

8.30 The Committee recommends that the Australian Government ensure the sixth National Mental Health and Suicide Prevention Plan acknowledges and addresses the social determinants of health and psychosocial supports needed in the treatment of mental illness and suicide prevention.

Mental health promotion and wellbeing

8.31 Mental health promotion approaches are generally described as taking a holistic, life course approach to equipping people with the skills to 'navigate life's challenges'.[38] Mental health promotion approaches do not mean people will not experience mental illness or rule out the need for clinical interventions, rather they look at building resilience in individuals and communities and ensuring access to services as and when required.[39]

8.32 The Western Australian Association for Mental Health explained the substance of mental health promotion approaches and how they interface with clinical interventions:

> … people have had the chance to learn the skills and live in environments and societies that support their mental health up until that crisis point. Then, if that crisis point does arise, that there are services or options available to people who don't necessarily rely entirely on acute and hospital based services, so that there is a range of support and a range of things people can call on in their

38 See, for instance: Dr Addie Wootten, Chief Executive Officer, Smiling Mind, *Committee Hansard*, Canberra, 26 July 2021, pages 19-20.

39 Although discussed separately in this chapter, wellbeing programs generally adopt a health promotion approach.

> time of need that don't all rely on having to go to hospital or having to present to an ED [emergency department].[40]

8.33 Some are of the view this type of prevention approach can be overlooked in the mental health field—Prevention United estimated only around one percent of federal expenditure in mental health is on wellbeing and prevention, the remaining 99 per cent is directed to mental healthcare supports and service delivery once someone is experiencing mental ill health.[41]

8.34 Jean Hailes advocated for building up resilience in the entire community, including investing in campaigns to identify needs, rather than just focusing on more psychiatrists and psychologists.[42]

8.35 The Prevention Coalition in Mental Health argued that there has been 'little emphasis on promotion and prevention, and instead we wait until after people become unwell or are in crisis before we respond'. The Coalition called for 'greater investment in the promotion of mental wellbeing and the primary prevention of mental health conditions':

> … mental health conditions are not inevitable and there is good scientific evidence to show that we can prevent, or at least substantially delay the onset of many common disorders through evidence-based programs and public policy initiatives that influence the underlying risk and protective factors for these conditions.[43]

8.36 Prevention United contended that this means taking action earlier, with leadership, planning and investment:

> We talk to people a lot about mental ill health, recognising the signs and symptoms when someone is struggling to cope, depressed, anxious and suicidal, and we encourage them to seek health. But it always starts at that point of the mental health continuum. It starts at when people are already not travelling well. Then we say, 'See your GP or your psychologist.' That's important but what are we telling them about how to stay well, how to cope with stress, how to manage life's challenges? That's where the mental health

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40 Dr Elizabeth Connor, Senior Policy Officer, Western Australian Association for Mental Health, *Committee Hansard*, Canberra, 19 July 2021, page 4.

41 Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, page 18.

42 Mrs Janet Michelmore AO, Chief Executive Officer, Jean Hailes, *Committee Hansard*, Canberra, 27 August 2021, page 2.

43 Prevention Coalition in Mental Health, *Submission 86*, page 3.

promotion conversation needs to be added to the mix, the focus on wellbeing, prevention.[44]

8.37 Beyond Blue called for creating a whole-of-government approach that positions mental health and suicide prevention as everyone's responsibility.[45]

8.38 Witnesses generally supported mental health promotion that builds resilience and wellbeing and encourages people to reach out for support. Mental health promotion initiatives and links to early intervention can often be implemented in schools and workplaces.[46]

8.39 In addition to wellbeing initiatives seeking to build resilience and encourage early help-seeking behaviours for mental health conditions, they may also focus on encouraging and educating 'help givers'—friends, family, teachers, supervisors and managers.[47]

8.40 This type of approach has the potential to expand the mental health safety net across communities. An example of the close links between promotion, prevention and early intervention is mental health first aid training, which in addition to educating people on what to look for in others, promotes understanding of mental health in a range of settings.[48]

8.41 Mental Health First Aid International (MHFA) called for the government to commit to 10 per cent of the Australian population being trained in mental health first aid. The organisation suggested this was a practical and tangible

44 Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, pages 19-20. See also: Bella Cini, National Advisory Group Member and Board Member, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 24.

45 Beyond Blue, *Submission 157*, page 7.

46 Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, page 42.

47 See a range of descriptions in: Ms Katherine Newton, Chief Executive Officer, R U OK?, *Committee Hansard*, Canberra, 28 July 2021, page 19; Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 2; Bella Cini, National Advisory Group Member and Board Member, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 24.

48 Ms Shannon Anderson, Chief Executive Officer, Mental Health First Aid International (MHFA), *Committee Hansard*, Canberra, 13 August 2021, page 29.

approach to mobilising community action at scale and complemented mental healthcare pathways.[49]

Social connectedness and loneliness

8.42 While a number of issues may be addressed through wellbeing initiatives, a key aspect of wellbeing raised during the inquiry was social connectedness—described as a fundamental requirement for human wellbeing.[50] As noted in Chapter 2, the pandemic has magnified social and economic vulnerabilities, which in turn have increased loneliness and social isolation.[51]

8.43 Social connectedness is particularly important as communities live with the COVID-19 pandemic. Ordinarily, at any given time, the Committee was told the estimated prevalence of problematic levels of loneliness is around 5 million Australians.[52]

8.44 There appeared to be very little disagreement with the sentiment shared by headspace that 'there's no more important time than now for young people to feel connected in an in-person sense'.[53] While headspace and Dr Kristy Goodwin noted that there were plenty of online opportunities for engagement, this cannot replicate or replace in-person connections.[54]

8.45 As with other mental health interventions, the Committee heard promoting social connectedness and addressing loneliness requires education of community practitioners to assess, monitor and redirect people to appropriate services, and of communities themselves.[55]

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49 Ms Shannon Anderson, Chief Executive Officer, MHFA, *Committee Hansard*, Canberra, 13 August 2021, page 29.

50 Dr Kristy Goodwin, *Committee Hansard*, Canberra, 19 August 2021, page 18; Mr Graeme O'Connor, Acting Chief Executive Officer, Interrelate, *Committee Hansard*, Canberra, 28 July 2021, page 10; Healthy North Coast, *Submission 153*, page 3.

51 Mr Graeme O'Connor, Acting Chief Executive Officer, Interrelate, *Committee Hansard*, Canberra, 28 July 2021, page 10.

52 Ending Loneliness Together, *Submission 192*, page 4.

53 Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation, *Committee Hansard*, Canberra, 26 July 2021, page 26.

54 Dr Kristy Goodwin, *Committee Hansard*, Canberra, 19 August 2021, page 18.

55 Dr Michelle Lim, Chairperson and Scientific Chair, Ending Loneliness Together, *Committee Hansard*, Canberra, 28 July 2021, page 8.

8.46 Necessary first steps, according to Interrelate, is awareness, destigmatisation, and normalisation. Subsequent steps, however, are less clear. While it is known that a number of factors reduce loneliness and increase social connectedness, Interrelate explained there was not a single solution:

> As with any complex, wicked social problem, we need all target groups and stakeholders working towards solutions. So we need to engage with business, with the community, with education, with the for-purpose sector. We need to engage with the community. We need to co-design solutions. It's really important as well that any solutions need to be co-designed.[56]

8.47 Like all other interventions, funding has an influence on outcomes. The Committee was told any decision as to funding for mental health and suicide prevention interventions requires a trade-off between reactive responses to problems as they present themselves and investment in long-term change. The Healthy North Coast contended that social connectedness is one area where there is insufficient long-term investment:

> Out of all the interventions, social connectedness has been demonstrated to have the largest impact on suicide rates over time. It is a matter of balancing the investment. Obviously, if we had unlimited resources we would invest in everything all the time, but it is a challenge to recognise that we need to invest now but also not forget that we've got to invest to actually change the dial.[57]

Promoting wellbeing in the workplace

8.48 The Committee heard workplace responses to mental health and suicide prevention have a role in alleviating pressure on frontline health systems. While this type of approach is separate from the health system, it is also complementary. There is now greater recognition 'peer based early intervention case management models can dispense with the need for professional gatekeepers' and thereby help ease the burden on the health system.[58]

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56 Ms Sharon Grocott, Head of Research and Innovation, Interrelate, *Committee Hansard*, Canberra, 28 July 2021, page 11.

57 Ms Julie Sturgess, Chief Executive Officer, Healthy North Coast (North Coast Primary Health Network), PHN Cooperative, *Committee Hansard*, Canberra, 19 July 2021, page 11.

58 Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, page 42.

8.49 Through its own experience, MATES in Construction stated the issues seen in workplaces 'are not going to be a surprise to anyone—relationship issues for 38 per cent of those presenting, work related issues are about a quarter, family issues are about a quarter, and financial stress is about one in seven cases'.[59]

8.50 Recognising the 'fluid factors' in suicide prevention and the fact a significant number of people may not see a psychologist or other mental health professional, the Australian Association of Psychologists Inc (AAPi) spoke in support of a community focus on suicide prevention, including education in the workforce and in areas where rates of suicide may be higher.[60]

8.51 The Chamber of Minerals and Energy of Western Australia agreed that mental health issues in society require a holistic approach, acknowledging the role employers have to play in addressing mental health as a community issue.[61]

Promoting wellbeing in schools

8.52 The Committee was told the over-representation of young people experiencing mental illness made it necessary to act early in life.[62] The Productivity Commission Report concluded schools should have a clearly defined role in supporting the social and emotional wellbeing of students and recommended making the social and emotional development of school children a national priority.[63]

8.53 Stakeholders suggested a number of reasons it would be appropriate for schools to focus on student wellbeing, including 'their universality and the proportion of children and young people who attend school'.[64]

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59 Mr Christopher Lockwood, Chief Executive Officer, MATES in Construction, *Committee Hansard*, Canberra, 26 July 2021, page 42. See also: Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 4.

