

Contributing lives,
thriving communities

Report of the National Review of Mental Health Programmes and Services

Volume 3

What people told us – analysis
of submissions to the Review

30 November 2014



Australian Government
National Mental Health Commission

About this Review

This document is Volume 3 of a four-volume report of the National Review of Mental Health Programmes and Services. All volumes can be downloaded from www.mentalhealthcommission.gov.au. A complete list of the Commission's publications is available from our website.

A number of electronic fact sheets and a summary document are available on our website.

Many of the quotes in this publication come from people and organisations in Australia who participated in the Commission's Call for Submission process.

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Throughout this report when we have named people and organisations in quotes or case studies we have gained their prior permission. When people did not respond to our request for permission the quote was de-identified.

The volume of information provided was substantial, and the Commission is optimistic that this unique resource can be drawn upon in the future.

All submissions received were considered by the Commission in preparing its final report to Government, and informed the development of the Review's recommendations and analysis.

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Executive summary

This report provides an overview of key findings from the National Mental Health Commission's public call for written submissions to the 2014 Review of Mental Health Programmes and Services. This public call, held over March and April 2014, was the main mechanism for people using and working in these programmes and services to contribute their views, and more than 1,800 written and online submissions were made by organisations and individuals.

The formal call for submissions was conducted as an online survey, with questions seeking views as to what was working, what was not and what should change in regard to the areas specific to the terms of reference. The collective effort put into these submissions was substantial, and the depth and breadth of information provided was clear. Through their submissions, the voices of people with lived experience of mental illness, their families and support people, as well as the views of professionals, advocates and peak bodies were loud and clear.

It is evident that there is considerable nationwide concern about the future direction of mental health reform in Australia. Respondents identified problems, opportunities and priorities. These 'grassroots' perspectives were an invaluable resource for the Commission in conducting its analysis and developing its recommendations to Government.

Interestingly, despite the diversity of their origins, these voices reveal considerable consensus about which elements of our mental health system are working, and which elements need fixing. None of these points of consensus is particularly surprising, and they have been repeated globally for decades. Perhaps the most prominent theme to emerge from this exercise was that the way the mental health 'system' is designed and funded across Australia means that meaningful help often is not available until a person has deteriorated to crisis point. This is either because mental health supports are not accessible to them, do not exist in their area, or are inappropriate to their needs. Along the way, they may have lost their job, their family or their home. Countless submissions pointed out that this makes neither economic nor humanitarian sense.

Another prominent area of consensus was the idea that services and programmes should be designed in consultation with the communities they aim to serve, and that they should be based on formal analyses of need. There were many examples provided in the submissions which show this is not happening, resulting in high levels of unmet mental health need. A picture emerges of a hit-and-miss arrangement of services and programmes across the country, seemingly based on no discernible strategy, creating duplication in some areas and leaving considerable unmet need in others.

This unmet need was highlighted particularly strongly in relation to people living in regional, rural and remote areas of Australia. It was also reported that programmes and services currently do not meet the needs of communities with particular mental health challenges; if services are available, they often feel inappropriate and irrelevant to the people they are designed for. Examples of inappropriate provision were those for Aboriginal and Torres Strait Islander communities and people who have migrated to Australia. People with interrelated and complex difficulties which include a mental health problem (including those with substance misuse, history of trauma and abuse, or intellectual disability) are also poorly served by a lack of collaboration across agency or disciplinary boundaries—each of their intertwined problems is viewed and treated in isolation.

Many and detailed suggestions were made about how the mental health system might be improved to support positive whole-of-life outcomes for people experiencing mental illness. Innovative and flexible use of existing funding, technology and human resources was reported to be a key mechanism to better meet the needs of diverse populations. Nationally consistent but locally relevant mechanisms to systematically measure outcomes—for accountability, quality improvement, and evaluation purposes—was widely considered to be the missing foundation stone for improving the experiences and outcomes of people living with mental illness in Australia.

This report presents the findings of a thematic analysis of submissions against each of the Review's terms of reference. For ease of navigation, each section is prefaced by a 'Key Findings' summary (boxed) for that particular term of reference. The language within this report refers to 'people with lived experience of mental illness' or 'people with lived experience' when presenting the survey findings. Likewise, the term 'support people' includes families and carers, but 'families and support people' is also used.

1. Overview of submissions received

A very enthusiastic response was received from all over Australia—more than 1,800 individuals and organisations submitted their views on the mental health system. The response represents good coverage of all geographical areas of the country, including rural and remote areas, and a good balance of people with lived experience/their support people (including family members) and professional responses (621 and 861 respectively).

A diverse range of interests and communities were represented. While there was over-representation of some groups and an under-representation of others, our focus during analysis was on drawing out common themes across all submissions, rather than giving more weight to points that were made more frequently.

1.1 Collection of the submissions

In March 2014 the Commission hosted an online call for submissions survey on its website. To promote the survey, the Commission wrote to more than 500 stakeholder organisations inviting them to participate in the survey and encouraging them to inform their networks. The Commission and Commissioners also actively promoted the survey and submission process.

The **online survey** was intended to elicit specific examples of:

- what is working in the mental health system
- what is not working in the mental health system
- recommendations for change.

The call for submissions was designed with three different online surveys appropriate to the respondent's role.

- **Survey 1:** for people with lived experience of mental illness, support people, family members and members of the public
- **Survey 2:** for professionals and other workers in the mental health support system
- **Survey 3:** for organisations

While Survey 1 asked in very general terms about peoples' experiences of what was working or not working for them, Surveys 2 and 3 required respondents to provide examples of good and poor practice for each of the Review's terms of reference. The design of the surveys considered the length and time for completion, the opportunity for respondents to provide their input in free text, consistency across surveys for analysis and relevance to the terms of reference.

1.2 Analysis of the submissions

As the majority of survey questions asked for free-text answers, standard analysis techniques for analysing qualitative (narrative) information was used. The same techniques were used to analyse submissions received in forms other than the online survey (for example, in letters and emails).

As the volume of responses was so high, a small team in the Department of Health, trained by the National Mental Health Commission team, undertook the first stage of analysis (coding of information). The Commission team then interpreted this coded information in terms of themes, against each term of reference. Coding was aided by the use of NVivo, a software programme which allows the user to categorise and group textual information for later interpretation. The phases of analysis are given in the table below.

Table 1: Phases of qualitative data analysis

Phase	Task
1: Preparation	Collection of survey responses via online survey
	Export of survey data to Excel, cleaning, organisation, de-identification
	Development of initial Term of Reference (ToR)—based coding scheme in NVivo
	Export of data to three NVivo master files (one for each survey)
2: Coding	Training of coders in NVivo and coding scheme
	Descriptive coding of all responses applying and modifying coding scheme as appropriate
3: Thematic analysis	Interpreting patterns or themes in the coded content against each ToR. This involved reading a selection of content which already has been coded with the ToR category, and using finely grained sub-coding to detect prominent themes. Sub-coding continues within each group of responses until saturation point is reached (no new themes are emerging).
4: Case study identification	Identifying stories of good or poor experiences from people with a mental illness/support person/professional against each ToR
	Identifying case studies of services/programmes commonly cited as displaying promising practice against each ToR
5: Write up	Staged write-up of thematic findings against ToRs to feed into the writing of final Review report
	Supplementary report describing all thematic findings as Volume 3 (this work) to support the final report.

1.3 Respondents and their interests

1.3.1 Who responded?

The Commission received 1,834 separate submissions:

- In total, 1,750 submissions were made using the online survey. Thirty-two of these were found to be duplicated submissions, making a revised total of 1,718 online submissions.
- A further 116 submissions were received as direct submissions; that is, outside the online survey format.

The numbers of responses to each of the three online surveys are shown in the following table.

Table 2: Numbers of online responses, by type of respondent

Online survey respondents	Number of responses
Professionals and workers in the system	861
People with lived experience, families, support people, general public	621
Organisations	236
TOTAL ONLINE SUBMISSIONS	1,718

The additional 11 responses were received by email, post or phone. They were analysed using the same methods as used for the online submissions. A breakdown of these responses is shown in the following table.

Table 3: Numbers of non-online responses, by type of respondent

Non-online respondents	Number of responses
Organisations	71
Professionals and workers in the system	26
People with lived experience, families, support people, general public	19
TOTAL NON-ONLINE SUBMISSIONS	116

1.4 People with lived experience and support person responses overview (Survey 1)

1.4.1 Key points

- 621 online submissions were received from people who identified as having experienced a mental illness or as a family/support person.
- There was good geographical distribution of responses, but there was an over-representation of people with lived experience/support person responses from Victoria and an under-representation from New South Wales.
- Interest was roughly even between people identifying as having lived experience and those identifying as families and support people; one-third of respondents to this survey said they both were a person with lived experience and a family member or support person of someone else.
- While experience of services such as hospital admission and general practitioner (GP) consultation for a mental health problem was about even between people living in capital cities and those living elsewhere, use of the Disability Support Pension (DSP) was substantially higher among respondents living in regional, rural and remote areas.

1.4.2 Respondent place of residence

- **Two-thirds of respondents lived in a state or territory capital city**, with the remaining one-third reporting that they lived in a regional town or a rural/remote area of Australia.
 - This means that the population distribution of respondents to Survey 1 by area of residence was representative of Australia's population distribution.¹

- **The biggest response to Survey 1 was received from Victoria (34.3 per cent of responses),** followed by NSW (26.4 per cent), Queensland (14.0 per cent), South Australia (10.5 per cent), Western Australia (9.3 per cent), the Australian Capital Territory (2.6 per cent), Tasmania (1.9 per cent) and Northern Territory (1 per cent).
 - This means there was an over-representation of people from Victoria (who make up 24.9 per cent of Australia's population), from the Australian Capital Territory (1.6 per cent) and from South Australia (7.3 per cent of the population) responding to Survey 1, with an under-representation of people from NSW (32.2 per cent of Australia's population), Queensland (20.2 per cent) and a slight under-representation of Western Australia (11.2 per cent), Tasmania (2.1 per cent) and the Northern Territory (1 per cent).²

1.4.3 Respondent lived experience

- 210 people (33.8 per cent) had lived experience as both a service user and family member or support person
- 173 (27.9 per cent) were service users and not family members or support people
- 154 (24.8 per cent) were family members or support people and not service users
- 16 (2.6 per cent) were interested members of the public
- The remaining 68 (11.0 per cent) were professionals who answered this survey rather than survey 2 [A note for the survey design and legibility].

1.4.4 Respondents' interaction with support systems

537 people with lived experience and family members or support people answered questions about how they had interacted with mental health supports over the past five years.

- As well as their lived experience, 24.7 per cent of people primarily identifying themselves as service users or support people considered themselves to **also have a job within the mental health system**. Those living in capital cities were slightly more likely than those living outside of capital cities to fall into this group.
- 59.4 per cent of people with lived experience and family members or support people reported that they or the person they support has attended a **GP** for mental health reasons. Those living in capital cities were slightly more likely to attend a GP for mental health reasons.
- 27 per cent of people with lived experience and family members or support people reported that they or the person they support has been admitted to a **hospital** bed for mental health reasons. Those living in capital cities were slightly more likely to be admitted to hospital.
- 20.5 per cent of people with lived experience and family members or support people reported that they or the person they support has received the **Disability Support Pension** for mental health reasons. Those living in regional, rural or remote areas (24.7 per cent) were more likely than those living in capital cities (18.4 per cent) to have received the DSP.

1.4.5 What works for people with lived experience, family members and support people?

Illustrative examples of common responses given by people with lived experience/family members/support people about what works for them in terms of mental health supports included the following.

- Services and professionals demonstrating genuinely caring attitudes.

- Supports and pursuits other than formal healthcare—such as support from friends and family, support to attend education, stay in employment, empowering self-help such as exercise and creative activities.
- Sufficient time being allowed for more formal interventions, such as therapies, according to a person's need. Building trust in the relationship between clinician and client is important to success of intervention.
- Being aware of what help is available through adequate information and signposting.
- Continuity of care over time and communication between professionals and services so a story does not have to be repeated.
- Peer support from those with similar experiences—whether online or in groups.

Q: What, in your experience, works in terms of mental health supports?

A: 'Support in terms of encouragement and friendly social support to feel you are once again part of the community. Goal setting, talking about the future, motivation. Lack of patronising and a certain amount of expectation of improvement in the situation.'

Person with lived experience, Western Australia

1.4.6 What is not working for people with lived experience, family members and support people?

Illustrative examples of common responses given by people with lived experience/family members/support people are given below.

- Insufficient appropriate services available to meet need, meaning that issues can escalate—and only being considered eligible for services when 'at risk'.
- Affordability determining access to treatment.
- Poor experiences of inpatient and crisis care, especially judgmental or dismissive staff.
- Low expectations by services and professionals of what is possible.

Q: What, in your experience, does not work in terms of mental health supports?

A: 'Not being able to afford private help, and the extremely limited subsidised services means problems are left to destruction, or an extended stay in a psychiatric facility.'

Person with lived experience, Victoria

1.4.7 What are the main changes people with lived experience, family members and support people would like to see?

Illustrative examples of common responses given by people with lived experience/family members/support people are given below.

- Greater involvement of people with lived experience, carers, family members and support people in design of, and decisions about, support and care.
- Greater support for carers and families who often feel excluded when their relative is ill.
- Increases in availability of longer-term Medicare Benefits Schedule-subsidised services (especially increased number of sessions under Better Access).
- More emphasis on early intervention, including school-based programmes.

- More emphasis on public understanding of mental illness.

Q: What improvements do you believe need to be made in terms of mental health support?

A: 'I think having two bureaucracies (federal and state) isn't working. The money needs to go into one very efficient and competently run system—not be fragmented across NGOs, GP-referred groups, and a lot of semi-trained/ unregistered service providers. It should be a one-stop-shop where people tell their story once and an appropriate referral for follow-up is made.'