60 Mrs Amanda Curran, Chief Services Officer, AAPi, *Committee Hansard*, Canberra, 21 July 2021, page 15.

61 Chamber of Minerals and Energy of Western Australia, *Submission 162*, pages 1-2.

62 Forensicare and Orygen, *Submission 75*, page 2; Prevention Coalition in Mental Health, *Submission 86*, page 2.

63 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 2. See also: Mind Australia Ltd, *Submission 68*, pages 2-3, 17-21, 64.

64 Dr Karen Martin, University of Western Australia and Dr Emily Berger, Monash University, *Submission 231*, page 1.

8.54 Australian Psychologists and Counsellors in Schools (APACS) told the Committee that although traditionally schools have been focussed on academic learning, over the past 20 years there has been research showing mental health and wellbeing contributes to better academic outcomes and happier children and school communities.[65]

8.55 Furthermore, APACS told the Committee, 'Most of these children and young people who are having mental health difficulties and sometimes suicidal ideation are in schools'.[66] While acknowledging high schools require more resourcing, APACS stated the focus should be on younger children:

> … it's in primary schools where you first see those kids starting to get stressed. They still talk to their parents, their parents will still talk to you, and you can do so much preventative work.[67]

8.56 The Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney also supported a focus on young people and student wellbeing, stating 'prevention has been demonstrated to give the best evidence of quality-of-life outcomes in their futures'.[68]

8.57 APACS suggested that substantively operationalising a student wellbeing role might require schools to adjust their priorities so measures of wellbeing become as important as National Assessment Program – Literacy and Numeracy (NAPLAN) scores.[69]

8.58 Clear and measurable wellbeing targets were similarly called for by the Productivity Commission in its report when it recommended governments

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65 Professor Marilyn Campbell, Media Spokesperson, Australian Psychologists and Counsellors in Schools (APACS), *Committee Hansard*, Canberra, 21 July 2021, page 33. See also: R U OK?, *Submission 171*, pages 3, 14; Save the Children Australia, *Submission 177*, page 4.

66 Professor Marilyn Campbell, Media Spokesperson, APACS, *Committee Hansard*, Canberra, 21 July 2021, page 33.

67 Professor Marilyn Campbell, Media Spokesperson, APACS, *Committee Hansard*, Canberra, 21 July 2021, page 34. See also: Mrs Dianne Giblin, Chief Executive Officer, Australian Council of State School Organisations (ACSSO), *Committee Hansard*, Canberra, 6 August 2021, page 19.

68 Professor Maree Teesson, Director, Matilda Centre for Research in Mental Health and Substance Use, University of Sydney, *Committee Hansard*, Canberra, 29 July 2021, page 1.

69 Professor Marilyn Campbell, Media Spokesperson, APACS, *Committee Hansard*, Canberra, 21 July 2021, page 33.

update the National School Reform Agreement to include student wellbeing as an outcome for the education system.[70]

8.59 Witnesses suggested a number of ways schools might address the wellbeing of their students and these are discussed below.

Mental health specialists

8.60 AAPi stated psychologists in schools have the capacity to provide early intervention and counselling support to reduce the need for students to be removed from schools to receive care. Bringing psychological care into schools, AAPi argued, would result in 'a big improvement in the mental health of our young people'.[71]

8.61 However, according to witnesses, several factors stymie actions in this area. One factor is a shortage of school psychologists which leads to the involvement of people who may not be qualified to provide counselling and psychological support:

> Because there aren't enough school psychologists and counsellors, what people have tried to do, realising the need, and in all good faith, is to put other people into the system. You start with school chaplains. School chaplains are not supposed to counsel, but they do.[72]

8.62 To address current shortages, other professionals with less training are being employed, such as wellbeing coordinators and chaplains under the National School Chaplaincy Program.[73] This stop-gap measure, according to APACS, leads to fragmentation.[74]

8.63 Further compounding this problem is the absence of a national standard for mental health professionals in schools. Not all school counsellors are registered psychologists. State education departments decide on the level of training required by school psychologists and counsellors, the tasks they

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70 Productivity Commission, *Productivity Commission Inquiry Report on Mental Health*, No 95, 30 June 2020, page 64.

71 Mrs Amanda Curran, Chief Services Officer, AAPi, *Committee Hansard*, Canberra, 21 July 2021, page 14.

72 Professor Marilyn Campbell, Media Spokesperson, APACS, *Committee Hansard*, Canberra, 21 July 2021, page 33.

73 Dr Karen Martin, University of Western Australia and Dr Emily Berger, Monash University, *Submission 231*, page 2.

74 Professor Marilyn Campbell, Media Spokesperson, APACS, *Committee Hansard*, Canberra, 21 July 2021, page 33.

undertake, and how they are allocated to schools. As gaps in the workforce are recognised, education departments may rely on professionals without experience working in school environments. APACS explained:

> We've had clinical psychologists sometimes come into a school to look after mental health, even though educational and developmental psychologists are fully trained in psychopathology as well. They come into a school and they work to this model of seeing one client per hour. You can't do that in a school. There is no way that you can pay a full-time person to see six clients a day in a school.
>
> As a school counsellor and as a psychologist, you hit the ground running at eight o'clock in the morning, you don't even draw breath as you're getting out of your car before all of these staff descend on you and kids descend on you. You say, 'Can I just get to my office? I need a drink of water. I just need to put these things down.' You don't get any breaks at all. Hopefully, sometimes you get into the playground so you can at least talk with kids and show them that you're a normal person. You're there until the last person leaves the school and the cleaner kicks you out. Everybody who does this job has overcommitted to work in this space and continues to make their professional development a high priority.[75]

8.64 APACS recommended not only a ratio of one school psychologist or counsellor to 500 students (an increase of 100 per cent on the current rate), but that school psychologists and counsellors be resourced and empowered to assume a leadership role in mental health promotion, prevention and early intervention.[76]

8.65 Noting 'the paucity of qualified psychologists in Australia' at the moment, Dr Karen Martin and Dr Emily Berger suggested there is a role for social workers to be integrated into school mental health care teams:

> Such implementation would enable psychologists to do the expert mental health care they are trained to do. Social workers are connected with social services and have policy knowledge held by few other trained professionals.[77]

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75 Professor Marilyn Campbell, Media Spokesperson, APACS, *Committee Hansard*, Canberra, 21 July 2021, page 34.

76 APACS, *Submission 8*, pages 1-2.

77 Dr Karen Martin, University of Western Australia and Dr Emily Berger, Monash University, *Submission 231*, page 2.

Wellbeing programs

8.66 The Matilda Centre told the Committee schools are an important opportunity to provide evidence-based wellbeing initiatives to prevent the onset of mental health and substance use disorders.[78] Evidence to the inquiry suggested this is something also sought by students who want the skills to recognise their own feelings but also the tools to manage their own mental health and to support their friends.[79]

8.67 Interrelate maintained that teaching children about social supports, empathy and maintaining healthy relationships is critical. Such 'preventative skills' and programs promote social interaction, connection and respect.[80]

8.68 Prevention United said concepts of self-care and the psychosocial skills that come from health, clinical and positive psychology can be taught in a positive mental health promotion course. Prevention United stated what is often taught as mental health first aid or mental health literacy 'is really mental illness literacy … you need to complement that with a similar course that is about how you support or enhance good mental health.[81]

8.69 Nevertheless, the Committee heard education about mental illness is also important. MHFA argued mental health education is an essential part of the overall mix of supports to complement clinical, medical and informal mental health service provision:

> There's a lot of awareness around mental health, but there's almost a fear of, 'I don't want to say the wrong thing; I don't want to make it worse, or I'm not going to be equipped to know how to respond if someone says that they're not okay.' That's almost a barrier for people. If they do a course such as mental health first aid, it gives them the skills not only to identify what is going on for people but also to actually practice those conversations and find their own authentic way to have a conversation.[82]

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78 Matilda Centre for Research in Mental Health and Substance Use, *Submission 74*, page 1.

79 Ms Kim Scanlon, General Manager, Mountains Youth Services Team, *Committee Hansard*, Canberra, 28 July 2021, page 28.

80 Mr Graeme O'Connor, Acting Chief Executive Officer, Interrelate, *Committee Hansard*, Canberra, 28 July 2021, page 10.

81 Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, page 21.

82 Ms Shannon Anderson, Chief Executive Officer, MHFA, *Committee Hansard*, Canberra, 13 August 2021, page 30.

8.70 Mountains Youth Services Team suggested all year 8, 9 and 10 students be trained in teen mental health first aid.[83]

8.71 Whilst emphasising the importance of embedding evidence-based wellbeing programs, the Black Dog Institute noted it is typically left to school principals to determine what should be happening in their schools and 'as a result there's a lot of stuff happening in schools which isn't in line with the evidence base of what should be occurring'.[84] batyr agreed, 'it is a crowded market in some ways, and schools need to know what's evidence based'.[85]

8.72 APACS questioned the value of some of these programs, suggesting that even when properly administered, programs to promote resilience, mental health and anti-bullying have been shown to have very small positive-effect sizes, 'in layman's terms, they don't make much difference'.[86] Further, APACS suggested there are many commercial programs that are not supported by any evidence at all. APACS urged instead a focus on the 'hidden curricula' which was explained as:

> … the way you teach … Teachers have to be taught about being kind, about thinking that this is a child that they are teaching … It's not the subject matter that is the most important to get through, it's taking the teachable moment. What makes resilience is knowing all that background. It's the way we conduct schools that counts, not running little programs like 'You do this and there won't be any of that.' It's not proven; it's not shown. And it won't be shown because it won't work.[87]

8.73 Not all agree with this perspective, arguing there is in fact a strong evidence base for some programs. The Australian Council of State School Organisations (ACSSO) suggested an Australian curriculum that provided

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83 Ms Kim Scanlon, General Manager, Mountains Youth Services Team, *Committee Hansard*, Canberra, 28 July 2021, page 28.