Member of the public, New South Wales

1.5 Professionals' responses (Survey 2)

1.5.1 Key points from Survey 2:

- 861 responses were received from people with a mental health-related job.
- Once again, Victorians were more enthusiastic respondents than those in other states and territories and were over-represented among professional respondents.
- Psychologists, and particularly clinical psychologists, were over-represented among professional respondents, while doctors and nurses were under-represented.
- One-fifth of professionals reported having personal experience of mental illness.
- Seven in ten responses were received from professionals working at least some of their time in the private sector, far outnumbering not-for-profit and public sector employees.

1.5.2 Respondents' professional background

- Clinical psychologists (n=370) accounted for 43 per cent of people responding to the professionals' survey.
- All types of **psychologists accounted for 63.5 per cent of professional respondents**. 'Other' psychologists identified themselves primarily as registered psychologists, but counselling, education, occupational, specialist, research and neuropsychologists were also represented.
- The remainder of responses were made up of counsellors and psychotherapists (11 per cent of total responses); other allied health (5.2 per cent); nurses (3.6 per cent); managers (3.0 per cent); peer workers (2.7 per cent); doctors (1.8 per cent); researchers (1.4 per cent) and miscellaneous professions (2.8 per cent). People with lived experience (not working in mental health) who answered the wrong survey made up the remaining 5 per cent. [A note for the survey design and legibility]
 - When compared to the overall mental health workforce, the responses to Survey 2 show an **over-representation of psychologists and an under-representation of nurses and doctors**. Within the Australian mental health workforce, there are an estimated 6.4 times as many nurses as psychiatrists, and an estimated 7.6 times as many psychologists with full registration as psychiatrists.³ Psychiatrists as a group therefore are heavily under-represented when compared to psychologists in this survey, and nurses are also heavily under-represented.
- 21.5 per cent of all professional respondents reported having had personal lived experience of a mental illness.

1.5.3 Respondents' place of residence

- Two-thirds of professionals lived in a state or territory capital city, with the remaining one-third reporting that they lived in a regional town or in a rural/remote area of Australia.
 - This means that the population distribution of professionals by area of residence was representative of Australia's population distribution—but not distribution of mental health professionals generally, which is concentrated in capital cities.¹
- The biggest professional response was received from Victoria (27.74 per cent), followed by NSW (25.8 per cent), Queensland (19.4 per cent), South Australia (10.6 per cent), Western Australia (11.8 per cent), Tasmania (2.5 per cent), the Australian Capital Territory (1.3 per cent), and Northern Territory (0.6 per cent).
 - This means there was an over-representation of professionals from Victoria (which makes up 24.9 per cent of Australia's population) and from South Australia (7.3 per cent of the population), with an under-representation of people from NSW (32.2 per cent of Australia's population), and a slight under-representation from Queensland (20.2 per cent), from the Australian Capital Territory (1.6 per cent) and the Northern Territory (1 per cent).²

1.5.4 Respondents' place of professional practice

Of the 820 professional respondents (excluding people with lived experience who accidentally answered this survey):

- 33.1 per cent reported working for public sector mental health or community health services
- 17.7 per cent reported working for a nongovernment sector organisation
- 70.5 per cent reported providing services through the private sector or private practice.

Some respondents reported working part-time for different sectors, which means the above percentages total more than 100 per cent.

1.5.5 What is working for professionals?

Illustrative examples of common responses about what works for them as given by professionals are as follows.

- Leveraging multi-disciplinary collaboration, often on an ad-hoc basis, and often with non-health agencies such as schools, to provide a more holistic set of interventions to a client. Liaison between GPs and psychologists via Better Access also is frequently mentioned as facilitating improved care.
- Technology is used to improve the efficiency and effectiveness of a professional's practice—from administrative matters such as use of EFTPOS machines and text message appointment reminders, to clinical uses such as online therapies and telehealth interventions in remote areas, to training and professional development activities.

The constant accessibility of programs and apps also allows the delivery of support and reminders (e.g. via SMSs or emails) at times and places where the challenges to coping are being faced, rather than having therapy being confined to sessions.

Clinical psychologist, Queensland

1.5.6 What is not working for professionals?

- By far the biggest complaint in this survey was connected to the reduction in Better Access sessions to ten per calendar year per client. Reinstating the previous 18-session maximum, or addressing the inequity between the numbers of sessions subsidised for psychologists and for psychiatrists, were both commonly suggested solutions.
- Psychologists who have a specialist registration equivalent to that of a clinical psychologist believe they are treated inequitably in terms of Medicare subsidies.

1.5.7 What are the main changes professionals would like to see?

Illustrative examples of common responses given by professionals are given below.

- Increase subsidised services: as well as increasing the number of sessions rebateable under Better Access, mention is made of the need to subsidise according to case complexity, for non-client-facing activity, and for particular allied health services such as telehealth and family therapy.
- Create incentives for professionals to work in rural and remote areas.
- Changes to workforce training/development: university-based training should be relevant to practice challenges and updated to reflect changes in practice, including multi-disciplinary working; ensure that the work clinicians are allowed to do matches their level of training, expertise and specialisation (especially differentiation of those with basic and specialist APS registration).

1.6 Organisational responses (Survey 3)

1.6.1 Key points

- 236 organisations completed our online survey. They ranged from small private providers to national peak bodies representing hundreds of organisations, and from professional representative organisations to university departments.
- The range of organisations responding ensures that the views of the whole mental health sector (and beyond) are heard in our analysis; this compensates for any over or under-representation of certain professions or interests in the individual submissions.

1.6.2 Types of organisation

In total, **236 responses** were received via the online survey from organisations. These were divided into four categories as follows, according to the organisation's self-defined main purpose.

Table 4: Organisational responses by type of organisation

Type of organisation	No. respondents	Percentage of respondents
Provider of mental health related support	138	58.5
Advocacy or representative organisation	49	20.8
Professional peak body	28	11.9
Research body	21	8.8
TOTAL	236	100

Of the 138 providers of mental health-related support:

- 42 per cent (n=58) were not-for-profit organisations
- 26 per cent (n=36) were operating in the private sector
- 21 per cent (n=29) were Medicare Locals
- 11 per cent (n=15) were operating in the public sector

Of the 49 advocacy and representative organisations:

- 46.9 per cent (n=23) were advocacy or lobbying organisations, of which eight also provide support to people with lived experience or carers
- 24.5 per cent (n=12) represent a number of similar organisations
- 20.4 per cent (n=10) were national interest peaks for a particular diagnosis or mental health
- 8 per cent (n=4) were public legal or policy organisations

Of the 28 professional peak bodies:

- 6 represented psychologists
- 6 represented counsellors or psychotherapists/psychoanalysts
- 5 represented other allied health disciplines
- 4 represented doctors
- 4 represented all professional disciplines
- 3 represented nurses

Of the 21 research bodies:

- 38.1 per cent (n=8) were research departments specifically for rural and remote health

1.6.3 Jurisdiction of operation

Organisations reported operating in jurisdictions as described in the following table (many organisations operate in multiple jurisdictions). The number of organisations operating in the smaller states and territories (in terms of population size) is greater than might be expected.

Table 5: Organisations' jurisdiction(s) of operation

Jurisdiction	Number of respondents	Percentage of respondents
All—National	31	13.1
New South Wales	116	49.1
Victoria	102	43.2
Queensland	84	35.6
South Australia	74	31.4
Western Australia	71	30.0
Australian Capital Territory	53	22.5
Tasmania	53	22.5
Northern Territory	52	22.0

1.6.4 Organisations' mental health-related interests

We asked organisations to nominate the principal issues with which their organisation is engaged in relation to mental health. They could nominate more than one from a list. It is noteworthy that a sizeable minority of organisations did not identify as being involved in clinical community-based or hospital health care. The list below also illustrates that there was a wide variety of whole-of-life issues which were perceived by respondents to be directly related to their overall support of people's mental health. This shows that the philosophy of a 'contributing life' is one which resonates across the mental health sector and beyond.

- 59 per cent (n=140) were engaged in health care (community or hospital-based)
- 35 per cent (n=82) were engaged in education
- 27 per cent (n=64) were engaged in carer/family support
- 23 per cent (n=54) were engaged in peer support
- 16 per cent (n=37) were engaged with substance use issues
- 14 per cent (n=34) were engaged with cultural issues
- 14 per cent (n=32) were engaged with housing/homelessness issues
- 12 per cent (n=28) were engaged in online support
- 12 per cent (n=28) were engaged in employment (for people with mental health difficulties)
- 11 per cent (n=25) were engaged with justice system issues
- 5 per cent (n=11) were engaged with sport, leisure or creative pursuits

1.6.5 Interest in Commonwealth programmes

The table below reflects how many times organisations mentioned particular Commonwealth mental health programmes in their responses.

Table 6: Commonwealth programme mentions in the text of organisations' survey responses

Programme	Mentions in Survey 3 responses
ATAPS	1,114
Better Access	749
headspace	644
Partners in Recovery	580
Mental Health Nurse Incentive Programme	350
Personal Helpers and Mentors	263
National Disability Insurance Scheme	156

1.6.6 What works well in the mental health system?

- Effective collaboration and integration between agencies and services was the most frequently mentioned example of things working well in the organisations' experiences.

Good integration requires trust and genuine partnerships... the health gains that have been provided by Aboriginal Controlled Community Health Services is due to the model ... initiated by the local Aboriginal community, governed by the local Aboriginal community, and implemented by the local Aboriginal community ...

National Aboriginal Community Controlled Health Organisation

1.6.7 What is not working in the mental health system?

Illustrative examples of common responses given by organisations are given below.

- Inefficient use of funding was attributed to clumsy or duplicative administration processes, to inappropriate distribution of the workforce, and to an overall imbalance of funding within the mental health system. However, inefficiency was most commonly associated with the provision of ineffective or inappropriate support to people with lived experience.
- The most commonly cited sources of a poor experience of mental health support were access difficulties, lack of a person-centred approach, lack of consideration of interrelated needs, and falling through gaps between services.
- Workforce concerns emerge from these responses principally in terms of training curricula and professional development not keeping up with developments in population needs and new ways of working; gaps in expertise for particular difficulties and among particular professionals; and a perceived inflexibility in the deployment of the workforce at present.

Transition periods lead to individuals not effectively having their needs met in a holistic manner. Examples of transition periods are from primary school to secondary school, and also from youth to adulthood. There appears to be a lack of attention paid and services available ... which leads to consumers and carers falling through the cracks and not obtaining the type of support they may require.

Batyr Australia Ltd.

1.6.8 What are the main changes that organisations would like to see?

The most common desired changes were as follows:

- Changes to funding
 - e.g. more investment 'upstream' in early intervention
 - e.g. longer funding cycles
- Changes to policy or strategy
 - e.g. 'National strategy' for particular special interest
 - e.g. Strategic planning of services (e.g. intellectual disability)
- Changes to how or where support is provided
 - e.g. addressing more than one need at once
 - e.g. alternatives to inpatient care for acute crisis

One practical step to improve the mental health system would be to facilitate timely and efficient transfer and clinical handover for consumers transferring between acute, sub-acute and primary care settings including:

- timely access to secure and high-level care settings when this is needed
- streamlined transfer and clinical handover between public and private sectors when this is clinically necessary and/or requested by the consumer
- effective coordination of care for consumers requiring care for multiple conditions (psychiatric and non-psychiatric).

Australian Private Hospitals Association

2. Cost-effectiveness of existing services and programmes

2.1 Key findings

1. The most prominent characteristics of **cost-effective** mental health services and programmes are that they:
 - a. Respond to identified needs of people with lived experience in a timely, accessible way.
 - b. Address interrelated needs and enable rapid re-engagement in life.
 - c. Are evidence-based and well evaluated.
 - d. Demonstrate resourcefulness and creativity, including leveraging collaboration.
2. The most frequently cited sources of **inefficiencies** in programmes and services are:
 - a. Failure to consult communities about what they need.
 - b. Administrative inefficiency and inflexibility.
 - c. Failure to match professional skills to tasks.
3. Common **recommendations** for improving the cost-effectiveness of programmes and services are:
 - a. Greater flexibility in how funding is used to enable it to be tailored to local needs.
 - b. Greater emphasis on equity of support for different populations.
 - c. Investing in more sustained interventions which prevent the revolving door effect.

2.2 Overview

Term of reference 1 asked the National Mental Health Commission to assess:

The efficacy and cost-effectiveness of programmes, services and treatments

The present chapter deals with cost-effectiveness, while the efficacy aspect is considered in chapter 4.

2.2.1 Survey questions

The analysis below is primarily based on answers to the following survey questions.

Professional and organisational respondents were asked to provide an example from their own experience (or that of their organisation) of a service, programme, policy or initiative:

- a. demonstrating value for money (cost-effectiveness)
- b. demonstrating or encouraging inefficiency in the organisation or delivery of services

While people with lived experience, family members and support people were not asked specifically about cost-effectiveness, we have included in our analysis references made by those respondents to this issue.

2.2.2 Survey responses

For question (a), 82.2 per cent of organisations (n=194) and 87 per cent of professionals (n=749) provided a response.

For question (b), 66.1 per cent of organisations (n=156) and 66.4 per cent of professionals (n=572) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

2.2.3 Note on interpretation

High response rates could be a result of these questions being presented first in their respective sections. The analysis presented below focused on finding patterns in what respondents believe to be a cost-effective or inefficient service or programme, and this information should be interpreted in conjunction with other thematic findings.

2.3 Thematic findings

2.3.1 Overall

Responses to questions about cost-effectiveness of services and programmes show that for people using and working in the mental health system, this is not a simple calculation to make. Cost-effectiveness for many of these stakeholders does not just mean maximising outcomes per dollar spent. Their submissions show that an assessment is complicated by four factors:

- Mental health problems can be chronic or episodic over a lifetime, and so cost-effectiveness needs to take into account the future impacts of the present intervention.
- Mental health problems also can affect and be affected by many aspects of a person's life, including family circumstances, employment and education, housing, physical health—and these ramifications also must form part of cost-effectiveness considerations.
- Individual responses to different types of mental health supports and interventions often are highly particular to that individual and therefore effectiveness often is hard to generalise.
- An effective response to a person experiencing mental illness often does not consist of a discrete intervention (such as a single drug or surgical procedure) but requires a combination of interconnected supports.

Overall, the key characteristic of a cost-effective mental health programme is that people actually find it accessible, appropriate and relevant to their needs. Large numbers of respondents thought that services and programmes which are forward-thinking and are able to forestall the need to access other services—either because multiple needs are not recognised, or when things deteriorate later on—demonstrated cost-effectiveness. An example is the higher cost of delivering the same programme in a rural or remote area; sometimes greater relative spend is needed in some areas to ensure equity across the country.

The key argument here is that what is cost-effective for people with lived experience (because it meets their needs and prevents deterioration) also can be cost-effective for governments and taxpayers.

2.3.2 What makes a mental health service or programme cost-effective?

This section describes the most prominent characteristics of a cost-effective mental health service or programme.

The service or programme enables early intervention

The most important feature of a cost-effective programme or service, according to our submissions, is that it aims to intervene early in the course of a person's mental illness. This is seen to be cost-effective because enabling people to access appropriate help early, before symptoms significantly impair daily functioning, will a) avert the need for use of more intensive (and expensive) services such as inpatient admission, and b) prevent cycles of disadvantage which occur when a problem becomes entrenched and jobs or housing are lost as a result.

When asked specifically about examples of a cost-effective service, many respondents cited services which seek to support children and young adults' mental health.

... evidence-based early childhood programs [...] are the key to the primary prevention of both mental and physical illness and will save the community a lot of funding in the future in terms of jail, supported accommodation, employment etc.

Central Australian Aboriginal Congress

Early intervention was seen as a key principle of cost-effectiveness across all age groups, not just the young. For example, for someone who has been living with a severe mental illness for some time, early intervention means keeping them out of hospital—whether through preventing crises occurring or through alternative crisis support.

Community mental health working in an assertive case manager model where clients are remaining on the books if they have a serious and persistent mental health problem so that they are followed up regularly to ensure they stay well. This model maintains people in the community and allows them to remain there whilst having an exacerbation of their illness as a crisis service can accommodate their needs for daily or more often, contact with a mental health professional thus avoiding hospitalisation. Well utilised, this model needs less beds in the hospital but more staff working in the community over a 24 hour period to provide the support necessary. Research into this model showed it was more efficient and less costly than hospital based care.

Allied health professional, New South Wales

The prevention of knock-on impacts in other parts of a person's life, expense to other parts of the health and welfare system, and the cost of lost productivity also were recognised through individual stories such as the following.

A man who had formerly been a successful entrepreneur, a valued family man and a significant contributor to community activities, developed severe depression which, despite medication, had him sitting staring at the wall for seven years, when he was referred for clinical psychology services. He began treatment feeling little expectation of change. After 16 sessions he was so well that a business colleague offered him a franchise opportunity and he soon developed a new thriving business ... This occurred during the few years when Medicare rebates could be paid for up to 18 sessions in a calendar year. The total treatment cost (at today's rates including a gap fee of \$42.00 per session) was \$4,400.00 or \$3,392.00 to the taxpayer through Medicare rebates. Compare that to seven years of Centrelink payments, not to mention the people who were not employed by him over those years!

Clinical psychologist, New South Wales

The service or programme meets users' needs

Many responses to questions about cost-effectiveness followed the argument that if you build something (a service or programme) and people cannot access it or find it does not meet their needs, it is bad value for money. Good value for money therefore relies on the service or programme being accessible (financially and physically), as well as being relevant and

appropriate to a person's needs and world view (such as their cultural or age-specific needs). In addition, services or programmes which are set up in ways which recognise that people presenting with a mental health difficulty may have other inter-related needs also were frequently mentioned as offering good value for money.

Affordability

Making services affordable to the end-user was seen as an important aspect of cost-effectiveness, because of the preventive gains made when services are accessed in a timely manner. Being unable to access services because they are unaffordable was frequently mentioned in relation to the limit of ten sessions accessible under Medicare rebates for Better Access; a few psychologists reported working pro bono or for a nominal fee for some clients after the Medicare sessions ran out. People with lived experience reported feeling that they were left without support because of the lack of availability of any other appropriate service once their psychology sessions were exhausted.

Location

Services located close to home were thought to be cost-effective, partly because they aided timely access, and partly because, for people living in regional or rural areas, transport costs to the individual or to the health service could be averted.

Country Health SA Mental Health Service provides a community-based sub-acute level of care (known as intermediate care service) in five regional communities, Whyalla/Port Augusta, Mt Gambier, Pt. Lincoln and Kangaroo Island. The nurse-led service enables consumers to stay in their own community, and generally in their own home with their family, avoiding transfers to the metropolitan service and mental health inpatient admissions. The team works closely with the local hospital and is well integrated with the community mental health team, and local NGO providers.

National Alliance for Rural and Remote Health

The service or programme enables rapid re-engagement in life

Services or programmes which enable people to quickly re-engage in the normal activities of daily living—such as work, education, family duties and community participation—are thought to offer good value for money. This is because productivity losses associated with prolonged illness can be minimised, and because factors such as having a meaningful occupation and strong social networks in turn are protective of mental health.

Eating disorders (anorexia nervosa, bulimia nervosa, binge eating disorder and atypical presentations of each) impair physical, psychological and social health and untreated/unsupported have very high productivity and burden of disease costs (\$15.1B and \$52.6B respectively in 2012 as calculated by Deloitte), due to their early onset, duration when not properly treated, and high fatality rate. Deloitte estimated that 4 per cent of the population (+913,000) Australians had eating disorders in 2012 with less than 25 per cent in treatment. [...] A focus on ability rather than disability is key to reducing negative impact. Someone with an eating disorder is able to participate but needs support and flexibility, during their treatment and through recovery. This is particularly important during school years. Ironically, those with a genetic disposition to an eating disorder such as anorexia nervosa are typically highly intelligent and high achievers—those able to contribute significantly to

Australia's productivity if they receive encouragement to stay engaged in education and employment.

Butterfly Foundation

Community-based activities and drop-in centres that cater for people with complex needs, including mental health needs, are low-cost initiatives that provide significant, and at times, life-saving benefits to mental health consumers. Some of these centres are part of a neighbourhood centre and some are part of a mental health NGO. An example is the Day to Day Living program which is commonly run in drop-in centres. Consumers said these are safe spaces that help reduce social isolation. The activities and social interactions also serve as important stepping stones into more active community participation.

NSW Consumer Advisory Group - Mental Health Inc. (now trading as BEING)

The service or programme is evidence-based

Many respondents associated cost-effectiveness with implementing services and programmes which are 'evidence-based'. The evidence cited by respondents to justify claims of cost-effectiveness ranged from formal research such as randomised controlled trials which 'proved' the positive impact of a particular intervention, to in-house evaluations of services which had been assessed positively by service users or which showed good clinical outcomes.

When evaluated in 2010, the RichmondPRA Young People's Outreach (YPOP) Program cost \$278,000 per year to operate. (The cost has gone up in intervening years to now being around \$330,000 per year.)

Data about hospitalisation rates for 44 of the 45 young people for the two years prior to entry to YPOP was obtained. The total number of hospital days for this period was 1,321 days. The total number of hospital days for the same group after entry to YPOP was 265. This is a reduction of about 80 per cent in the amount of time spent in hospital by the young people.

This also represents a cost saving of \$915,522 for acute admissions or \$691,680 for non-acute admissions (based on Mental Health Drug and Alcohol Office, NSW Ministry of Health average costs for adult inpatient hospital admissions and average length of stay, December 2011).

RichmondPRA

The service or programme leverages joint working and economies of scale

A surprisingly prominent aspect of respondents' understandings of cost-effectiveness was the value of cooperative working. Commonly cited examples of cooperation that contribute to the cost-effectiveness of services and programmes were:

- deliberate coordination between different services to offer greater continuity of care to people with lived experience and therefore reduced duplication of information
- pooling of expertise to make funding and staffing go further, especially in rural and remote areas
- coordination of multiple programme funding streams to gain administrative economies of scale

- centralised referral processes and triage
- collocation of multiple services, offering benefits in terms of reduced overheads for providers and also convenience for people with lived experience
- capacity-building through partnerships between mental health professionals and volunteers and peer workers.

Using a train-the-trainer approach and building the capacity of teaching staff to implement the Peer Support Program and the capacity of students to run the program provides a very effective and highly successful method of increasing penetration, and impacting on school communities throughout Australia. To use the program schools pay a small fee for service and an annual membership. Based on school enrolments for schools using the program, at March 2014 almost 517,000 students were actively involved. The cost to run the organisation is approximately \$1m p.a. This equates to less than \$2 per student. Approximately 50 per cent of this (\$1 per student) is met by government funding (state and federal). The balance is covered by philanthropic support and fee for service.

Peer Support Australia

The Adelaide Hills 'SHARE-Doing Life Together' program ... is a partnership between the Adelaide Hills Community Mental Health team [state funded] and a network of churches in the region, which combines a 0.20FTE community mental health nurse role with training and mentoring for volunteers to reduce social isolation. The return on investment from this minimally funded program is magnificent.

Northern Adelaide Medicare Local

An example combining several of these cooperation strategies is provided by a Medicare Local which operates across regional, rural and remote areas of its state, and reports that it achieves cost-effectiveness by integrating funding streams and staffing across Commonwealth programme delivery.

Our mental health service is delivered in an integrated model—so the funding streams across ATAPS, headspace, MHNIP, Better Access and RPHS [Rural Primary Health Services] match the needs of the individual and the community. These services have a one-stop-shop approach [which] cuts down on other overhead costs, improves access for clients, and attracts a multidisciplinary workforce rather than isolated practice. This model supports growing a workforce especially vital for regional and rural communities as we are able to support interns and new graduates. This is cost-effective over time as it reduces the burden on FIFO/DIDO workforce while being more acceptable to communities.

Townsville-Mackay Medicare Local

The service or programme is cheap to run

Small NGOs as well as some professionals and people with lived experience reported the value of services which are cheap to run and which are resourceful in gaining funding from philanthropic, industry and other fundraising. Cheap-to-run services often were those which provided activities offering social connection and support, especially to people living with severe or chronic mental illness.

Scalable interventions include those which require little further investment after initial development to reach additional users, such as online information portals and unsupervised e-therapies. For example, young people responding to the survey reported that online forums hosted by sites such as *reachout.com* gave them a safe, anonymous place to feel less alone and to offer mutual support as part of the website's forums. The use of e-therapies as part of an integrated support system as a first line approach for mild difficulties also could be cost-effective:

E-health platforms reach large numbers of people and are scalable. Standard therapies such as cognitive behaviour therapy (CBT) can be effectively delivered online to large numbers of individuals for a fraction of the cost of face-to-face therapies. The per-person cost of providing this level of treatment has become very low. Likewise, preventive services that promote mental wellbeing can be targeted to people with few symptoms who would not meet the clinical criteria for a mental disorder.

Black Dog Institute

2.3.3 Aspects of Commonwealth programmes offering good value for money

By substantially increasing the numbers of people accessing mental health treatment, Better Access is seen as filling a large gap in provision for people with mild to moderate mental health difficulties who previously would not have had any access to affordable mental health care unless they deteriorated to crisis point. Making such a service available on demand to the wider community is thought to increase the timeliness of access to appropriate help.

The Better Access to Mental Health has allowed many of our clients in a regional area to access mental health services that were previously inaccessible to them. Our clients who would previously only be seen once they have reached severe crises are now able to be proactive and seek support before it overwhelms them and can then contribute to society rather than withdraw or need expensive inpatient assistance.

Port Stephens Clinical Psychology Services

The collocation model adopted by many headspace services—whereby GPs, psychiatrists, psychologists and other allied health and vocational advisory staff are located in the same youth-friendly environment—is reported by some people with lived experience as being convenient and approachable, and by some providers as providing economies of scale.

headspace has an innovative funding model which comprises a core grant of slightly less than \$1 million annually, together with an establishment grant of \$400,000, supplemented by local contributions from a lead agency (grant holder) and other local agencies in a consortium partnership. These services are also supported by a range of Medicare Benefit Scheme (MBS)-funded service providers co-located on the headspace site, meaning that a comprehensive range of services are available to young people to improve their mental health.

The Benevolent Society

2.3.4 What makes a mental health service or programme inefficient?

Failure to consult communities

The failure to develop, design and plan services and programmes in consultation with the communities to which they are targeted is seen by many as a key cause of inefficiency. This was particularly true with regard to the particular challenges, needs and preferences of people whose first language is not English or whose cultural background may mean they understand mental illness and its appropriate treatment in different ways. Without consultation, money spent on services and programmes may be wasted because they are not felt to be relevant or appropriate for the communities concerned. As the following example illustrates, when there is a further failure to acknowledge the specific requirements of these communities during the everyday operation of clinical care, experiences of people with a mental health difficulty and outcomes can suffer.

Failure by general mental health services to consult specialist state-wide transcultural mental health services in a timely fashion often leads to delayed diagnosis as well as poor consumer and family engagement. It also has the added risk of health care services prematurely terminating treatment, which can result in multiple complications and readmissions. Unpublished state and territory data demonstrates that people born overseas from non-English-speaking backgrounds tend to experience increased risk of hospitalisation compared to Australian-born and/or people from English-speaking backgrounds. Once admitted, this population group tends to experience longer lengths of stay and severity of mental illness.

Mental Health in Multicultural Australia (MHIMA)

Location

People with lived experience in many regional, rural and remote areas find logistical challenges to accessing services because of low per capita numbers of psychologists and psychiatrists outside of capital cities. Long drives for each appointment are not uncommon. For those in remote areas, fly-in/fly-out clinicians often are different each time, preventing continuity of care which is important in the therapeutic process.

Common examples of inefficiencies in Commonwealth programmes

Although Better Access is generally seen as providing good value for money, there were two aspects of the programme's design which were seen by many respondents as inefficient.

The first was a widespread questioning of the requirement for GP referral and later review; GP Mental Health Care Plans generally were not seen as a good use of resources because assessments of problems usually are made again by psychologists or other clinicians during the initial Better Access appointment.