84 Mr Samuel Harvey, Acting Director, Black Dog Institute, *Committee Hansard*, Canberra, 28 July 2021, page 3.

85 Tom Riley, Research and Policy Manager, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 23.

86 Professor Marilyn Campbell, Media Spokesperson, APACS, *Committee Hansard*, Canberra, 21 July 2021, page 36.

87 Professor Marilyn Campbell, Media Spokesperson, APACS, *Committee Hansard*, Canberra, 21 July 2021, page 36.

guidance to teachers on programs that are beneficial for particular age groups would be helpful.[88]

8.74 Others highlighted the Be You program from Beyond Blue that provides a framework for assessing social and emotional learning programs and mental health programs. It is regarded as a useful tool to assist schools to make informed choices about the programs available without limiting the range of options to meet their particular needs.[89]

Teacher training

8.75 The Committee heard wellbeing programs on their own are not sufficient to address mental health in schools. Several witnesses told the inquiry that greater teacher training is required—training to teach certain programs, and to develop the skills to respond to wellbeing concerns in their students.

8.76 Prevention United supported school-based mental health promotion. However, it cautioned that while there is evidence supporting the capacity of some social and emotional learning programs to boost wellbeing and prevent mental health, this could depend on how they are taught. For some programs, teachers require professional development in particular skill sets, 'not just generic professional development in mental health'.[90]

8.77 A focus on training was also raised by University of Wollongong's Professor Brin Grenyer, who suggested teachers are also looking for evidence-based responses to signs of emotional disorders in children. In addition to global interventions that focus on giving all children a level of mental health and wellbeing and wellness, Professor Grenyer said there is a need for a workforce strategy to give school counsellors, psychologists and members of the welfare team the skills and strategies to address these issues directly.[91]

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88 Mrs Dianne Giblin, Chief Executive Officer, ACSSO, *Committee Hansard*, Canberra, 6 August 2021, page 21.

89 See, for instance: Tom Riley, Research and Policy Manager, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 23; Mr Ivan Frkovic, Queensland Mental Health Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Canberra, 12 August 2021, page 3; Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, page 20.

90 Dr Stephen Carbone, Chief Executive Officer, Prevention United, *Committee Hansard*, Canberra, 13 August 2021, pages 20-21.

91 One such program is Project Air Strategy for Schools. Professor Brin Grenyer, Professor of Psychology, University of Wollongong and Director, Project Air Strategy for Personality Disorders, *Committee Hansard*, Canberra, 19 August 2021, page 8.

8.78 batyr supported this, and noted helping teachers develop the skills to deliver wellbeing programs is only part of the task. batyr called for the training of teachers as gatekeepers. It argued teachers are under enormous pressure to support young people—'they play incredibly important support roles but they're not necessarily equipped to do that'.[92] batyr emphasised that when young people do reach out early, they must get the support they need to prevent worsening mental health outcomes.[93]

8.79 Evidence from ACSSO supported this general sentiment. It stated a key set of tools teachers need includes trauma informed practice, student wellbeing, and resilience. These should be implemented in teacher education.[94] Smiling Mind agreed, teachers need training and support to implement programs that take a social and emotional learning framework approach within the context of the curriculum.[95]

8.80 Wesley Mission confirmed 'a multilayered approach is really needed. It's not just targeting students; it's also, working with staff, working with parents, working with the whole community'.[96]

Multiple contact points for students

8.81 ACSSO reflected that while there was no consistent route that children might take to speak to an appropriate person within a school, it was important that students were not required to explain themselves to multiple people before they received the support they needed, or required to talk with people with whom they did not feel comfortable. ACSSO suggested an approach that combined consistency and flexibility so:

> … children know that they can go directly to the professional in their school or they can go to their classroom teacher, who they feel really comfortable with and already have a good relationship with, but they don't have to follow a

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92 Tom Riley, Research and Policy Manager, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 22.

93 Tom Riley, Research and Policy Manager, batyr, *Committee Hansard*, Canberra, 28 July 2021, page 23.

94 Mrs Dianne Giblin, Chief Executive Officer, ACSSO, *Committee Hansard*, Canberra, 6 August 2021, page 19.

95 Dr Addie Wootten, Chief Executive Officer, Smiling Mind, *Committee Hansard*, Canberra, 26 July 2021, page 21.

96 Mr James Bell, Group Manager, Wesley Mission, *Committee Hansard*, Canberra, 29 July 2021, page 19.

> strict process of X number of people where they have to lay their soul bare to everybody.[97]

Connecting schools with local services

8.82 The Committee received evidence that there can be a disconnect between schools and their local services.[98] ACSSO said schools ‘aren't particularly good at building relationships with other key people in children's lives, be it the child's family, let alone maybe the child is seeing a psychologist outside of school. Schools still haven't quite broken down that interagency barrier either yet’.[99]

8.83 APACS was of the view school psychologists and counsellors can serve as the critical link between student, family, community, school and external support agencies—if there are sufficient psychologists and counsellors, and if they are sufficiently resourced.[100]

Committee comment

8.84 Mental health promotion approaches, by building resilience over time in the community, have the capacity to move the dial on the incidence of mental illness and suicide in Australia. These approaches both encourage and require the community to recognise it has a role in mental health and suicide prevention.

8.85 Mental health promotion, however, should not be mistaken as a panacea for addressing mental health problems and suicide interventions. Mental health promotion approaches must sit alongside and complement interventions that recognise the social determinants of health and respond with appropriately funded and targeted supports.

8.86 The need for social connectedness is one area brought into sharp focus by the COVID-19 pandemic. The Committee encourages the Australian Government to ensure sufficient long-term investment in measures to increase social connectedness and address loneliness—across the population.

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97 Mrs Sharron Healy, President, ACSSO, *Committee Hansard*, Canberra, 6 August 2021, page 21.

98 Ms Julie Abramson, Commissioner, Productivity Commission, *Committee Hansard*, Canberra, 18 March 2021, page 4.

99 Mrs Dianne Giblin, Chief Executive Officer, ACSSO, *Committee Hansard*, Canberra, 6 August 2021, page 22.

100 APACS, *Submission 8*, page 4.

8.87 The Committee is of the view workplaces and schools have an important role to play in promoting wellbeing and building resilience across the community. If successfully implemented, wellbeing interventions have the potential to reduce the incidence of mental health problems and the strain on frontline health systems.

8.88 The importance of wellbeing programs in schools, from a young age, cannot be underestimated. Young people are over-represented in mental health statistics and the Committee agrees with the Productivity Commission Report that schools should have a clearly defined role in supporting the social and emotional wellbeing of students. The Committee is of the view clear and measurable targets for student wellbeing as an outcome should be established and supports the Productivity Commission Report recommendation to this effect.

8.89 However, to effectively take on wellbeing as a responsibility, schools require support and funding. The Committee heard there is a shortage of school psychologists and counsellors which sometimes results in people without appropriate training being called on to provide psychological and counselling support. Students must receive professional and evidence informed psychological support when it is needed from qualified professionals with experience in school environments.

8.90 The Committee supports a ratio of one full-time equivalent school psychologist on-site for 500 students. It also supports school psychologists being empowered to assume a leadership role in schools. Consideration should be given to integrating other qualified mental health professions into the mental health care team, but this must be done on the basis of clearly defined roles and qualification requirements.

Recommendation 41

8.91 The Committee recommends that the Australian Government work with state and territory governments to:

- **conduct an independent evaluation on the effectiveness of existing programs that support wellbeing in schools, including the National School Chaplaincy Program, with a focus on the outcomes of children participating**

- **implement an agreement to increase the ratio of school psychologists to a minimum of one full time equivalent on-site for every 500 students across all levels of school.**

8.92 If schools are to be made responsible for wellbeing outcomes, they require assistance to sort through the plethora of wellbeing programs. The Committee supports greater guidance being provided to schools on evidence-based and appropriate wellbeing programs through the Australian curriculum, and through the continuation of Beyond Blue's Be You program.

8.93 The Committee supports teachers being trained to provide wellbeing programs and the inclusion of mental health in teacher education and professional development programs. It is also essential teachers receive training to respond appropriately when students reach out for help. The Committee supports and strongly urges the inclusion of trauma informed practice, student wellbeing, and resilience in teacher education.

8.94 Finally, young people themselves have a role to play. More often than not, the first person a teen will turn to will be a friend. Making sure they have the skills to know how to respond when a peer reaches out for help, or just seem to be out of sorts, is another layer of protection that can be applied.

8.95 The Committee would like to see mental health first aid taught to all young people no later than in the early years of high school.

Recommendation 42

8.96 The Committee recommends that the Australian Government prioritise the needs of young people by implementing a national prevention and wellbeing strategy through the Australian curriculum, which includes upskilling staff and students.