Removing the essential requirement of an initial GP plan would remove unnecessary administrative costs. If psychologists could give people even an initial appointment without a GP referral to assess what is needed and then send people back to GPs with a tentative diagnosis to have a plan constructed, that would be more efficient, accurate and cost-efficient. Psychologists are well trained and placed to make such a judgement.

JumpStart Psychology

From the GP's perspective, the process is burdensome for some, to the extent that some people with lived experience are blocked from Better Access because their GP is unwilling to complete the paperwork.

One GP said "oh that's too much paperwork" when a friend who was suffering depression wanted a referral to a psychologist. When people are depressed they also feel disempowered and will not press for a referral.

Support person, Victoria

I had a feeling of guilt that the GP and psychologist seemed to have to fill in so much paperwork. Both the GP and psychologist mentioned this and I felt like a burden, even though they were very nice about it.

Person with lived experience, New South Wales

The second and most common complaint—made by hundreds of psychologists and people with lived experience—about Better Access was related to the reduction in numbers of sessions eligible for Medicare rebates, from the original 18 to ten in 2012–13. Respondents commented that this reduction often makes the difference between offering a complete treatment and offering only part of what is needed. If a person has more complex difficulties than mild depression or anxiety, ten sessions appears to not be enough, leaving the person without services or to try to access (more expensive) specialist mental health services. Ultimately, the reduction was felt to be inefficient, especially because building a therapeutic relationship takes time and having to access a different service only duplicates that effort.

The Australian Psychological Society (APS) undertook a survey of psychologists to investigate the impact on consumers of the reduction in sessions. Data was collected on 900 consumers who, at the end of the allowable 10 sessions, were judged by their psychologist to need further treatment. Treating psychologists managed these consumers in a variety of ways but nearly a quarter were required to wait until the new calendar year to obtain further treatment due to lack of alternative arrangements. Only 16 per cent were able to obtain treatment from another mental health service.

Australian Psychological Society

I think 10 sessions is not enough support. Mental health is not like a physical illness where it just 'heals'. It can linger and remain present; the symptoms may become less severe but they do resurface and although I have weeks where I feel fine, there are also weeks where I can barely survive. Having the ability to see a psychologist when I need to would be really beneficial. Mental health does not operate on a 10-week time frame, therefore neither should treatment.

Person with lived experience, Victoria

The previous 18 sessions granted under the Better Access scheme meant that an adolescent client was able to stay at school and still complete relatively intensive mental health treatment. Under the current system, that same girl has had to leave school to participate in a more expensive day patient program.

Clinical psychologist, Victoria

At 93 years of age, the man who created cognitive therapy, Dr Aaron T Beck, has written to our Minister for Health, Peter Dutton MP, suggesting that 24 visits of psychological care would be more optimal for most cases of depression (<http://bit.ly/1gph8Vy>). We think this is a powerful expression of the need for a change in Medicare policy. Our suggestion is that the allowance of 50 visits of psychiatric care per annum could be more equitably shared with psychological treatment. For the vast majority of Australians needing psychological care, an allowance of a maximum of 25 visits would be more than adequate and far more cost-effective in the long term.

Alliance for Better Access

The National Suicide Prevention Programme is criticised by some for funding too many small, uncoordinated initiatives which are not integrated with other mental health supports.

There is widespread frustration in the mental health sector that suicide prevention monies are being spent using a scattergun approach, not informed by the evidence, and in small bundles with no alignment between the states. Additional dissatisfactions include: (a) poor targeting of funding to specific risk groups (young men, indigenous youth, displaced and separated men, those with mental health disorders, particularly depression); (b) many suicide prevention organisations do not deliver treatments or early interventions that research evidence suggests “works”; (c) there has been no attempt to reform the mental health services that provide help so that services are accessible to those at risk; and (d) there is a divide between population-based approaches and mental health treatment (almost parallel universes). The outcome is that our response to suicide prevention is not integrated, cohesive or effective. Many suicidal people remain “under the radar”.

Black Dog Institute

2.3.5 Options for improving the cost-effectiveness of services and programmes

‘Invest to save’ in early intervention, prevention and promotion

Increasing investment in services and programmes which offer early intervention and prevention approaches was suggested by many respondents as helping to rebalance the system away from expensive acute services and preventing secondary impacts on a person’s social and economic circumstances and welfare service use.

There are significant gains to be made in improving the quantity and quality of mental health promotion, early intervention, community development and service integration. These gains can be made in the reduction in suicide, improved educational and employment retention,

reduced costs to the criminal justice system, families sustained and fewer lives dissolved. The meaningful contributions of people who might otherwise be isolated and excluded can make up meaningful components of families and communities. The value from these investments is not just in the money saved but in the quality of life for individuals and their families and in the lives saved.

Victorian Aboriginal Community Controlled Health Organisations (VACCHO)

There is a great burden of mental illness among tertiary students. These illnesses affect individuals at an emergent stage of life, and the cost in terms of productivity lost is immense. These students are also all readily accessible on campuses. Universities must develop strategies that include the provision of mental health services on campus, strategies to detect at-risk individuals and follow-through with their care, and connections between on-campus services and community services. This would be a cost-effective way to reach a significant proportion of the population affected by mental illness.

Australian Medical Students' Association

Greater flexibility in use of funding

Inflexibility in the use of funding, particularly funding for Commonwealth programmes, can sometimes mean that the programmes can come across as siloed and not addressing the needs of the whole person. Efforts to increase flexibility are demonstrated by an innovative group of volunteers described in the extract below.

headspace has been conducting counselling for youth and until recently the main emphasis was on the youth. As the program was evaluated it was recommended that a whole family approach was needed. However, the headspace charter has no real provision for the inclusion of partners or parents in the process. There was a perceived need and with the assistance of volunteers a program was instigated to address this need. This program has great potential to be an entry point to assist all parents or partners of those with mental health issues.

Allied health professional, South Australia

Reforming the Better Access initiative in order to take into account the complexities associated with the management of mental health in the community. The demand for psychological services will continue to rise. Therefore, it is important the program not only evolves to improve access issues, but also ensures that the quality and quantity of mental health services provided is proportional to need. This involves implementing a flexible funding model to enable complex mental health cases to access more than 10 consultations, when deemed necessary. This funding model should also be flexible to provide additional support and resources to clients with diverse and special need.

General Practice Mental Health Standards Collaboration (RACGP)

Greater emphasis on equity of support for different populations

Inequities in the availability of appropriate support for Aboriginal and Torres Strait Islander peoples and for regional, rural and remote communities were commonly cited by respondents and will be dealt with in detail in dedicated sections of this report. As an example, the arguments for greater equity between metropolitan and rural areas include the following.

More equitable distribution of existing resources for rural and remote areas from existing budgetary allocations. Improved equity is essential due to:

- the higher comorbidity and greater number of suicides in rural and remote Australians (Kolves, et al, 2012)
- the disproportionate contribution by rural and remote workers to Australia's economic prosperity through agriculture and mining, which account for 67 per cent of the value of Australia's exports
- the prediction that the population outside capital cities will grow by 26 per cent by 2026.

De-identified research organisation

Other inequities were identified in the availability of appropriate mental health support for people given certain diagnoses (especially eating disorders and personality disorders), communities with particular mental health challenges (including diverse sexualities, veterans, prisoners and ex-prisoners), and culturally and linguistically diverse communities, including refugees.

Lack of specialist provision for these different groups is perceived by many to lead to increased use of crisis services when needs cannot be met.

The criminal justice system contains many people with various levels of mental illness. They generally go untreated and unsupported while incarcerated, contrary to the duty of care of the prison, prior to their release back into the general community. The government's fiscal situation could be greatly assisted by justice reinvestment programs across the mental health, drug and alcohol and community development systems.

VACCHO

Previous funding of \$22.4m for the Mental Health: Taking Action to Tackle Suicide package, to be allocated across all at-risk groups, is insufficient to adequately address consumer needs across all high-risk groups including LGBTI people. Additional funding will allow for currently targeted suicide prevention activities to reach a greater audience across high-risk groups. Funding should also be increased for support and crisis services that have the ability to offer specialised support to LGBTI people.

NSW Gay and Lesbian Rights Lobby

Options for increasing cost-effectiveness through equity of support provision include:

- not assuming that mental health service models designed for one community can be transplanted without adaptation to a different community—one size does not fit all

- a strong grasp of how different communities understand the origin and nature of mental illness
- involvement of community members in the design, implementation and delivery of a service or programme.

Investing in more sustained interventions to prevent the revolving door effect

There is a sense that the lack of flexibility with Better Access and ATAPS in terms of number of sessions does a disservice to people with more complex difficulties and therefore is ultimately inefficient. More sustained interventions, particularly in terms of talking therapies, are recommended by many respondents. An example is longer-term psychotherapy for people living with personality disorders:

Intensive psychodynamic psychotherapy is a specialised intensive form of psychotherapy that helps severely traumatised and disadvantaged mentally ill patients, and those with personality disorders who are resistant to other forms of mental health care; it is usually offered after simpler methods have failed, and more thorough treatment is required; it undertakes deep change of the personality, and is different to supportive measures; it is required for patients whose lives are often stuck in severely self-destructive cycles, and it reduces high costs in other parts of the health care system and wider society.

Australian Psychoanalytical Society

2.4 Promising practice demonstrating cost-effectiveness

NACCHO represents 150 Aboriginal Community Controlled Health Organisations (ACCHSs) who are located in urban, regional, remote and very remote Australia. The model of service provided by ACCHS's is comprehensive primary health care which is inclusive of Mental Health and Social Emotional Wellbeing. NACCHO's ACCHS's Report Card and [Economic Value of ACCHSs Report](#) 2014 demonstrated that 80 per cent of ACCHS's saw 311,000 Aboriginal and Torres Strait Islander people and other Australians, perform 2 million episodes of care annually, as an industry employs over 5,500 health professionals and receives 1/4 of the Indigenous Health Expenditure compared with mainstream providers who receive 3/4 of this expenditure without demonstrating health outcome or gains. Both of these current NACCHO reports demonstrated cost effectiveness and efficiency however investment into ACCHS's to deliver appropriate Mental Health and SEWB services has been lacking over a 10 year period with majority of the mental health funding being distributed to mainstream providers.

National Aboriginal Community Controlled Health Organisation

2.4.1 Lifeline social return on investment (SROI) evaluation

Lifeline's online Crisis Support Chat service: translating the Lifeline 13 11 14 telephone crisis line to an online chat environment, utilising Australian Government funding for initial development plus operational funding from a private corporate donor. A Social Return on Investment study, also funded by the corporate donor to demonstrate the impact of the service on help seekers, found an \$8.40 return for every dollar invested in the chat service, providing a case for other parties, including government, to invest in funding the service.

Lifeline Australia

2.4.2 Housing and Accommodation Support Initiative (HASI)

The NSW Housing Accommodation Support Initiative (HASI) provides intensive home-based service delivery for people with serious mental illness. It relies on a strong partnership and collaboration between housing agencies, public clinical health services and non-government service providers. The aim of the program is to provide stable housing, coordinated clinical care and social/rehabilitation support based on social inclusion principles. Although cost per package is considerable, HASI is both cost-effective in absolute terms and comparable, as it targets people who would otherwise be at risk of repeated re-admission to acute inpatient care or homelessness. HASI improves participants' mental health by keeping people in accommodation, clinically well and socially engaged.

Australian Association of Social Workers

Within HASI, consumers are successfully maintaining their tenancies and using relevant mental and physical health services; have improved mental health outcomes, decreased hospitalisations, improved social contact with family and friends, and increased participation in community activities, including engagement in work, education and training for some consumers. Furthermore, results indicate that there has been a 59 per cent decrease in the average number of days spent in hospital per year, a 68 per cent decrease in the average number of days hospitalised per admission, and a 24 per cent drop in the number of admissions to hospital (Social Policy Research Centre, 2012).

Murrumbidgee Medicare Local

2.4.3 Individual Placement and Support (IPS)

The WA Mental Health Commission [MHC] has provided two project funding grants of \$150,000 (2013–14) and \$165,000 (2014–15) to the Western Australian Association for Mental Health (WAAMH), from which WAAMH has provided development and technical assistance to establish 12 formal Individual Placement and Support (IPS) partnerships between mental health services and disability employment services in metropolitan and rural WA. WAAMH's approach is based on the State Trainer model developed at Dartmouth Medical School in the USA and implemented by the National Health Service in the UK.

Through these partnerships mental health services receive direct access for their clients to specialist employment services, have an employment specialist co-located within their service, and receive expert development support and technical assistance from an independent specialist IPS development unit.

IPS has been evaluated in 19 randomised controlled trials in North America, Europe, Asia and Australia. 60 per cent or more of IPS clients obtain competitive jobs, compared to about 24.3 per cent of those achieved by the DES service in Australia in 2012 (Australian Government, Department of Education, Employment and Workplace Relations, Evaluation of Disability Employment Services Interim Report Re-issue March 2012.)

Western Australian Association for Mental Health

2.4.4 Alcohol supply reduction in Alice Springs

Alcohol supply reduction measures in Alice Springs, based on increasing the minimum price of alcohol, are incredibly cost-effective in the primary and secondary prevention of mental illness. An increase in the price of 25 cents per standard drink, which cost nothing, has reduced population alcohol consumption by 10 per cent and prevented a large number of hospital admissions, including admissions for assault. As a result, children in their early years are less exposed to the type of violence and trauma which the Californian Adverse Early Childhood Study has demonstrated lead to the development of mental illness, especially depression, in later life. In addition, as adults get less drunk less often they are less likely themselves to suffer from alcohol-caused mental illnesses and more able to respond to the needs of their own children. Further reduction of alcohol supply is one of the most cost effective initiatives that could be undertaken in the primary and secondary prevention of mental illness. This is also true for the impact of the former system of photo licensing at the point of sale and the Banned Drinkers Register which effectively targeted the heaviest drinkers and led to a major reduction in hospital admissions (see the paper from the NDRI on Alcohol Control Measures in Alice Springs for further details).

Central Australian Aboriginal Congress

2.4.5 Return on Investment for StandBy Suicide Response service

StandBy Response is a national suicide postvention initiative to support people and communities bereaved by suicide. The argument below is an example of cost-effectiveness calculations made by the organisation delivering this initiative, which demonstrate an attempt to quantify the benefits of their service in economic as well as human terms.

If the StandBy Response Service was providing coverage of the Australian continent, it would mean even further economies of scale, greater service cohesion and reduced gaps for those experiencing the devastating effects of the loss of a loved one to suicide. Currently the Department of Health has invested \$4.5M annually across 16 StandBy Response Service sites in Australia. United Synergies has recently completed modelling that has estimated a further \$9.2M would complete the coverage of Australia. Thus a total of a \$13.7M annual investment would provide national coverage and support by the StandBy Response Service. Expanding the StandBy Response Service coverage to the entire Australian population would mean the following further investments and sites (using the combinations of Medicare Local Boundaries) would be made in each state and territory. In completing this we have made some further economies to bring together some sites under more efficient coordination and natural boundaries.

Return on investment (Model 1):

- Over the next three-year period (the financial years 2015 to 2018), calculating 2 per cent CPI the total investment would be \$42 million.
- Using the findings of the economic evaluation into the StandBy Response Service for this investment the 'net economic benefit' over the three-year period would be between \$19 and \$43 million (calculated on a 50–70 per cent uptake of the service)
- It should also be remembered that the benefits of the StandBy Response Service intervention has lasting benefits so the benefit can only assume to have larger economic returns/impacts than calculated here.

United Synergies Ltd

3. Duplication in current services and programmes

3.1 Key findings

- Many respondents denied that any duplication in provision of services or programmes existed, instead emphasising lack of services and unmet need.
- Most examples of duplicated service provision were linked to overlapping remits of, and lack of coordinated planning between, Commonwealth and state/territory-funded mental health supports and services.
- Some duplication of remit was perceived between Commonwealth programmes, especially Better Access and ATAPS.
- Respondents argued that reducing duplication should be seen as an exercise in increasing equity of access to mental health supports across Australia, rather than as an excuse for cutting services.
- Respondents also thought that reducing duplication should not be at the cost of restricting choice available to people with lived experience.
- A commonly suggested strategy for reducing duplication is a geographically based collaborative mental health needs analysis process and mapping of current service provision to ensure that the introduction of new programmes or services fills geographical or needs-based gaps.

3.2 Overview

Term of reference 2 asked the National Mental Health Commission to assess:

Duplication in current services and programmes

This chapter addresses duplicated provision or remit of services and programmes. Duplication in reporting and administrative activity is addressed separately in Chapter 5 of this document.

3.2.1 Survey question

Organisations and professionals were asked the question:

- a. Please give a specific example of an area where there is duplicated provision of services or programmes.

While people with lived experience, family members and support people were not asked specifically about duplication, we have included in our analysis references made by those respondents to duplicated provision of services or programmes.

3.2.2 Survey responses

For question (a), 37.7 per cent of organisations (n=89) and 22.1 per cent of professionals (n=190) provided a response.

Analysis for this chapter considered three sources of evidence—responses to this particular survey question, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

3.2.3 Note on interpretation of the responses

It is not clear whether the low response rates to this question were because respondents could not think of any examples of duplication or whether they simply chose not to answer the

question. The analysis presented here focuses on examples of duplication which were provided, but this information should be interpreted in conjunction with other thematic findings (particularly those about gaps in provision under term of reference 5).

3.3 Thematic findings

3.3.1 Prevalence of duplicated services and programmes

Duplication as a foreign concept

Of the 75 organisations providing a valid response to the question, a total of 24 (32 per cent) stated explicitly that they knew of no duplication and that, on the contrary, there are not enough services to meet need. Some greeted the idea of duplication with derision or comments such as 'I wish'. The same response was seen in 20 per cent of valid professional responses.

The Australian Psychological Society (APS) is not aware of any instances of duplication of mental health services or programs across Australia. Anecdotal feedback from members of the society is that the demand for mental health services continues to exceed supply.

Australian Psychological Society

Duplication vs. choice

Some respondents argued that duplication is not always a bad thing. They cautioned against removing perceived duplication, which is actually empowering choice among people with lived experience. Others noted that knowing whether one service is duplicating another or not requires a detailed investigation of how, where and with what purpose each is delivered, and whether services which appear to be very similar are in fact catering to different client preferences and need.

Duplication should not be confused with genuine consumer choice around their own individual needs, and services should have flexibility to deliver individually tailored options rather than providing a 'menu' or programmatic response.

De-identified national provider organisation

There is a danger in significantly reducing the 'choice' clients/consumers have as it creates an unequal power balance and reduces clients' opportunity when there is only one provider and this provider only provides a limited number of services in a defined manner.

Merri Community Health Services, Victoria

3.3.2 Types of duplicated services and programmes

Duplication between Commonwealth and state/territory-funded services

Duplication was most commonly perceived to occur as a result of confusion between the responsibilities of different levels of government to directly deliver services.

Australia's mental health system is trapped in multiple inefficiencies of cost and efficacy, in large part because of the sheer complexity of funding, levels of government, departments, delivery points and pathways. Successive well-intentioned governments have responded to this by new initiatives which only serve to create new levels of complexity onto those which already exist. [...] Further, funding must focus on the person's recovery ahead of existing organisational, professional or governmental preferences.

SANE Australia

Examples of Commonwealth/state duplication of service delivery usually were framed in terms of Commonwealth-funded services being 'dropped' into an area without adequate consultation about local need or existing provision. This can result in a confusing multiplicity of uncoordinated services in particular geographical areas, as illustrated by this nurse's experience working in Victoria.

Historically the service planning and program implementation catchments of Commonwealth programs do not align with state-funded catchments. This leads to a swathe of services operating within areas that are poorly understood by professionals, let alone the general community. This has also been exacerbated historically through the process of tendering for services, which has also led to a multiplicity of providers operating within geographical catchment areas.

Nurse, Victoria

Examples mentioned multiple times:

- Existing arrangements for care coordination in an area being duplicated by the introduction of Partners in Recovery.

PIR - Central West and Western NSW There already exists, in [regional towns in this area], Care Coordination Committees whose role is almost identical to Partners in Recovery. Why did someone not do a needs analysis and find this out?

Psychologist, New South Wales

- Duplication of public community mental health services in some areas by Commonwealth-funded services which are perceived to do the same job. An example cited several times was the introduction of headspace centres to towns where public child and youth mental health services and youth support NGOs were already operating.

There seems to be overlap in our region between the services provided by Jigsaw and headspace. As a local psychologist I cannot confidently say that I am aware of the difference between these services and what would constitute an appropriate referral to one and not the other.

Clinical psychologist, Victoria

Duplication between Commonwealth programmes

The most commonly cited case of duplication between Commonwealth-funded programmes was between Better Access and ATAPS. While respondents acknowledged that the purpose of these two initiatives was different, many argued that they did not work in practice as intended.

- Many private psychologists saw ATAPS as an expensive, over-administered version of Better Access. Some told of their experiences of trying to get registered as an ATAPS psychologist, reporting that they had given up because of the amount of paperwork and re-education required even for very experienced clinicians.
- In many areas there is a perverse situation where the least qualified professionals are seeing the most complex clients. This is because of the comparative pay structures of the two programmes. While registered psychologists can earn more under ATAPS payments than under Better Access rebates, for clinical psychologists the situation is reversed and they gravitate towards Better Access.
- Although the idea of targeting funds for certain disadvantaged communities through ATAPS is thought to be a good one in principle, many respondents felt that the same goal of addressing disadvantage could be achieved using the less onerous administrative and governance arrangements of Better Access through bulk-billing arrangements.

Remit duplication

Examples were given of services which seemed to be catering to the same need. These included:

- Many government-funded organisations running similar initiatives such as mental health helplines and online resources, including in the suicide prevention space and the youth mental health space.

Australia has a large number of mental health telephone helplines and online services, which operate independently and cause confusion and difficulty for people seeking help. There is an opportunity to improve the efficiency and effectiveness of telephone support lines in particular. Australians should have a single national number to call as a starting point. National helpline workers could ask and assess what people need and then connect them to the most appropriate service or support, which could range from online therapies to other, highly specialised lines, crisis services or simply information. Technology could link up information and show where and how people are travelling through 'the system'. This would avoid duplication, minimise the risk of people 'falling through the cracks', and measure outcomes. It would also provide savings to government by minimising the management costs inherent in managing multiple contracts.

Beyondblue

- Local NGOs with ‘psychosocial support’ remits not being clearly differentiated from each other or from government services.

A number of government and non-government services in WA are funded for psychosocial support and/or clinical rehabilitation. However, there is a lack of guidance about which agencies should target which needs, resulting in duplication and under-utilisation of excellent services.

Allied health professional, Western Australia

3.3.3 Reported consequences of duplication

Inequitable provision between metropolitan and other areas

Respondents pointed out that it often is the wealthiest areas of the country which also have the best mental health provision and the greatest choice of public and private providers. Eastern Sydney and metropolitan Perth and Brisbane were all cited by multiple respondents as being over-supplied with services.

The RANZCP has concerns that the ongoing lack of Commonwealth-state coordination in funding and service provision creates significant regional disparities in service provision, from very high in inner city areas to very variable outside these. The RANZCP would like to highlight the lack of data exploring the apparent poor access to services in outer metropolitan areas that are often very socio-economically disadvantaged and in high need of mental health support.

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

Inequitable provision between different rural and remote communities

Numerous examples were provided of communities in regional, rural and remote Australia which have been descended upon by multiple providers, creating duplication of services in some communities while their neighbours go without. However, the chaos produced by the number of (often visiting) providers means that community needs still are not met.

We know that in some regions there are too many visiting services with overlapping and sometimes competing roles that do not collaborate or work closely with either the primary health care service or each other. This leads to inefficiencies, miscommunications and a lack of a patient and family-centred approach. It also takes up a huge amount of primary health care time and does not employ or involve local Aboriginal people who know the community and can provide sustainable, culturally appropriate care.

Aboriginal Medical Services Alliance Northern Territory

Impact on people with lived experience

Many services which appear to do the same thing can make it more difficult for people with lived experience, family members and their support people to navigate their way to appropriate services. This also can result in people with multiple needs receiving a fragmented

service, where providers deal with a narrow problem and do not talk to each other. We also received reports of mental health clients having multiple case managers.

There are a number of programs in western Sydney that provide services to a range of people with mental illness. These include federal and state-funded services which are distributed to a number of NGOs, private and state organisations, many of which essentially deliver services to the same or similar population group. Many of these programs are offered by more than one provider (organisation), adding complexity for the patient to navigate the system.

WentWest

Impact on providers

Where many small providers compete for funding in a small community, service provision and care coordination can become less important than survival.

In one community within our region with a population of 15,000 persons, as many as 17 organisations are in some way involved in service delivery or service support. While options and choice for the consumer are ideal and should be promoted, it becomes impossible to better coordinate services when the organisations have to focus on service delivery but also continuity of their organisation.

Country North South Australia Medicare Local

2.3.4 Suggestions to reduce duplication

- Use systematic geographically based needs and gap analysis, as well as meaningful community involvement, to form the basis of coordinated service planning.
- Prioritise filling gaps in areas where needs are not being met by existing services, rather than aiming for universal coverage of a particular programme.

Scoping rural and remote community needs is required to identify local issues prior to programme development. Such scoping would provide a deeper understanding of rural and remote mental health care needs to which health care provision can then be tailored for greater efficiency and effectiveness.

Mental Health Academics of the Australian Rural Health Education Network

- Examine opportunities for pooling Commonwealth funding to particular geographical areas to enable local decision-making about mental health priorities and needs.

To avoid duplication of services and ensure local needs were met it would seem appropriate to pool all primary mental health funding (i.e.: Commonwealth and state, including for example MH Nurse Incentive scheme, ATAPs, PHAMS etc.) and allocate these to Medicare Locals on a flexible basis—allowing them to commission a fully integrated primary health care service system based upon the identified and agreed needs of their local communities: thereby cutting out duplication and waste and targeting those most in need.

De-identified Medicare Local

- Examine opportunities for leveraging collaboration in particular localities between programmes or organisations which have similar remits and a shared vision.

I had a maternal health nurse call me up this week to work out how she could best refer a struggling father to me for psychological therapy. She had initially referred to me via ATAPS, but then realised that I was not registered for ATAPS. She subsequently sent this father to his GP to get a Mental Health Care Plan so he could see me under Better Access, but the GP refused to do a referral ... A cost-effective and non-stigmatising system would allow people to be referred to a clinical psychologist by a variety of health professionals, schools or even self-refer.

Clinical psychologist, Victoria

3.4 Promising practice examples in avoiding duplication

3.4.1 Mates in Construction

Mates in Construction [a suicide prevention and mental health case management scheme for construction workers] is provided in Queensland, New South Wales, South Australia and Western Australia. Similar programs are provided in Victoria through Incolink, the Australian Capital Territory and Northern Territory through Oz Help Australia and in Tasmania by OzHelp Tasmania. Each of these organisations has formed a collaborative working party that ensures service provision is not duplicated and that a joint message of mental health and wellbeing is delivered to the industry. OzHelp and Mates in Construction have jointly created the Life Skills Tool Box Pty Ltd initiative aimed at pooling our resources in development of a program targeting young workers.

Mates in Construction

3.4.2 Federal and state-funded services collaborating

The [Medicare Local] is, in partnership with the [Local Health District] developing an integrated care model which will be built upon an established base of longstanding strategic relationships and local joint services including government, non-government and private sector service providers. Through increased integration, the [area] will have a responsive, flexible network of service providers and improved capability of the primary health care sector to increase their capacity to provide local services that add value and reduce duplication. [...] Local commissioning of services will ensure that services meet the needs of the community, improve access, provide better outcomes and are efficient and sustainable at a regional level. Integrated service delivery will reduce duplication and span service gaps through new models of care, new or improved workforce roles/capability and improved operational efficiencies.