Culturally informed practice

8.97 Culture is a fundamental aspect of health for many communities, particularly Aboriginal and Torres Strait Islander communities for whom cultural identity is a core component of resilience. The Aboriginal Health and Medical Research Council of NSW (AHMRC) clarified that there is a clear link to improved mental health and social outcomes when there is a strong cultural connection.[101]

8.98 The National Aboriginal Controlled Community Health Organisation (NACCHO) explained that for Aboriginal and Torres Strait Islander peoples, social and emotional wellbeing:

[101] Dr Peter Malouf, Executive Director of Operations, Aboriginal Health and Medical Research Council of NSW (AHMRC), *Committee Hansard*, Canberra, 29 July 2021, page 7.

> … describes the holistic nature of health, encompassing our social, emotional, physical, spiritual and cultural wellbeing. It recognises our connection to country, community and culture, family and kinship, and spirituality and our ancestors. It recognises that a person's wellbeing is influenced and impacted by past events, traumas and government policy. It is a term that encompasses both mental health and mental illness.[102]

8.99 As such, when considering risk factors for mental health, the Kimberley Aboriginal Law and Cultural Centre advised:

> … the risk is not having culture. To build that culture is a preventative. To build culture is your support and it's your protective factor in a person's whole wellbeing. And, if you're Aboriginal, culture is everything and it's in everything that you do.[103]

8.100 This understanding of what mental health means to Aboriginal and Torres Strait Islander peoples, must, according to NACCHO, be understood and acted upon by governments.[104] Absent an understanding of culture, services are unlikely to meet the needs of the community.

8.101 AHMRC described how Aboriginal people overwhelmingly report a lack of cultural competency and safety when engaging in mental health and suicide prevention services. For instance:

> … many Aboriginal people find the language of psychiatry alienating and stigmatising and the classification can mask the real health needs of Aboriginal people. This has been a persistent barrier that compounds the impact of intergenerational trauma and institutionalised racism that underscores the experience of every Aboriginal person who enters the Australian health system.
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> We know that health services, with their predominantly biological paradigm, have paid scant attention to the connection between history, culture and individual health.[105]

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102 Ms Patricia Turner, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (NACCHO), *Committee Hansard*, Canberra, 12 August 2021, page 7. See also: Queensland Aboriginal and Islander Health Council, *Submission 142*, page 3.

103 Ms Erica Spry, Executive Board Member, Kimberley Aboriginal Law and Cultural Centre, *Committee Hansard*, Canberra, 27 August 2021, page 13.

104 Ms Patricia Turner, Chief Executive Officer, NACCHO, *Committee Hansard*, Canberra, 12 August 2021, page 7.

105 Dr Peter Malouf, Executive Director of Operations, AHMRC, *Committee Hansard*, Canberra, 29 July 2021, page 6.

8.102 Across culturally and linguistically diverse communities, witnesses to the inquiry spoke of the necessity for cultural competence in the mental health sector. AHMRC defined cultural competencies as knowledge, behaviours and attitudes that impact policies and systems.[106]

8.103 The Centre for Multicultural Youth said every person should be able to 'walk in and see a professional who is culturally responsive, who has the intercultural awareness of their own values and their own world views'.[107]

8.104 The Multicultural Youth Advocacy Network described the impact of mental health services that are not culturally responsive, particularly for younger people:

> I myself have gone to some sessions with mental health professionals and often feel worse afterwards because I have to maybe give emotional labour for myself, explaining my culture, explaining my problems to them, and often reacting to quite inappropriate comments and inappropriate understanding about my issues.[108]

8.105 In addition to developing cultural competence in the mental health workforce, diversifying the workforce was suggested as a way to improve the cultural appropriateness of care. For instance, the Royal Australian and New Zealand College of Psychiatrists described the benefit of employing people from diverse backgrounds:

> … people have experience of training in a different system elsewhere—in their country of origin or in another country—it enhances their knowledge and skill level in addressing, dealing with and talking to people who come from different and diverse backgrounds. So, in many ways, they are actually at an advantage to contribute to a multicultural and diverse society in a better way to help them achieve their goals, compared to somebody who hasn't had that experience of working in a different system … They are more adept in many ways to address that issue of multiculturalism and diversity.[109]

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106 Dr Peter Malouf, Executive Director of Operations, AHMRC, *Committee Hansard*, Canberra, 29 July 2021, page 7.

107 Ms Willow Kellock, Senior Policy Advisor, Centre for Multicultural Youth, *Committee Hansard*, Canberra, 6 August 2021, page 33.

108 Ms Yatha Jain, Youth Representative, Multicultural Youth Advocacy Network, *Committee Hansard*, Canberra, 6 August 2021, pages 32-33.

109 Associate Professor Vinay Lakra, President, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 6 August 2021, pages 8-9.

8.106 Further discussion on the development of the mental health workforce is included in Chapter 5.

Committee comment

8.107 Culturally informed practice means that rather than solely investing in traditional mental health service interventions; investments may be equally required in language and culture, and to promote healing from intergenerational trauma, racism, and sustained grief.

8.108 The Committee is aware many of the steps to promote wellness and resilience in Aboriginal and Torres Strait Islander communities are set out in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023. This framework reflects evidence presented during the inquiry that cultures must be strong to support social and emotional wellbeing and mental health.[110]

8.109 The Committee acknowledges the framework is intended to help guide and support Indigenous mental health policy and practice, but notes that absent funding no framework can improve health outcomes.

8.110 The Committee recalls evidence from AHMRC that sufficient funding must be allocated to ensure the adequate implementation of Commonwealth strategies and frameworks.[111] The Committee urges the Australian Government to ensure sufficient funding is provided for the implementation of measures to achieve the outcomes identified in the framework, and for this funding to be provided in a manner that is flexible to meet the needs of communities on the ground.

8.111 More broadly, the Committee emphasises that mental health interventions that do not provide a culturally safe experience for people may cause greater harm or result in people not seeking the support they require. Accordingly, the Committee is of the view there needs to be a common mental health language that is shared across the community, and especially vulnerable groups. This would include increasing people's understanding of the role of the various professions in the wider mental health workforce.

8.112 In addition, there should be compulsory training of the mental health workforce in the provision of culturally appropriate care. Though the

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[110] Department of the Prime Minister and Cabinet, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, October 2017, pages 20-26.

[111] AHMRC, *Submission 88*, page [2].

Committee cautions this should not be the sum extent of training for the workforce in cultural competence.

Recommendation 43

8.113 The Committee recommends that the Department of Health and the National Mental Health Commission develop, define and promote a common mental health language that can be shared across the community, and especially vulnerable groups including Aboriginal and Torres Strait Islander peoples, other culturally and linguistically diverse communities, elderly, youth, and LGBTIQ+ people.

Recommendation 44

8.114 The Committee recommends that the Australian Government fund the development of training resources for the mental health workforce in the provision of culturally appropriate and sensitive services to Aboriginal and Torres Strait Islander peoples, other culturally and linguistically diverse communities, and LGBTIQ+ and sex and/or gender diverse individuals. Such training should be mandated through Australian Government funding agreements.

8.115 This report has covered a range of issues of relevance to mental health and suicide prevention. It closes with the following simple observation—over and over again throughout the course of this inquiry, the Committee has been reminded that there is a great deal of knowledge about how to build resilience in communities, about the factors that contribute to mental health problems and suicide, and effective and evidence based holistic responses that provide a broad range of psychosocial supports. The Committee is of the view governments should get on with operationalising this knowledge and funding it appropriately.