Central Coast NSW Medicare Local

4. Efficacy of programmes and services in supporting aspects of a contributing life

4.1 Key findings

Respondents identified a number of key characteristics of an effective journey for people with lived experience, their family and support people. These include:

- Easily and readily accessible mental health services.
- Effective and ongoing collaboration and communication between mental health care providers.
- Effective therapeutic relationships with mental health providers.
- Holistic and individualised approach to recovery, meeting the needs of the “whole person”.
- Peer support, community and family support.

Effective support for a contributing life included four main characteristics. These were:

- Coordinated approach to provide integrated mental health support.
- Ongoing and community-based mental health service delivery.
- Supportive community environment.
- Inclusion of community, family members and friends in recovery.

Primary barriers to supporting a contributing life included:

- Inaccessible, unaffordable professional services and support.
- Over-emphasis of medical model approach to mental health therapy and recovery.
- Ineffective utilisation and integration of services and agencies.
- Social exclusion and stigma for those experiencing mental illness.

Strategies to produce “whole-of-life” outcomes included:

- Increased opportunities and support for those experiencing mental illness outside mental health services.
- Integration of opportunities for social participation, engagement and inclusion.
- Use of a whole-of-community approach to mental health support and integration.
- Family-oriented service delivery.

4.2 Perspectives of people with lived experience

Mental health is something that affects so many Australians during their lifetimes, whether it's through them experiencing issues with mental health themselves or watching someone close to them experiencing issues. Therefore, I believe that it should be held as a top priority at a government level to make sure that our system of delivering mental health services is a supportive, efficient and as well formed as we can possibly make it.

Person with lived experience, WA

Living with mental health conditions is difficult because stigma makes it hard to speak up about your issues. At the same time, you don't have a physical sign that makes the community aware that you need a little bit of extra support. A person with a broken leg carries crutches and will receive the kind help of strangers. A person going through depression may be brushed aside. While the government does not have a huge role in this particular aspect of living with mental illness, it's important to remember that these attitudes are pervasive. We will fund cancer research because the effects of cancer are obvious—and devastating. We forget that the DALYs [Disability Adjusted Life Years] of mental illness are often greater. The costs to our economy, society, and services as a result of mental illness are well worth re-looking at funding models.

Person with lived experience, New South Wales

4.3 Overview

This chapter assesses submission responses which address experiences and outcomes for people with lived experience, family members and support people. It responds to two terms of reference, as follows.

Term of reference 3 asked the National Mental Health Commission to assess:

The role of factors relevant to the experience of a contributing life such as employment, accommodation and social connectedness (without evaluating programmes except where they have mental health as their principal focus).

Term of reference 1 asked the National Mental Health Commission to assess:

The efficacy and cost-effectiveness of programmes, services and treatments

The 'cost-effectiveness' aspect was the subject of a separate analysis (Chapter 2 of this document). The current chapter deals with the 'efficacy' aspect of ToR 1 in terms of improving the lived experience of people living with mental illness and their family members and support people.

4.3.1 Survey questions

Organisations and professionals were asked to give an example of a service or initiative which:

- a. supports multiple aspects of a contributing life (e.g. physical health, housing, education and training)
- b. has proven to be efficient and effective and has resulted in good outcomes for people experiencing mental health problems and/or their families
- c. does not effectively address or meet needs of the whole person (e.g. physical health, housing, education and training)
- d. results in people living with mental health problems and/or their supporters having a poor experience
- e. has proven to be inefficient or ineffective and has not resulted in good outcomes for people experiencing mental health problems.

Although these were the questions directly related to supporting a contributing life, references to improving the lived experience of people with mental illness and their family members and support people also were found throughout responses to other questions in the survey and were coded appropriately. Material from unsolicited submissions was also considered.

People with lived experience and support people were not asked to provide any specific examples regarding aspects of a contributing life, but relevant references to this issue were found throughout their responses and coded accordingly.

4.3.2 Survey responses

For question (a), 67.4 per cent of organisations (n=159) and 51.8 per cent of professionals (n=446) provided a response.

For question (b), 51.3 per cent of organisations (n=121) and 38.7 per cent of professionals (n=333) provided a response.

For question (c), 56.4 per cent of organisations (n=133) and 42.5 per cent of professionals (n=366) provided a response.

For question (d), 66.1 per cent of organisations (n=156) and 56.3 per cent of professionals (n=485) provided a response.

For question (e), 36.0 per cent of organisations (n=85) and 29.5 per cent of professionals (n=254) provided a response.

4.4 Thematic findings

4.4.1 Aspects of an effective journey for people with lived experience, family members and support people

The Commission received many stories from people with lived experience and support people of positive encounters with health and other support services. Most often, these related to the support of one individual professional who went out of their way to ensure a person was well cared for. However, there were also examples of journeys of people with lived experience through multiple services which worked together to achieve both a positive experience and a good outcome.

Friends who sounded the alarm, the family GP who contacted a terrific psychiatrist and a really wonderful clinic in the next suburb. All of these contributed to a speedy diagnosis of depression. A fast turnaround with drugs and two weeks of psychologist-directed group sessions inside the clinic, allowed the young person to learn from others in the same boat, how to recognise the signs of stress and to reach out for help if things start to overwhelm. The system really worked for us because the groundwork had been laid by heaps of media coverage of mental health issues and a lifting of the stigma attached.

Support person, New South Wales

Key characteristics of a positive journey for people with lived experience, a family member and support person include:

- easily and readily accessible mental health services
- effective and ongoing collaboration and communication between mental health care providers
- effective therapeutic relationships with mental health providers
- holistic and individualised approach to recovery, meeting the needs of the 'whole person'
- peer support, community and family support.

4.4.2 Characteristics of effective support for a contributing life

Coordinated approach to provide integrated mental health support

Examples were frequently provided of effective collaboration and coordination with various service providers and other disciplines to provide a person-centred approach to recovery involving various aspects of an individual's life. An individual approach to recovery that incorporated various life aspects and multiple disciplines often was perceived to be effective.

Building up a team of health professionals to support different aspects of a mentally ill person's life, such as a GP, psychologist, psychiatrist, art therapist, school liaison, social worker, etc. Good case management of this team is essential; there is often no clear person to fill this role and the patient or carer often lacks experience to fill this role well.

Person with lived experience, Victoria

Positive examples also were commonly mentioned where educational institutions were engaged in mental health support.

I work in the public education sector in policy, planning and management of psychology services for preschool (kindergarten) and school age students. Managing mental health issues for children and youth works well when a psychosocial perspective is taken and a team is wrapped around the young person, coordinated by a delegated lead professional. Engaging the education support services and school staff is critical to support the young person.

Psychologist, South Australia

Other successful examples often mentioned included the inclusion of services that offered support for drug and alcohol use, as well as housing and employment assistance.

After the problems listed below, I finally started seeing a clinical psychologist who bulk-billed me in mid-2013, after my doctor did a referral to him under Better Access to psychologists. They finally did a proper assessment of my life and drug and alcohol and mental health. They got me doing homework tasks and taught me relaxation to use instead of drugs and alcohol. Since I have been seeing this person I have done very well. I am on a disability pension due to my mental health but am now starting to look for work. I have cut back my drinking and stopped using drugs.

Person with lived experience, New South Wales

Ongoing and community based mental health service delivery

People's mental health needs extend beyond the walls of an acute mental health ward.

Support person, South Australia

Mental health is a lifelong battle for many people in our community. Long-term support and ongoing access to psychologists can mean the difference between a precarious existence spent in and out of hospital and surviving day-to-day, and living a fairly stable, almost normal life as a productive member of society.

Person with lived experience, Victoria

Respondents often provided examples where ongoing support delivered in the community allowed recovery to occur outside the acute care or 'traditional' mental health setting.

Commonly, respondents provided examples of how positive life outcomes were received by integrating mental health services into peoples' daily lives.

An important aspect of community-based supports appears to be that these are provided for as long as a person needs them in order to attain meaningful personal and clinical recovery and to return to full engagement in life.

The use of trainee (Master of Psychology - Clinical) students at [name removed] University to provide an extended (now over 2 years) community-based treatment program for a [young] male. He had been housebound for [many] years (could not even walk to the house letterbox) suffering severe social anxiety, panic disorder, depression, and agoraphobia. Suicidal risk was extremely high at the time of referral which came via his mother seeking help from a private clinical psychologist for her own anxiety and depression. Notably, the standard public health (CAMHS) service and private psychiatry since age nine could not meet his clinical needs. The client is now catching public transport, going into shops and purchasing goods, studying online, obtained a learner's driver's license, etc. While there is still work to go, the client's sense of future is now hopeful and positive.

Clinical psychologist, Victoria

I make reference specifically to the Mental Health Nurse Incentive Program. This program has demonstrated that it stops hospital admissions, allows people to remain at home and in their own environment and to remain employed. It supports both client and carer and is cost-effective. As there is no session limit in this program, I may respond to client's needs as and when necessary. I have many concrete examples, should you wish to hear of them, where clients have been free to live lives without fear of hospitalisations and concomitant loss of job, self-esteem and even family.

Mental health nurse, New South Wales

Supportive community environment

A supportive environment in the community setting was mentioned as significant to aid recovery, experience of a contributing life and positive mental health outcomes. Mental health support, awareness and understanding from employers and educators were examples of vital non-clinical supports for recovery.

An employer who you can feel comfortable talking with about mental health issues and any ways it might affect your work. Understanding and a little bit of flexibility on occasion is something I am very grateful for. I am more loyal to my employer because of this.

Person with lived experience, New South Wales

The option in schools or universities to talk to a counsellor or a trained professional in such areas about any problems regarding school, family, friends or mental health. In my personal experience during both high school and university they have made sure we are aware that these types of services are provided for us. I think that has worked well and the fact that they are making us more aware that mental health problems are real problems.

Person with lived experience, New South Wales

Inclusion of community, family members and friends in recovery

Support from family members, friends and peers from the community can make an important contribution to positive mental health outcomes. The need for support services to proactively involve informal support networks in the care 'team' is encouraged by both support people and people with lived experience. This helps individuals feel less isolated and alone in their recovery, and enables family members and support people to receive the valuable advice and support they themselves need.

I think that having an integrated approach where the mental health professionals involve family and friends in a care plan can work very well. In my experience as a carer, it is really helpful to understand what services are available, and what the community team is planning.

Support person, Victoria

Such inclusive services include family-centred services and specific support for families and other support people. Services which come to meet people in their home context also were highly praised by people with experience of mental illness.

I personally have found that having a mental health nurse regularly visit me in my home has not only been beneficial for me but also for my children and my husband; she supports all of us, not just me. She has been extraordinary really in her support: you hear of so many cases of family breakdowns due to mental illness and I know that would have applied to us if it wasn't for the support of my mental health nurse.

Person with lived experience, Victoria

Formal and informal support groups often are mentioned as aiding in recovery and providing meaningful opportunities to connect with others in the community.

Group programs give meaningful experiences, opportunities for sharing experiences, give a voice, socialising, stimulation and an opportunity to be considered for who they are, and recognise the skills they do have.

Support person, Victoria

Groups! Meeting people with the same or similar issues. Or even people who are totally different, who can help each other. Buddy systems. Social things. Obviously it would be harder for people with social anxiety and things like that, but for other issues and mental health problems it can be really awesome to meet people who can identify personally.

Person with lived experience, New South Wales

Peer Support Groups and our 24/7 Peer Grief Telephone Support Line has proved efficient and effective, resulting in good outcomes to bereaved parents and siblings. Frequently we receive written expressions of the fact that the connections with these services ‘saves’ people’s lives and sanity and ability to rebuild their lives. The words of the parents who use the services best articulate this message:

“When I lost my daughter to suicide I was put in touch with The Compassionate Friends quite quickly. The support that they gave me in those early dark days was immeasurable. Without the ongoing contact with other bereaved parents, people who actually understand what I am going through, I think I would have lost my sanity. At every meeting I attend I find a comfort in knowing I can speak about my feelings and my lost daughter and not be judged or misunderstood.”

The Compassionate Friends Victoria Inc.

4.4.3 Primary barriers to supporting a contributing life

Inaccessible, unaffordable professional services and support

The existence of multiple barriers to accessing appropriate mental health supports was one of the main concerns highlighted by all groups of participants. Access difficulties often were attributed to the cost of services, stigma and inflexible working practices. Inflexible eligibility criteria for a service were criticised by many—where it was felt to be obvious that a certain service would help a person but, because of their age or diagnosis, they were prevented from using supports that would have helped their recovery. Organisations quoted many instances of people being told that they are either ‘too complex’ or ‘not ill enough’ and then being turned away completely or being ‘fobbed off’ to one agency after another. In rural and remote areas, the requirement to see a GP to access other MBS mental health services often was felt to be a barrier due to lack of GPs in some areas.

This inflexibility is related to a common perception that services and professionals are organised for their own convenience, rather than around the needs or preferences of people using them. A ‘one-size-fits-all’ approach is seen to predominate over a person-centred, needs-based approach. The tendency of services to work in silos also results in a failure to recognise peoples’ interrelated needs. This was especially frequently mentioned in relation to physical health needs being allowed to deteriorate by services which only can ‘see’ a person’s mental health diagnosis. For people with complex needs, only having one element of their problem addressed while other elements are neglected can reduce the impact of any help that is provided. There appears to be a widespread failure to take a whole-of-life approach to support.

Common examples provided by respondents indicated the inability to access ongoing professional support with the current number of Medicare-subsidised appointments.

I think 10 sessions is not enough support. Mental health is not like a physical illness where it just 'heals'. It can linger and remain present; the symptoms may become less severe but they do resurface and although I have weeks where I feel fine, there are also weeks where I can barely survive. Having the ability to see a psychologist when I need to would be really beneficial. Mental health does not operate on a 10-week time frame, therefore neither should treatment.

Person with lived experience, Victoria

Mental health issues are not solved in such a short space of time and people need ongoing help to achieve better outcomes. For someone to miss out on seeing a psychologist because they have run out of sessions and can't afford the ongoing costs is unacceptable.

Person with lived experience, Victoria

Over-emphasis on medical model

Respondents often mentioned that an over-emphasis on medical treatments and psychological interventions was a barrier to achieving a positive mental health outcome and long-term recovery. Examples often were provided of the need to consider the 'whole person' and all aspects of an individual's life in order to produce positive mental health outcomes.

Medical-centric service delivery that emphasises medical symptoms over social, personal, financial, environmental issues. People's lives are very complex and to treat perceived symptoms conveniently ignores the many other barriers and issues that a person may be experiencing.

Person with lived experience, South Australia

I feel that there is an over-medicalisation of mental health which leads many treating doctors to ignore the broader context of patients' lives and the broader contributing factors which lead to people being unwell. There is a tendency to treat the symptoms of mental illness rather than to undertake the more time-consuming and relation based work of helping patients to build their own self-awareness, identify triggering events and patterns for poor mental health episodes or to find strategies for coping with long-term mental health problems. A person with mental health issues is a whole person and they come with lived experiences, challenges, family relationships and so on. They are not merely a patient with symptoms.

The attitude of some medical staff (not all) is that they are the experts and that family members are a nuisance that need to be 'handled' or managed. This is a shame, as concerned family members and friends can often have knowledge of the broader context behind a patient's mental illness, as well as knowledge about symptoms, behaviour and patterns which it might be difficult to gain from discussions with a mentally ill person.

Support person, Australian Capital Territory

Lack of collaboration between services and agencies

The complexity of coordinating and navigating the wide range of agencies and services involved in supporting a contributing life was felt by many to be a barrier to effective whole-of-life approaches to people's needs.

Provision of care and support for people with mental health issues lacks effective coordination across healthcare, community services and support payment systems. The nature of mental illness increases the likelihood that consumers will interact frequently with multiple parts of the healthcare system, relevant community services (including employment services) and support payment systems. However, there is a lack of coordination between these systems. [There are a] large number and variety of service providers that contribute to the complexity of the mental health system. In this context the coordination of an individual's care and support across the different systems is a challenging task.

Community Services and Health Industry Skills Council

Fragmentation and siloed working negatively affects people when they fall through the cracks between organisations and as a consequence do not have any of their needs met. This contrasts with the continuity of care and trusting relationships with professionals which many view as essential components of a person's recovery. Damaging and traumatising experiences, some ending in the suicide of the person concerned, were reported to be the result of being pushed around between services. In some circumstances, informal carers can become the only consistent source of support.

Communication between and within departments in the health system, mental health system, community mental health system, private health system, NGOs, housing and other departments involved in the consumers' lives is very poor. We, the carers, have had to become the co-ordinators. We have many examples of the miscommunication and inappropriate actions. You have only asked for one example but one example does not demonstrate how bad it is or how much it impacts on the person and their family.

Support person, Australian Capital Territory

Failure to collaborate was especially often mentioned in relation to the interface between the public sector and private sector, the interface between mental health and substance misuse services, and between disability or physical health services and mental health supports. This results in a general failure to support complex or interrelated needs in a holistic way.

For example, if a client goes to a drug and alcohol service to deal with their drug addiction issues, they are not being supported for other issues such as trauma, medication management and housing support. These services all tend to run separately and can become disjointed in their approaches to managing clients.

Counselling psychologist, Western Australia

Examples also were provided by people with lived experience, family members and support people of being unaware of or unable to access various services.

In the four years since our child has been diagnosed we are still finding out about services that would have been immediately available to us and very helpful but because we did not know about them have not accessed. e.g. health care card, disability support at school, special programs at the [name removed] school. These services would have made a huge difference to our child and family.

Person with lived experience and support person, Victoria

Social exclusion and stigma

People with lived experience commonly reported encountering stigmatising attitudes from employers and other members of the community, which had the effect of excluding them from opportunities to achieve a contributing life.

I had to leave my last job because of a combination of bullying from a co-worker and a boss who didn't understand depression; she suggested that, although my standard of work was not an issue, I should stay home when I am depressed because I dragged the whole team down.

Person with lived experience, Victoria

Schools and all workforces need to realise that mental health is very real; just because it's not a physically visible disorder does not mean it's not real. We aren't lazy or irresponsible; we're incapable of getting out of bed for the most part, and our brains lack a specific chemical. It's not because we're trying to get out of work/school because of laziness.

Person with lived experience, Western Australia

4.4.4 Suggested strategies to support positive “whole-of-life” outcomes

Increased opportunities and support outside of health services

Increased opportunities for gaining secure housing and employment often were mentioned as necessary to facilitate mental health recovery and result in positive outcomes. The provision of stable accommodation was seen by many as a prerequisite for starting on the road to recovery.

The Doorway project, by Mental Illness Fellowship in Victoria, has ... [helped] 50 people with a mental illness and their families who are homeless or at risk of homelessness to secure housing in the private rental market. Early evaluation of The Doorway in 2013 has found that those who have participated in the program have improved their day-to-day living skills in areas such as financial planning and maintaining their housing and have experienced greater connection to their community.

Psychiatric Disability Services of Victoria (VICSERV)

In terms of employment, some respondents felt they needed to access a specific programme to support them into employment, recognising their experience with mental illness. Others felt that the onus should be on employers to create flexible working practices and support to enable them to fulfil their potential.

Applying for jobs and going to interviews is stressful for anyone, but when you have anxiety it feels almost impossible. I know that if someone would just give me a chance that I am as capable as anyone else. I think that's why more emphasis should be placed on creating opportunities for job seekers with mental health problems, rather than throwing them in the pool with everyone else out there who is also looking for a job. I also think that specific support needs to be provided to jobseekers with a university degree. DESPs [Disability Employment Service Providers] seem to be more geared towards helping unqualified jobseekers look for work.

Person with lived experience, Queensland

Engagement with the community through social and recreational activities is important to many people with lived experience to maintain and improve their mental health. Opportunities for physical activity and other creative or recreational activities frequently were acknowledged as positive in contributing to recovery and developing a sense of social inclusion, meaning and life purpose. Supporting children to remain in school despite difficulties also is cited as an important way to promote and enhance their mental health.

In Aurukun there exists a range of primary school children who had not been engaged with the schooling system and who have very low/poor social supports and traumatic histories leading to emotional difficulties. The RFDS (Queensland) Wellbeing Centre initiated a program to target these children and be involved across a full spectrum of needs. The program involves collecting children from home where necessary, providing a nutritional breakfast, walking to school, remaining in class with the children *and intervening when emotional difficulties arise. After school the children are involved with a range of sporting, art and craft and music activities along with assisting their support workers with a range of ancillary duties such as tidying and gardening Wellbeing Centre grounds.*

Royal Flying Doctor Service

Whole-of-community approach to mental health support and integration

Examples commonly mentioned the need for a “whole-of-community” approach to help those experiencing mental illness, their family members and their support people achieve positive whole-of-life outcomes. Examples were commonly provided of the need to increase mental health awareness within the community and provide all individuals with the tools needed to help and support those who are experiencing mental illness.

The prevalence and burden of mental health problems in the community is so great that we need a whole-of-community approach where every citizen has some skills in how to support their own and other people's mental health, including prevention and mental health first aid skills. Carers and consumers also need to be trained, because they are the real frontline of care.

Researcher, Victoria

Family-oriented service delivery

People with lived experience, family members and support people commonly mentioned examples of how mental illness is a family experience, and that to ensure adequate outcomes, mental health support also is required for carers and the ‘whole family’. Examples often were provided of carers and support persons themselves experiencing mental illness which was perceived as an added barrier to achieving recovery and positive outcomes.

Services need to be more family-oriented to support the family unit as a whole. It is the carers/families/support people who are the one constant in their lives and when all else fails they are the treating team. The family needs to be included, listened to and informed and educated on equal terms and not be looked on as part of the problem. The family is very important in supporting consumers to lead better quality of lives. We need more understanding, less stigmatisation, more education and support.

Support person, Australian Capital Territory

4.5 Positive programme examples contributing to positive “whole-of-life” outcomes

4.5.1 Partners in Recovery Programme:

My ... son has suffered from schizophrenia for nearly 13 years. He has had four occasions of acute care in mental health units. The effect on his family has been devastating, financially, emotionally, physically. When my son is in psychosis he is a danger to me, his mother, and has violently assaulted me on a number of occasions. Acute care has worked to making him psychologically well, but as soon as that care stops, he goes off medication and becomes acutely unwell again.

In recent months he has connected with Partners in Recovery. For the first time in 13 years he is supported, has stable supported housing, is getting physical and psychological support, is being assisted to gain employment, training, social engagement. For the first time in 13 years, I feel safe from attack; I can become a parent again, can see a time when my son reconnects with family and community, gains employment, gets off Disability Pension, pays taxes. He can have a life again and so can I. PIR has been fantastic wrap-around support for consumers, but most of all, it has been of enormous benefit for CARERS. I plead that PIR remains, is given time to be established and measured—there is nothing else for people like my son who is living with severe and persistent mental illness.

Support person

Example of an effective “whole person” approach to recovery:

The philosophy of the Harte Felt Centre provides evidence-based services from a person-centred perspective. We don't work from the medical model which categorises people into diagnoses but formulates people's problems and mental health issues from an evolutionary and developmental perspective. "What has happened to this person that has led to their behaviour being this way?" From this perspective we ascertain what has contributed to this person's problems and look at how to respond in respectful and collaborative ways. We aim to understand and support people using evidence-based interventions but from a non-pathologising perspective. We see people as fellow human beings who haven't been given the same opportunities as others or who have had trauma as part of their background history. We understand mental health as at times circumstantial, a "cry for help" and not just a malfunctioning of people's brain chemistry. Our clients respond really well to this evidence-based philosophical and theoretical approach. The outcome is seeing people who have journeyed into despair and dysfunction come through to living full and empowered lives.

Registered psychologist, Victoria

Example of a successful supported employment service for mental health recovery:

Cleanforce—a subsidiary of Wise employment services—Amazing and inspiring example in Melbourne of a successful social enterprise that has soul and meaning and is making a difference to vulnerable people's lives via work. 80 per cent of the workforce starts working at this organisation with a severe mental illness and are nurtured to get well through work and support and patience but also boundaries where the commercial reality is gently but firmly addressed. Many success stories—the workforce is ready for the open market in about 5 years. All are paid on an award rate; this is not a working shelter but a real workplace. One person who started had severe schizophrenia, after 5 years he was able to go to university and graduated as a doctor!

Consumer advocate, Victoria

5. Regulation, reporting and red tape

5.1 Key findings

Service providers and professionals recognise reporting as an essential aspect of system regulation and service and programme accountability. Respondents tell us that reporting is appropriate when:

- reported information does not just go one way—that it is used and becomes part of a whole system of feedback
- reported information can be used to assist in planning and for quality improvement efforts both by the reporters and by the authorities requesting the information.

However, there are many circumstances in which reporting currently is not considered a productive activity, including where:

- reported information is ‘sat on’ by the authority requesting it, without being used
- multiple funders and agencies request similar information, resulting in duplication of effort by organisations and professionals
- reporting requirements are subject to gaming, have perverse consequences or have a detrimental effect on the quality of care delivered to people with lived experience.

Suggested steps to improve the effectiveness and efficiency of reporting for regulation and accountability purposes included:

- Focusing data collection on clinical and whole-of-life outcomes as well as activity.
- Streamlining reporting requirements by rationalising funding sources and assessment/referral pathways, and by developing consistent, user-friendly data collection tools which can be standardised nationally, harnessing the power of ICT.

5.2 Overview

Term of reference 4 asked the National Mental Health Commission to assess:

The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services

5.2.1 Survey question

Organisations and professionals were asked to give an example of a service, programme, policy or initiative which:

- a. demonstrates effective and efficient use of reporting
- b. is subject to excessive red tape
- c. is not subject to excessive red tape

While people with lived experience, family members and support people were not asked specifically about reporting and red tape, we have included in our analysis references made by those respondents to this issue.

5.2.2 Survey responses

For question (a), 52.1 per cent of organisations (n=123) and 43.3 per cent of professionals (n=373) provided a response.

For question (b), 50.4 per cent of organisations (n=119) and 46.7 per cent of professionals (n=402) provided a response.

For question (c), 56.8 per cent of organisations (n=156) and 49.9 per cent of professionals (n=430) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

5.2.3 Note on interpretation of the responses

In our analysis, we interpreted ‘reporting requirements’ to mean regular submission of any information about the provision of mental health-related supports to a funding or oversight organisation. The reporting may be done either by organisations or by individual professionals.

Many individual professionals, especially those providing services under Better Access, regard the reporting of a client’s progress to the referring GP to be their primary reporting activity.

‘Regulation’ has been interpreted here as ensuring compliance with policies, laws, rules and guidelines. Reporting is the principal mechanism through which regulation is achieved.

5.3 Thematic findings

5.3.1 Overall

The importance of reporting and regulation

Respondents to our surveys emphasised the real everyday impacts that reporting and regulation activity had on their practice or on their experience of services. What stands out in the respondents’ commentary about reporting is that this activity should not just be for the benefit of regulating authorities. They gave us many examples of where reported information is used in multiple (and creative) ways by the reporters themselves, to improve the quality and safety of their services, to assess gaps, to assess trends over time, to assist in service planning, and to inform and improve the care they offer to an individual client in real time. In turn, reporting by third parties to the providers (such as client satisfaction surveys) was thought to be useful to improve the responsiveness of services.