Dr Fiona Martin MP

Chair

27 October 2021

A. Submissions

1 Australian Physiotherapy Association

2 Mr Robert Heron

3 Sex and Gender Education (SAGE) Australia

- 3.1 Supplementary to submission 3
- 3.2 Supplementary to submission 3

4 Ms Aimee Santos

5 *Name Withheld*

6 *Name Withheld*

7 *Name Withheld*

8 Australian Psychologists and Counsellors in Schools

9 National Mental Health Commission

10 Dr Louise Metcalf

11 *Name Withheld*

12 *Name Withheld*

13 *Name Withheld*

14 *Confidential*

15 *Name Withheld*

16 *Name Withheld*

17 Dr James Alexander

18 *Name Withheld*

19 Ms Lara Sullivan

20 Help Centre Psychology

21 *Name Withheld*

22 Ms Carol Swenson

23 *Name Withheld*

24 *Name Withheld*

25 Gellibrand Counselling

26 *Name Withheld*

27 Mr Lyn Thomson

28 *Name Withheld*

29 *Name Withheld*

30 *Name Withheld*

31 Dr Michael Carr-Gregg

32 *Name Withheld*

33 *Confidential*

34 Ms Catherine Lally

35 Mr Graeme King

36 Mr Gregg Chapman

37 Mr Peter Smith

38 *Name Withheld*

39 Australian Patients Association

40 Dr Vanessa Ghea, Dr Joella Storey and Ms Cherie Haig

41 Department of Health

- 41.1 Supplementary to submission 41

42 *Name Withheld*

43 Ms Sylvia Smith

44 Mr Mark Layson

45 *Name Withheld*

46 *Name Withheld*

47 *Name Withheld*

48 MIGA

49 Ms Carly Dober

50 *Name Withheld*

51 *Name Withheld*

52 Lifeline Australia

- 52.1 Supplementary to submission 52

53 Mental Health Families and Friends Tasmania

54 Miss Kirrily Mann

55 Ms Jane Jervis

56 *Name Withheld*

57 *Name Withheld*

58 First Nations Media Australia

59 Western Sydney University Counselling Service

60 Consumers Health Forum of Australia

61 *Name Withheld*

62 *Name Withheld*

63 MindSpot Clinic

64 SANE Australia

65 Australian Federal Police Association

66 headspace National Youth Mental Health Foundation

67 Jesuit Social Services

68 Mind Australia Ltd

- 68.1 Supplementary to submission 68

69 Mental Health Australia

70 Centre for Rural and Remote Mental Health

71 National Mental Health Consumer and Carer Forum

- 71.1 Supplementary to submission 71

72 Psychotherapy and Counselling Federation of Australia

- 72.1 Supplementary to submission 72

73 Brisbane North PHN and Metro North Hospital and Health Service

74 The Matilda Centre for Research in Mental Health and Substance Use

- 74.1 Supplementary to submission 74

75 Forensicare and Orygen

76 Ms Karen Donnelly

77 Mr Paul Cummins

78 Mental Health First Aid International

79 The Salvation Army

80 Australian Institute of Health and Welfare

- 80.1 Supplementary to submission 80

81 Australian Medical Association

82 Senator Malcolm Roberts

83 Police Federation of Australia

84 Independent Private Psychiatrists Group

- 84.1 Supplementary to submission 84

85 Australian Association of Psychologists Inc

- 85.1 Supplementary to submission 85

86 Prevention Coalition in Mental Health

87 StandBy

- 87.1 Supplementary to submission 87

88 Aboriginal Health and Medical Research Council of NSW

89 La Trobe University

90 Exercise and Sports Science Australia

- 90.1 Supplementary to submission 90

91 Transforming Australia's Mental Health Service Systems

- 91.1 Supplementary to submission 91

92 Suicide Prevention Australia

93 Mr Dave Martelozzo

94 *Name Withheld*

95 Amaze

- 95.1 Supplementary to submission 95

96 Ms Kristina Challands

97 Mr Ken Barnard

98 *Name Withheld*

99 *Name Withheld*

100 *Name Withheld*

101 *Name Withheld*

102 North Brisbane Psychologists

103 *Name Withheld*

104 Raymond Rudd and Henry Jackson

105 Professor Anthony Jorm

106 Lived Experience Australia

107 Niall McLaren

108 Dr Sue Eaglesham

109 Dr Peter Baldwin

110 Zero Suicide Institute of Australasia

- 110.1 Supplementary to submission 110

111 Australian Association of Social Workers

112 Smiling Mind

113 Queensland Nurses and Midwives' Union

114 *Name Withheld*

115 Youth Insearch

116 Mr Michael Nuttall

117 Queensland Mental Health Commission

- 117.1 Supplementary to submission 117

118 Ms Jacqueline McCabe-Austin

119 *Name Withheld*

120 Trans Health Research Group, University of Melbourne

121 *Name Withheld*

122 Stride Mental Health

123 VolunteeringACT

124 Ms Linda Vij

125 *Name Withheld*

126 Australian Counselling Association

127 Orygen

128 Australasian College for Emergency Medicine

129 Ms Tabitha Seymour Lloyd

130 Australian Clinical Psychology Association

131 *Name Withheld*

132 Anglicare Australia

133 Volunteering Australia

134 HelpingMinds

135 PHN Cooperative

136 National Rural Health Alliance

137 Equally Well Australia

138 Mental Health Carers Australia

139 Wellways Australia

140 Australian Psychological Society

- 140.1 Supplementary to submission 140

141 Royal Australian and New Zealand College of Psychiatrists

- 141.1 Supplementary to submission 141

142 Queensland Aboriginal and Islander Health Council

143 TrackSAFE Foundation

144 Mental Health Victoria

145 Prevention United

146 Centre for Multicultural Youth

147 *Confidential*

148 Dietitians Australia

149 Black Dog Institute

- 149.1 Supplementary to submission 149

150 Consult Australia

151 LGBTIQ+ Health Australia

152 Family and Relationship Services Australia

153 Healthy North Coast

154 Mental Health Community Coalition ACT Inc

155 Carers Australia

156 *Name Withheld*

157 Beyond Blue

158 *Name Withheld*

159 *Name Withheld*

160 *Name Withheld*

161 *Confidential*

162 Chamber of Minerals and Energy of Western Australia

163 *Confidential*

164 MATES in Construction

165 *Confidential*

166 *Confidential*

167 Professor Perminder Sachdev

168 ReachOut

- 168.1 Supplementary to submission 168

169 Mountains Youth Services Team

- 169.1 Supplementary to submission 169

170 Royal Flying Doctor Service of Australia

- 170.1 Supplementary to submission 170
- 170.2 Supplementary to submission 170

171 R U OK?

172 Department of Veterans' Affairs

173 Western Australian Association for Mental Health

174 Everymind

175 Department of Home Affairs

176 Australian Health Practitioner Regulation Agency

177 Save the Children Australia

178 WA Primary Health Alliance

179 Australian Council of State School Organisations

180 Gayaa Dhuwi (Proud Spirit) Australia

- 180.1 Supplementary to submission 180
- 180.2 Supplementary to submission 180

181 Financial Services Council

182 batyr

183 yourtown

184 Wesley Mission

185 AIA Australia

186 Northern Territory Department of Health

187 Eating Disorder Alliance of Australia

188 Christine Newton

189 Australian Rural Health Education Network

190 Royal Australian College of General Practitioners

191 Australian Commission on Safety and Quality in Health Care

192 Ending Loneliness Together

193 Australia Council for the Arts

194 *Confidential*

195 *Name Withheld*

196 Susan Kopittke

197 Citizens Commission on Human Rights Victoria

198 Relationships Australia

199 DiGii Social

200 Z-Card Australia

201 *Name Withheld*

202 Mental Health Coordinating Council

203 Mr Mark Doneddu

204 Women's Legal Service NSW

205 Citizens Commission on Human Rights

206 Kimberley Aboriginal Law and Cultural Centre

- 206.1 Supplementary to submission 206
- 206.2 Supplementary to submission 206

207 Forensicare and the Centre for Forensic Behavioural Science

208 *Confidential*

209 Ms Heidi Swan

210 *Confidential*

211 Occupational Therapy Australia

- 211.1 Supplementary to submission 211

212 Dr Robbie Lloyd

213 The Partners of Veterans Association of Australia Inc - Western Australian Branch

214 Submissions related to Productivity Commission recommendations

215 Brenna Waller

216 National Aboriginal Community Controlled Health Organisation

- 216.1 Supplementary to submission 216

217 Interrelate

218 Brisbane South PHN and Metro South Addictions and Mental Health Services

219 Dr Adam Heaton

220 Dr Grenville Rose

221 Gidget Foundation Australia

- 221.1 Supplementary to submission 221

222 *Confidential*

223 LivingWorks Australia

224 Women's Mental Health Alliance

225 National Mental Health Consumer Alliance

226 Mama You Got This

227 Uniting

228 Professor Brin Grenyer

229 Speech Pathology Australia

230 Department of Education, Skills and Employment

231 Dr Karen Martin and Dr Emily Berger, University of WA and Monash University

232 Mental Illness Fellowship of Australia

B. Exhibits

1 Confidential

2 *Youth Insearch - Videos*

3 *National Suicide Prevention Final Advice - Slide Presentation*, Christine Morgan, National Suicide Prevention Adviser to the Prime Minister

4 *Plenary Presentation - Royal Australian and New Zealand College of Psychiatrists*, Professor David Copolov AO

5 *Advocacy Brief - Culturally and Linguistically Diverse (CALD) Mental Health, April 2021*, National Mental Health Consumer and Carer Forum

6 *11-year follow-up of mortality in patients with schizophrenia: a population-based cohort study (FIN11 study), 13 July 2009*, Jari Tiihonen et al

7 *COVID-19 and Australia's Mental Health - Report of June 2021 Meeting of Australia's Mental Health Think Tank*, Australia's Mental Health Think Tank

8 *Reducing youth suicide: systems modelling and simulation to guide targeted investments across the determinants, 2021*, Jo-An Occhipinti et al

9 *Efficacy of the Zero Suicide framework in reducing recurrent suicide attempts: cross-sectional and time-to-recurrent-event analyses, 2021*, Nicolas J C Stapelberg et al

10 *Implementing a systems approach to suicide prevention in a mental health service using the Zero Suicide Framework, 2021*, Kathryn Turner et al

11 *Inconvenient truths in suicide prevention: Why a Restorative Just Culture should be implemented alongside a Zero Suicide Framework, 2020*, Kathryn Turner et al

12 *Suicide risk classifications do not identify those at risk: where to from here?, 2021*, Kathryn Turner et al

13 *We've Got Your Back (WGYB) Policy Escalation Safety Working Alone and Communication Policy, 18 November 2019*, Royal Flying Doctor Service

14 *How are you going?*, Rural Adversity Mental Health Program and Centre for Rural and Remote Mental Health

15 *RFDS Drought Support - We've Got Your Back Q3 Report (1 January - 31 March 2021), 3 May 2021*, Royal Flying Doctor Service

16 *Royal Flying Doctor Service Drought Support and We've Got Your Back - Report August 2019 to 30 June 2020, October 2020*, Royal Flying Doctor Service

17 *Supporting GROW (Guiding Rural Outback Wellbeing) Information for Foundations*, Royal Flying Doctor Service

18 *We've Got Your Back (WGYB) RFDS SE Service Framework, 18 November 2019*, Royal Flying Doctor Service

19 *Application for an area of practice endorsement on completion of an approved registrar program - Psychology (AECR-76), 28 September 2020*, Psychology Board AHPRA

20 *Australia's Better Access initiative: an evaluation, 2011*, Jane Pirkis et al

21 *EuroPsy - the European Certificate in Psychology, July 2019*, European Federation of Psychologists' Associations

22 *Australia's Better Access initiative: do the evaluation data support the critics?, 2011*, Anthony F Jorm

23 *Not letting the ideal be the enemy of the good: the case of the Better Access evaluation, 2011*, Jane Pirkis et al

24 *Private Practice Survey 2020*, Australian Association of Psychologists Inc

25 *Final assessment of competence - 5+1 internship - Psychology (PACF-76), 28 October 2020*, Psychology Board AHPRA

26 *Final assessment of competence - 4+2 internship program - Psychology (PPAC-76), 1 June 2017*, Psychology Board AHPRA

27 *Registration Standard: General Registration, 2 May 2016*, Psychology Board AHPRA

28 *International Declaration on Core Competences in Professional Psychology*, International Association of Applied Psychology

29 *Measuring the scale of underinvestment in Australia's mental health services system: a dynamic modelling analysis - Preliminary Report, 17 May 2021*, Brain and Mind Centre, University of Sydney

30 *Closing the gender gap: Supporting the mental health of Australian women during the COVID-19 era, 20 April 2021*, Brain and Mind Centre, University of Sydney

31 *Right care, first time, where you live*, Brain and Mind Centre, University of Sydney and BHP Foundation

32 *Program for Aboriginal kids shows promising impacts on language and development skills, 6 August 2021*, Murdoch Children's Research Institute

33 *Baya Gawiy Position Paper: DSS Data Collection, August 2021*, Marninwarntikura Women's Resource Centre and Baya Gawiy Buga Yani Jandu Yani U Centre

34 *Baya Gawiy Staff Handbook*, Marninwarntikura Women's Resource Centre and Baya Gawiy Buga Yani Jandu Yani U Centre

35 *Baya Gawiy Trauma Informed Practices*, Baya Gawiy Buga Yani Jandu Yani U Centre

36 *Arrwekele Akaltye-Irretyeke Apmere: Congress Child Health and Development Centre Evaluation Report 2017 - 2020, 3 February 2021*, Centre for Community Child Health, Murdoch Children's Research Institute

37 *Arrwekele Akaltye-Irretyeke Apmere: Congress Child Health and Development Centre Monitoring and Evaluation Framework, January 2021*, Central Australian Aboriginal Congress

38 *Arrwekele Akaltye-Irretyeke Apmere: Congress Child Health and Development Centre Summary*, Central Australian Aboriginal Congress

39 *Evaluation of the Arrwekele Akaltye-Irretyeke Apmere Early Childhood Learning Centre - Final Report, March 2019*, Baker Heart and Diabetes Institute and the Centre for Community Child Health for the Central Australian Aboriginal Congress

40 *Increasing mortality gap for patients diagnosed with bipolar disorder - A nationwide study with 20 years of follow-up, 2018*, Pernille Staudt Hansen et al

41 *Can school counselors deliver cognitive-behavioral treatment for social anxiety effectively? A randomized controlled trial, 2016*, Carrie Masia Warner et al

42 *Counselling Efficacy between Professions - A comparison between Counsellors, Psychologists and Social Workers delivering Employment Assistance Programs, 2020*, Converge International

43 *Using peer workers with lived experience to support the treatment of borderline personality disorder: a qualitative study of consumer, carer and clinician perspectives, 2020*, Karlen R Barr, Michelle L Townsend, Brin F S Grenyer

44 *Australian National Workforce Institute for Mental Health and AOD Workforce, Emergency Workers, Peer Workers and all Stakeholders, August 2020*, Professor Maree Teesson AC, Professor Alan Rosen AO

45 *The future of community psychiatry and community mental health services, July 2020*, Alan Rosen, Neeraj S Gill, Luis Salvador-Carulla

46 *Beyond the Prime Minister's Bushfire Response Mental Health Package: Some Concerns and Opportunities, February 2020*, Professor Alan Rosen AO

47 *A Call to Action for resetting an optimal balance between face-to-face, assertive outreach and digitally enhanced community focused mental health services*, Professor Alan Rosen AO

C. Hearings and witnesses

Thursday, 18 March 2021

CANBERRA

Department of Health

- Ms Tania Rishniw, Deputy Secretary
- Mr Mark Roddam, First Assistant Secretary, Mental Health Division

National Mental Health Commission

- Ms Christine Morgan, Chief Executive Officer
- Ms Lyndall Soper, Deputy Chief Executive Officer

Productivity Commission

- Ms Julie Abramson, Commissioner
- Dr Stephen King, Commissioner
- Ms Rosalyn Bell, Assistant Commissioner

Thursday, 13 May 2021

CANBERRA

Ms Christine Morgan, National Suicide Prevention Adviser to the Prime Minister

Thursday, 3 June 2021

CANBERRA

Mental Health Australia

- Dr Leanne Beagley, Chief Executive Officer
- Ms Ingrid Hatfield, Senior Policy and Projects Officer

Suicide Prevention Australia

- Ms Nieves Murray, Chief Executive Officer
- Mr Christopher Stone, Acting Director, Policy and Government Relation
- Mr Stan Piperoglou, Board Member

Wednesday, 16 June 2021

CANBERRA

Wesley Mission

- Mr Jim Wackett, General Manager
- Mr James Bell, Group Manager

Thursday, 17 June 2021

CANBERRA

Australian Rural Health Education Network

- Ms Joanne Hutchinson, National Director
- Professor Lisa Bourke, Chair
- Dr Sharon Varela, Chair, Mental Health Academic Staff Network

Royal Flying Doctor Service of Australia

- Mr Frank Quinlan, Federation Executive Director
- Ms Lauren Gale, Director, Policy and Programs
- Ms Vanessa Latham, Manager, Mental Health Services

VolunteeringACT

- Ms Sarah Wilson, Policy Manager

Volunteering Australia

- Mr Mark Pearce, Chief Executive Officer

Thursday, 24 June 2021

CANBERRA

Gayaa Dhuwi (Proud Spirit) Australia

- Mr Thomas Brideson, Chief Executive Officer
- Ms Tara Ali, Senior Policy Officer

Royal Australian and New Zealand College of Psychiatrists

- Associate Professor Vinay Lakra, President

Royal Australian College of General Practitioners

- Dr Caroline Johnson, Member, Senior Representative

Monday, 19 July 2021

CANBERRA

Forensicare and Centre for Forensic Behavioural Science

- Distinguished Professor James Ogloff AM, Director, Centre for Forensic Behavioural Science, Swinburne University of Technology and Executive Director, Psychological Services and Research, Forensicare
- Dr Shaymaa Elkadi, Executive Director, Strategy Policy and Performance, Forensicare

HelpingMinds

- Mrs Deborah Childs, Chief Executive Officer

Kimberley Aboriginal Law and Cultural Centre

- Mr Wesley Morris, Coordinator
- Mr Stephen Kinnane, Research Coordinator

MindSpot Clinic

- Professor Nickolai Titov, Executive Director

PHN Cooperative

- Adjunct Associate Professor Learne Durrington, Chief Executive Officer, WA Primary Health Alliance and Chair, National PHN Cooperative
- Ms Julie Sturgess, Chief Executive Officer, Healthy North Coast (North Coast Primary Health Network), PHN Cooperative
- Mr Paul Martin, Mental Health Working Group, PHN Cooperative

The Partners of Veterans Association of Australia Inc – Western Australian Branch

- Mrs Beverley Benporath, President
- Mrs Evette House, Grants Officer

Western Australian Association for Mental Health

- Ms Taryn Harvey, Chief Executive Officer
- Dr Elizabeth Connor, Senior Policy Officer

Wednesday, 21 July 2021

CANBERRA

Australian Association of Psychologists Inc

- Ms Tegan Carrison, Executive Director
- Mrs Amanda Curran, Chief Services Officer
- Ms Karen Donnelly, Vice-President, Psychologist

Australian Counselling Association

- Mr Philip Armstrong, Chief Executive Officer

Australian Health Practitioner Regulation Agency

- Mr Chris Robertson, Executive Director, Strategy and Policy

Australian Psychologists and Counsellors in Schools

- Professor Marilyn Campbell, Media Spokesperson

Brisbane North PHN and Metro North Hospital and Health Service

- Ms Libby Dunstan, Chief Executive Officer, Brisbane North PHN
- Professor Brett Emmerson AM, Executive Director, Mental Health, Metro North Hospital and Health Service

Brisbane South PHN and Metro South Hospital and Health Service

- Mrs Jennifer Newbould, Director, Mental Health, Suicide Prevention, Alcohol and Other Drugs, Brisbane South PHN
- Mr Kieran Kinsella, Executive Director, Addiction and Mental Health Services, Metro South Hospital and Health Service

Exercise and Sports Science Australia

- Mrs Anita Hobson-Powell, Chief Executive Officer
- Dr Caroline Robertson, Senior Strategic Adviser
- Ms Joanne Webb, Manager, Policy and Advocacy

Nursing and Midwifery Board of Australia

- Adjunct Professor Veronica Casey AM, Chair

Psychology Board of Australia

- Ms Rachel Phillips, Chair

Queensland Aboriginal and Islander Health Council

- Mr Cleveland Fagan, Chief Executive Officer

Queensland Nurses and Midwives' Union

- Ms Kathleen Veach, Assistant Secretary
- Mr Allan Shepherd, Professional Officer, Team Leader

StandBy Support After Suicide

- Ms Karen Phillips, General Manager
- Mr Stephen Scott, Partnerships Manager

yourtown

- Dr Marion Byrne, Manager, Advocacy, Research and Innovation
- Ms Kathryn Mandla, Head of Advocacy and Research

Monday, 26 July 2021

CANBERRA

Amaze

- Mr Chris Templin, Senior Policy Analyst

Australasian College for Emergency Medicine

- Dr Simon Judkins, Immediate Past President

Australian Physiotherapy Association

- Mr Scott Willis, National President
- Mr Simon Tatz, General Manager, Policy and Government Relations

Beyond Blue

- Ms Carolyn Nikoloski, Chief Strategy Officer

Different Journeys

- Ms Mel Spencer, Executive Officer

Dr Emma Radford, Psychiatrist, Melbourne Health

headspace National Youth Mental Health Foundation

- Mr Jason Trethowan, Chief Executive Officer
- Ms Amelia Walters, headspace Board Youth Advisor

La Trobe University

- Associate Professor Alessandra Radovini
- Professor Amanda Richdale, Professorial Research Fellow, Olga Tennison Autism Research Centre
- Dr Darren Hedley, Senior Research Fellow, Olga Tennison Autism Research Centre

LGBTIQ+ Health Australia

- Ms Nicky Bath, Chief Executive Officer
- Ms Zed Tintor, Deputy Chief Executive Officer

MATES in Construction

- Mr Christopher Lockwood, Chief Executive Officer

Mind Australia Ltd

- Ms Gill Callister, Chief Executive Officer
- Mrs Nicola Ballenden, Executive Director, Research, Advocacy and Policy Development

Occupational Therapy Australia

- Associate Professor Genevieve Pepin, Member, Mental Health National Reference Group

SAGE Australia

- Dr Tracie O'Keefe, Co-Founder

SANE Australia

- Ms Rachel Green, Chief Executive Officer
- Ms Grace McCoy, Head of Partnerships and Lived Experience

Smiling Mind

- Dr Addie Wootten, Chief Executive Officer

Trans Health Research Group, University of Melbourne

- Dr Ada Cheung, Head and Senior Research Fellow
- Sav Zwickl, Researcher

Yellow Ladybugs

- Ms Katie Koullas, Founder and Chief Executive Officer

Wednesday, 28 July 2021

CANBERRA

batyr

- Bella Cini, National Advisory Group Member and Board Member
- Tom Riley, Research and Policy Manager

Black Dog Institute

- Mr Samuel Harvey, Acting Director

Ending Loneliness Together

- Dr Michelle Lim, Chairperson and Scientific Chair

Interrelate

- Mr Graeme O'Connor, Acting Chief Executive Officer
- Ms Sharon Grocott, Head of Research and Innovation

Jesuit Social Services

- Dr Louise Flynn, General Manager

Mountains Youth Services Team

- Ms Kim Scanlon, General Manager

ReachOut

- Mr Ashley de Silva, Chief Executive Officer
- Mr Ben Bartlett, Director of Government Relations and Communications

R U OK?

- Ms Katherine Newton, Chief Executive Officer

The Salvation Army Australia

- Mr Stuart Foster, General Manager, Community Services
- Ms Jennifer Kirkaldy, General Manager, Policy and Advocacy

Western Sydney University

- Mrs Arianne Reis, Senior Lecturer, School of Health Science
- Ms Emma Taylor, Mental Health and Wellbeing Clinical Manager
- Mrs Paula Diab, Senior Counsellor
- Ms Erin Helleur, Counsellor

Youth Insearch

- Mr Stephen Lewin, Chief Executive Officer
- Mrs Leanne Hall, Clinical Lead
- Ms Nelani Botha, Youth Leader

Thursday, 29 July 2021

CANBERRA

Aboriginal Health and Medical Research Council of NSW

- Dr Peter Malouf, Executive Director of Operations

Australian Clinical Psychology Association

- Professor Caroline Hunt, President

Dietitians Australia

- Ms Tara Diversi, President
- Dr Tetyana Rocks, Expert Representative
- Professor Tracy Burrows, Expert Representative

Lifeline Australia

- Mr Robert Sams, Executive Director, Lifeline Direct Services

Matilda Centre for Research in Mental Health and Substance Use, University of Sydney

- Professor Maree Teesson, Director
- Professor Frances Kay-Lambkin, National Health and Medical Research Council Leadership Fellow, University of Newcastle

Professor Perminder Sachdev

Stride Mental Health

- Mr Drikus van der Merwe, Acting Chief Executive Officer
- Mr Ben McAlpine, General Manager, Strategy, Innovation and Growth

Transforming Australia's Mental Health Service Systems

- Professor Alan Rosen AO, Chair
- Ms Vivienne Miller, Secretary

Wesley Mission

- Mr Andrew Moore, General Manager
- Mr James Bell, Group Manager

Zero Suicide Institute of Australasia

- Ms Susan Murray, Managing Director

Thursday, 5 August 2021

CANBERRA

Carers ACT

- Ms Lisa Kelly, Chief Executive Officer

Carers Australia

- Ms Liz Callaghan, Chief Executive Officer

Consumers Health Forum of Australia

- Ms Leanne Wells, Chief Executive Officer
- Tammy Wolffs, Senior Policy Officer

Mental Health Carers Australia

- Ms Kerry Hawkins, Vice Chair
- Ms Katrina Armstrong, Executive Officer

Mental Health Carers NSW

- Mr Jonathan Harms, Chief Executive Officer

National Mental Health Consumer Alliance

- Ms Irene Gallagher, Foundation Member

National Mental Health Consumer and Carer Forum

- Mr Keir Saltmarsh, Consumer Co-Chair
- Mrs Hayley Solich, Carer Co-Chair
- Ms Eileen McDonald, Carer Representative and Executive Member
- Ms Nevena Simic, Member

Friday, 6 August 2021

CANBERRA

Australian Association of Social Workers

- Cindy Smith, Chief Executive Officer

Australian Council of State School Organisations

- Mrs Dianne Giblin, Chief Executive Officer
- Mrs Sharron Healy, President

Australian Institute of Health and Welfare

- Mr Matthew James, Deputy Chief Executive Officer
- Mr Chris Killick-Moran, Unit Head
- Ms Amy Young, Head, Mental Health Evidence Base Improvement Unit

Australian Medical Association

- Dr Omar Khorshid, President
- Dr Danielle McMullen, NSW President

Australian Psychological Society

- Ms Tamara Cavenett, President

Centre for Multicultural Youth

- Ms Tempest Alphonse, Project Officer
- Ms Willow Kellock, Senior Policy Advisor
- Ms Yatha Jain, Youth Representative, Multicultural Youth Advocacy Network
- Ms Martha Metuisela, Youth Worker - Le Mana (Empower) Pasifika Youth Project
- Mr Tyson Tuala, Youth Worker - Le Mana (Empower) Pasifika Youth Project

Orygen

- Professor Patrick McGorry AO, Executive Director
- Mr David Baker, Manager, Policy

Royal Australian and New Zealand College of Psychiatrists

- Associate Professor Vinay Lakra, President

Thursday, 12 August 2021

CANBERRA

Australian Commission on Safety and Quality in Health Care

- Dr Suellen Allen, Director, Mental Health, Communicating for Safety and Cognitive Impairment
- Mr Chris Leahy, Director eHealth and Medication Safety
- Mr David McGrath, Executive Lead, Mental Health Standards

National Aboriginal Community Controlled Health Organisation

- Ms Patricia Turner, Chief Executive Officer
- Ms Anna-Louise Kimpton, Director of Policy
- Mr Billy Moore, Senior Policy Officer

Queensland Mental Health Commission

- Mr Ivan Frkovic, Queensland Mental Health Commissioner

Friday, 13 August 2021

CANBERRA

Gidget Foundation Australia

- Mrs Arabella Gibson, Chief Executive Officer

Gold Coast Mental Health and Specialist Services

- Dr Kathryn Turner, Clinical Director

LivingWorks Australia

- Mr Shayne Connell, Chief Executive Officer
- Mr Marc Bryant, Director, Suicide Prevention

Mental Health First Aid International

- Ms Shannon Anderson, Chief Executive Officer

Prevention United

- Dr Stephen Carbone, Chief Executive Officer

Psychotherapy and Counselling Federation of Australia

- Ms Johanna de Wever, Chief Executive Officer
- Dr Dianne Stow, President

Thursday, 19 August 2021

CANBERRA

Brain and Mind Centre, University of Sydney

- Professor Ian Hickie, Co-Director, Health and Policy

Dr Catriona Davis-McCabe

Dr Kristy Goodwin

Pharmaceutical Society of Australia

- Ms Hannah Loller, Senior Project Pharmacist

Pharmacy Guild of Australia

- Ms Claire Bekema, Acting Policy and Regulation Director

- Mr David Heffernan, National Vice-President and New South Wales Branch President

Speech Pathology Australia

- Ms Chantele Edlington, Former Senior Adviser, Justice and Mental Health

University of Wollongong

- Professor Brin Grenyer, Professor of Psychology and Director, Project Air Strategy for Personality Disorders

Friday, 27 August 2021

CANBERRA

Jean Hailes

- Mrs Janet Michelmore AO, Chief Executive Officer

Kimberley Aboriginal Law and Cultural Centre

- Ms Erica Spry, Executive Board Member

PANDA - Perinatal Anxiety and Depression Australia

- Ms Julie Borninkhof, Chief Executive Officer

Tandem Carers

- Ms Amaya Alvarez, Lived Experience Advisor

Women's Mental Health Alliance and Women's Health Victoria

- Professor Jayashri Kulkarni, Executive Member, Women's Mental Health Alliance and Director, Cabrini Health
- Ms Mischa Barr, Chair, Women's Mental Health Alliance and Policy and Health Promotion Manager, Women's Health Victoria
- Dr Sabin Fernbacher, Member, Women's Mental Health Alliance

Women's Mental Health Service

- Professor Marie-Paule Austin, Head

D. COVID-19 and bushfires mental health related funding

The tables below provide an indicative list of Australian Government funding announcements aimed at enhancing mental health services in response to the COVID-19 pandemic and the 2019-20 bushfires.

Mental health funding announced in response to COVID-19

Date	Funding details	Amount
15 May 2020	▪ $7.3 million for data research and modelling on the mental health impacts of COVID19 and suicide prevention research. ▪ $29.5 million to reach vulnerable groups such as older Australians, culturally and linguistically diverse (CALD) communities, carers of people with mental illness, and Indigenous communities. ▪ $0.9 million for connected mental health services. ▪ $10.4 million for a national mental health communications campaign.[1]	$48.1 million

1 The Hon Greg Hunt MP, Minister for Health and Aged Care, 'COVID-19: $48.1 Million for National Mental Health and Wellbeing Pandemic Response Plan', Media Release, 15 May 2020.

19 May 2021	▪ $24 million to support Kids Helpline operations over the next four years, and a further $2.8 million to meet the immediate demand caused by the pandemic.[2]	$26.8 million
24 June 2021	▪ $1.35 million grant to the Australian National University for their project, Co-creating safe space, which will examine the effectiveness of 'safe space' models in the Australian Capital Territory (ACT) and New South Wales (NSW) as alternatives to presenting to a hospital emergency department.[3]	$1.35 million
24 June 2021	▪ $1.28 million grant to the University of Western Australia (WA) for their project, Expand WA, which will seek to improve aftercare services among young people aged 10 to 17 who present to hospital with self-harm or suicidal crisis.[4]	$1.28 million
13 July 2021	▪ $3.5 million to headspace for additional youth support, with a particular focus on support for year 11 and 12 students, with funding to be matched by the NSW Government. ▪ $1.5 million to Lifeline to boost crisis counselling and increase community engagement. ▪ $1.5 million to Sonder to enhance mental health support for those in mandatory isolation, with funding to be matched by	$12.25 million

2 The Hon Greg Hunt MP, Minister for Health and Aged Care and the Hon David Coleman MP, Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention, '$26.8 million investment to support young Australians', Joint Media Release, 19 May 2021.

3 The Hon Greg Hunt MP, Minister for Health and Aged Care and the Hon David Coleman MP, Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention, 'Suicide Prevention Research Grants to Improve Crisis Response', Joint Media Release, 24 June 2021.

4 The Hon Greg Hunt MP, Minister for Health and Aged Care and the Hon David Coleman MP, Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention, 'Suicide Prevention Research Grants to Improve Crisis Response', Joint Media Release, 24 June 2021.

	the NSW Government. ▪ $4 million to Primary Health Networks (PHNs): $2 million to boost commissioned mental health services, including for Aboriginal and Torres Strait Islander people and $2 million to provide targeted support and to work with CALD communities and leaders in impacted areas. ▪ $500,000 for a communications campaign to increase awareness of available mental health services and support, aimed at CALD communities. ▪ $500,000 to Beyond Blue for services and to increase community engagement with NSW residents. ▪ $300,000 to Kids Helpline to extend online wellbeing sessions into secondary schools. ▪ $300,000 to the Butterfly Foundation to provide additional support for young people with, or at risk of, an eating disorder and their carers. ▪ $150,000 to the Gidget Foundation to boost services for parents suffering from perinatal depression and anxiety.[5]	
18 July 2021	▪ To support young Australians in Victoria, ensuring they can access mental health support if and when they need it during lockdown.[6]	$3 million
8 August 2021	▪ To establish 10 Head to Health pop up mental health support sites for areas currently facing extended COVID-19 restrictions in and around Greater Sydney and to extend the operation of at	$17.7 million

5 The Hon Greg Hunt MP, Minister for Health and Aged Care, 'COVID-19 Mental Health Boost for New South Wales', Media Release, 13 July 2021.

6 The Hon Greg Hunt MP, Minister for Health and Aged Care, 'More support for youth mental health in Victoria', Media Release, 18 July 2021.

	least 12 clinics in Victoria until 30 June 2022.[7]	
9 August 2021	▪ $3 million towards a surge workforce of clinicians in headspace services across Victoria.[8]	$3 million
16 August 2021	▪ $27.3 million to implement culturally-sensitive, co-designed aftercare services, for individuals following a suicide attempt or suicidal crisis. These will be delivered across Australia at a regional level, and Aboriginal and Torres Strait Islander organisations will be preferred service providers. ▪ $23.8 million to establish regional suicide prevention networks across each state and territory. ▪ $16.6 million will be provided to establish and evaluate a new culturally appropriate 24/7 crisis line, delivered by Aboriginal and Torres Strait Islander people. This will be a partnership between to Gayaa Dhuwi (Proud Spirit) Australia and Lifeline.[9]	$79 million
16 September 2021	▪ $15 million over three years to the National Wellbeing Alliance Pty Ltd to deliver mental health first aid training for Aboriginal and Torres Strait Islander communities across Australia.[10]	$15 million

7 The Hon Greg Hunt MP, Minister for Health and Aged Care, 'Mental health clinics to support Australians in lockdown in NSW and VIC', Media Release, 8 August 2021.

8 The Hon David Coleman MP, Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention and the Hon Luke Howarth MP, Assistant Minister for Youth and Employment Services, 'Supporting young Australians through COVID-19 lockdowns', Joint Media Release, 9 August 2021.

9 The Hon Ken Wyatt AM MP, Minister for Indigenous Australians and the Hon David Coleman MP, Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention, 'Young Indigenous Australians "Take a Step" for Mental Health', Joint Media Release, 16 August 2021.

10 The Hon Ken Wyatt AM MP, Minister for Indigenous Australians, '$15 million grant to support Indigenous Mental Health First Aid Training to 2024', Media Release, 16 September 2021.

21 September 2021	▪ $1.6 million to establish a Head to Health Pop-Up mental health clinic in the ACT and fast track the rollout of a phone Intake, Assessment and Referral support service. ▪ $400,000 to enhance eating disorder services in the ACT, including funding to boost clinical services at headspace and the Head to Health hub to provide additional support for young people with, or at risk of, an eating disorder and targeted e-therapy support. ▪ $320,000 to headspace for additional youth support, to assist headspace services with the surge in demand experienced during the lockdown. ▪ $150,000 to CatholicCare to support the Stepping Stones program for children aged 12 and under who have suffered trauma. ▪ $100,000 to Meridian ACT to boost support services for LGBTIQ+ people.[11]	$2.5 million

Source: See footnotes 1 - 11

11 The Hon Greg Hunt MP, Minister for Health and Aged Care, 'COVID-19 mental health boost for the ACT', Media Release, 21 September 2021.

Mental health bushfire support measures

Measure	Description	Allocation
Community Connectedness and Recovery grants	Primary Health Networks are administering Community Connectedness and recovery grants of up to $10,000 to fund grass-roots level activities to help mental health and healing activities after the bushfires.	$2.7 million
Immediate counselling	Free distress and trauma counselling sessions are available for individuals and families and emergency services personnel affected by bushfires.	$10.5 million
Bushfire Trauma Response Coordinator	Bushfire Trauma Response Coordinators are a single point of contact for individuals and communities to ensure the right mental health supports are offered in the right place at the right time.	$3.2 million
Expansion of mental health services	Primary Health Networks in bushfire affected regions were funded to commission additional mental health services to ensure services were available to meet increased demand.	$4.2 million
Community Wellbeing and Participation	This funding provides additional funding to Primary Health Networks, to boost localised support for bushfire affected individuals to ensure their emotional and mental wellbeing. **This was additional funding announced on 11 May 2020*	$13.5 million*
Boost to National School Chaplaincy Program	This measure boosted funding provided by the Australian Government to state and territory governments under the National School Chaplaincy Program (NSCP) in bushfire affected schools.	$2 million
Be You Bushfire Response program	Additional funding to Beyond Blue to provide mental health support to children	$8 million

	and young people through the Be You program in schools and early childhood services in bushfire-affected communities.	
National Disaster Mental Health and Wellbeing Framework	The National Mental Health Commission is leading the development of the national framework to guide a coordinated approach to support mental health and wellbeing in the context of natural disasters.	$0.5 million
Training in trauma informed care and psychological first aid	Training in trauma informed care and psychological first aid for frontline emergency services staff, GPs [general practitioners], pharmacists and psychologists. Training is evidence based and delivered by specialist organisations (Phoenix Australia, Australian Psychological Society and Pharmaceutical Society of Australia) with expertise in trauma informed care.	$2.0 million
Bushfire Recovery Medicare Benefits Schedule (MBS)	Bushfire affected individuals, families and emergency personnel will be eligible to receive Medicare Rebates for up to 10 psychological therapy sessions through eligible GPs, psychologists, social workers or occupational therapists. Ongoing psychological support, including telehealth.	$29.6 million
Supports for emergency services workers and their families	To ensure workers and their families are receiving the necessary support to prevent and treat the effects of trauma, both now and after the immediate fire threat has passed, the Government is funding specialist organisations, the Black Dog Institute and Fortem Australia, to provide PTSD [post-traumatic stress disorder] support services to emergency services workers (and their immediate families).	$15.9 million
Additional funding for headspace*	Provided additional funding for headspace centres in fire impacted areas.	$7.4 million *(Department of Health*

		funding, not NBRF [National Bushfire Recovery Fund])
Lifeline 13HELP and Kids Helpline	Funding provided to support Lifeline Australia to establish a dedicated helpline (13HELP) for individuals impacted by the bushfires, and boost the capacity of the Kids Helpline service.	$2 million *(Department of Health funding, not NBRF)*

Source: Department of Home Affairs, Submission 175, Appendix A, page [7].