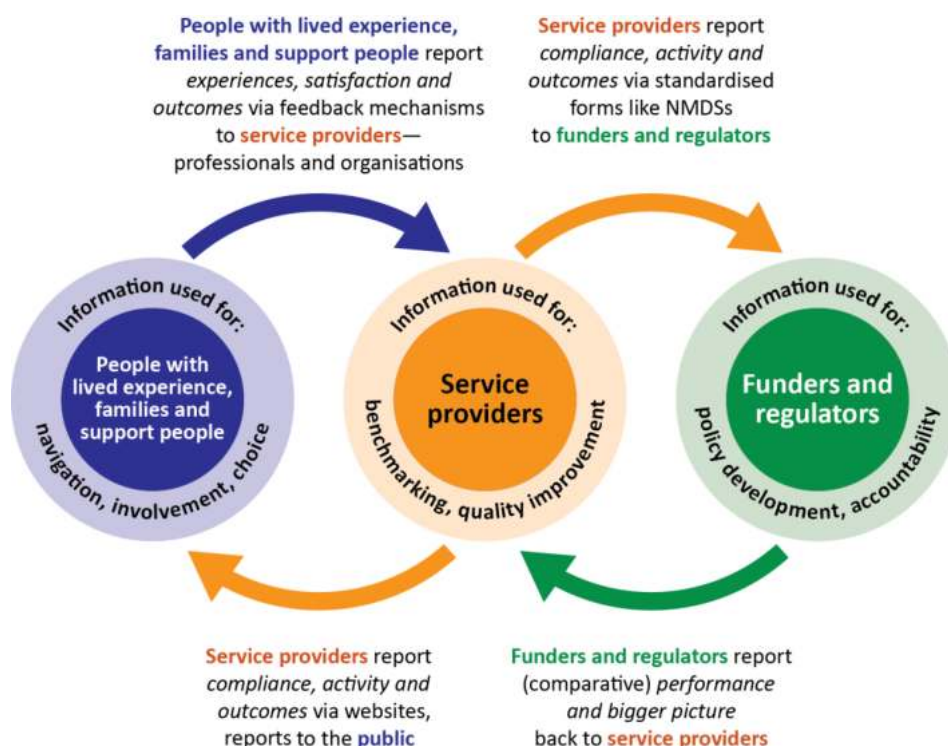
There was a tension evident in some responses regarding the right balance between convenience and accountability. For example, levels of reporting required of private providers under Medicare Benefits Schedule services generally is praised by providers as being manageable. However, some argued that convenience for providers needed to be balanced with governments’ need to know if they are getting good value for money.

5.3.2 Characteristics of effective and efficient regulation and reporting

Reporting should be useful to all stakeholders

Figure 1 represents a summary of what respondents want from a reporting and regulation system. From the perspective of those working in and receiving services ‘on the ground’, reporting should not be a one-way process (from provider to funder or regulator) which ultimately becomes a chore. Reporting to funding or regulating authorities should instead be part of a purposeful, whole-of-system feedback loop which drives improvement.

Figure 1 Summary of reporting and regulation relationships



Respondents want reporting to be useful to people with lived experience and carers, service providers, regulators and funders alike. They want information to be available in a form which can be easily interpreted and used. They want streamlined collection and reporting mechanisms, where information can be submitted once and used many times. They recognise that all stakeholders in the mental health system have a role to play in sustaining the feedback loop, and it needs to be as easy as possible for each stakeholder to play their part.

Effective reporting between people with lived experience and service providers

For organisations, effective service provision means using reports about quality, outcomes and satisfaction directly received from people with lived experience and their support people to improve the responsiveness of the service to local need. Collecting this information requires establishing accessible mechanisms for submission of feedback by people with lived experience and their families and supporters; more than this, it requires their meaningful involvement in determining what this feedback means for quality improvement.

ReachOut.com employs a suite of measures designed to obtain continuous feedback on our service and thus implement ongoing improvements, including regular monitoring of Google analytics, the ability for visitors to rate and comment on individual pieces of content or tools, regular rounds of user experience testing as well as an annual cross-sectional survey. The findings from each of these are then used to continuously implement improvements to the service, ensuring that it remains relevant and of a high quality.

ReachOut Australia

For professionals, obtaining client and family/support person outcome information (whether informally or through standardised scales and tools) is a useful indicator of progress and an essential component of 'real time' care planning.

For people with lived experience and families and support people, the most important thing is that reporting activity by providers does not interfere with the availability or quality of the support service they are receiving. This will be further elaborated upon in a later section. In terms of how people with lived experience and carers want to use information reported by service providers and governments, navigability of the system is paramount. It often is difficult for people to be aware of the choices they have for a certain type of support in their local area, even if they go actively looking for information.

I believe a process whereby you could have a better chance of accessing a mental health professional who is most suitable for your needs would be valuable. This could be in the form of a database where the therapist answers as many of a set of questions they feel comfortable with and may include their specialties or a bit about themselves. That way, a patient or their family or support people can access some information to make an informed choice about who to see. Also, an outline for anyone who needs to see a psychologist or psychiatrist that states what individuals are able to access, including Medicare, ATAPS, private health coverage and the costs involved, bulk billed vs. out of pocket costs; or a service (telephone or web based) that explains how to go about finding the best way to receive good mental health care.

Person with lived experience and support person, Victoria

There are some examples of efforts by organisations to present their public reports in an accessible format, as below—using the opportunity to spread healthy living messages as well.

Over the last few years, Dental Health Services Victoria (DHSV) has presented its report in a magazine format with a celebrity ambassador gracing the cover. The reporting requirements have been included in a series of stories that use simple and accessible language. The magazine includes patient stories, staff profiles, information on how to look after your teeth and general health as well as information on how to access treatment in the public system. It also includes recipes for healthy eating and a competition that offers free movie tickets to people who provide us with feedback on the magazine. This is an innovative way of hitting two birds with one stone—fulfilling reporting requirements and providing the community with a fun, informative and accessible publication.

Dental Health Services Victoria

Effective reporting between providers and funders/regulators

Reporting is considered efficient and effective when reported information is actively used as part of a feedback loop to inform policy and planning at both local and national or state/regional level. In the example below, the organisation feels that reporting has led to positive change.

Monitoring of quality and safety indicators particularly on high risk indicators such as seclusion, readmission rates, post discharge contacts. The monitoring through this reporting has driven change in the area. The review of inpatient deaths by the Office of the Chief Psychiatrist in 2009 provides a benchmark for deaths in inpatients settings. Utilisation of this data enabled Monash Health to benchmark death rates in the community and inpatient settings.

Victorian Healthcare Association

In order to inform policy and planning at a state, national or programme level, many respondents felt that standardisation of information format was important. The housing of all submitted information in a centralised repository was thought to be helpful, especially if the information could be accessed and used by providers themselves to assist in benchmarking and quality improvement activities.

An effective use of reporting is the ATAPS program that captures qualitative and quantitative local data and the collection of a minimum data set (MDS) at a national level, enabling local evaluation, quality improvement practices and national reviews to take place.

South Eastern Sydney Medicare Local

[Our organisation] has been conducting routine outcome measurement since 2001 (BASIS-32 & Camberwell Assessment of Need) and now has a very large database that enables us to analyse change over time for consumers against service use and needs in different cohorts. We use this data for program planning and to drive initiatives that target identified unmet need.

De-identified national provider organisation

Many service providers emphasised the value of having collated information about their local population and about service use to enable them to do needs analyses and gap analyses to inform service design and planning.

By having access to reports pertaining to the health of the population within our catchment, it has informed our decision-making processes and assisted with understanding where the greatest areas of need are and hence assist with planning and service redevelopment. It is important that there are agencies with responsibility to collect and provide population health data, such as: local government, so as to inform effective local planning.

De-identified mental health planning organisation

Reported information can be used by services for benchmarking and in safety and quality improvement efforts

Responses indicate that reported information should be actively used by service providers for quality improvement purposes. The detailed example below shows how one NGO used reported information on outcomes to re-orient its services towards a recovery approach.

Our new Management Team reviewed all aspects of service delivery to ensure it was supportive of recovery processes. Reviewed data showed that our organisation did not work towards people moving on and programs that were delivered resulted in long-term dependence built up, through messages about how "Safe" it was to come to us. Three years later our statistics show a reduction in support for all individuals on packages, with some no longer needing this support and all on block funding averaging a three to four month period of support before being exited from programs. We also now conduct monthly Outcomes reviews to identify a range of outcomes—these include:

- per cent participants have an individual plan
- per cent increase/decrease in support
- per cent participation in paid/unpaid work
- Hospitalisation rates
- per cent maintenance of sustainable housing
- per cent reduction/cessation of substance use
- per cent level of ability to self-manage daily activities
- per cent achievement of defined goals
- per cent engagement in community/recreational activities/hobbies
- per cent engagement in educational opportunities
- per cent engagement with family and/or developed family/social/spiritual connections
- per cent improvement in their self-care

Feedback from workshops, support groups and annual surveys are used to drive service improvement so long as they align with evidence based practice

De-identified provider organisation

Reporting that encourages collaboration

For many individual professionals, the main benefit of requirements to report on individual client progress is the collaboration it forces between different professionals looking after the same client with lived experience. This seems particularly true for private practitioners, many of whom value the collaborative approach facilitated by reporting back to referring GPs on a regular basis.

Some professionals also mentioned the value of a shared care record to their ability to provide collaborative continuity of care. In some states (such as Queensland and Victoria) this is a state-wide electronic repository.

Consumer Integrated Mental Health Application (CIMHA) is a consumer-centred electronic information system used across Queensland. It ensures a consumer's information, including medical, social, current issues and where treatment has occurred, is accessible to all health professionals between hospitals and health services. It allows for integrated and collaborative care for the patient; reduces the potential for missing information that could inform treatment plans, evaluate service delivery and assist with service planning.

Future Health Leaders (FHL)

5.3.3 Characteristics of inappropriate and unproductive reporting

Ineffective reporting was described both in terms of inefficiencies in how data is collected and how that data is used (or not used).

With a few notable exceptions, the use of data and reporting tools in Australia is not done particularly well, resulting in burden for clients, clinicians and inaccessible and poor quality data.

De-identified research organisation

The RANZCP notes that there is extensive reporting related to the expenditure and activity of public money at the Commonwealth level (such as the Report on Government Services, National Mental Health Reports, Mental Health in Australia, AMHOCN Web Decision Support Tool (wDST), but has concerns about its effectiveness.

Royal Australian and New Zealand College of Psychiatrists (RANZCP)

Most of the deficiencies of the 'system' have been recognised for long, and it may be burdensome to report them again.

Australian Centre for Psychoanalysis

Reporting processes are bound up in red tape

The most common complaint about reporting mechanisms was that they are bound up in unnecessary red tape, such as each funding body having separate reporting requirements (which duplicate one another); as well as cumbersome manual reporting mechanisms.

The WAAMH Mapping Report of the Community Mental Health Sector in WA identified that for many organisations there is a high level of administrative complexity in reporting and managing programs with similar target groups, sometimes in the same locations, from both state and federal funding sources. This arises as a result of the lack of a coordinated state and federal funding framework.

Western Australian Association for Mental Health

Reporting requirement of the EMLL MHNIP clinical sessions to Medicare Australia remains a manual process of delivery, evaluation, resubmission and sessional receipting. Delivery of clinical sessional data to Medicare requires 1FTE admin staff. The procurement, evaluation, submission, re-submission and receipting process of the EMLL MHNIP sessional data is a clear and accurate Government reporting requirement of unnecessary red tape.

Eastern Melbourne Medicare Local

Gaming the system

Some respondents complained that where funding is dependent on activity reported, there can be a perverse incentive to game the system in ways which detract from offering the best clinical care.

Activity-based funding/recording occasions of service wastes clinical time on administration and promotes inefficiency via organisations trying to maximise activity/occasions of service to maximise funding.

Clinical psychologist, New South Wales

Information is not used

The importance of information being used for some purpose—preferably by being fed back to the people who have provided it in the first place to enable them to improve their service—was repeatedly emphasised in professional and organisational responses. However, many respondents said that at present, their reporting efforts did not have any recognisable benefit for them or their service.

I provided weekly client data over 15 years of working in the public service and never saw any summarising information reported back to me on the data that I and others had collected.

Clinical psychologist, Victoria

The Victorian Dept. of Health's Quarterly Data Collection functions well in that it has easy reporting functions. A report can be created from an agency's database and sent electronically. Unfortunately the department lacks analytical capabilities to use the data for more detailed monitoring, feedback and evaluation of projects.

De-identified national provider organisation

Information requests are duplicative or inconsistent

Everything being picked up by both the ATAPS and PIR reporting frameworks are then required to be re-entered into online minimum data sets. Essentially we need to report on the information twice to two separate bodies. There is no new information that hasn't already

been provided. The MDS cannot be accessed, as a database, by Medicare Locals, which means it is of no value from an evaluation perspective to individual organisations. MDS money could be going directly into service delivery.

Central Coast NSW Medicare Local

The [ATAPS] paperwork duplicates information. The doctor and the psychologist both fill out demographic information. When a client has two consecutive tranches of sessions the psychologist has to fill out very similar paperwork after session and then again after session—this is nonsensical and a waste of time. The required forms are badly designed i.e. the session report to the GP is a new form rather than an addition to the report sent after session one so new information has to be re-input [...] why not just have one form that populates two parts with the same data?

Clinical psychologist, New South Wales

Perverse consequences of regulation for people with lived experience

Many people with lived experience reported that their experience of services often is made more stressful by administrative processes. They reported that this extra stress comes in the form of:

- the expectation that they can easily ask and advocate for what they need, when in fact this may be very difficult

Red tape & making it so hard (impossible now) to even get the DSP is unacceptable. Most people with mental health issues are ashamed of their illness & humiliated by their inability to cope with the simplest of things, so more often than not they won't be 100 per cent forthcoming about their problems when applying for the DSP. Giving more financial support for medications. I'm on five different medications that need to be refilled every three weeks—that adds up fast, especially if you don't have a concession card.

Person with lived experience and support person, New South Wales

- overly complex referral pathways which require them to tell their story to multiple professionals; many mentioned the GP Mental Health Care Plan here

Obtaining a MHTP through GPs for ATAPS and Better Access restricts accessibility to a large population. Also prevents referrals from other sources, such as other health professionals, teachers. It creates a gap in service delivery to a population who may not be able to pay for a GP appointment or access a GP.

Southern NSW Medicare Local

- form filling and assessments which feel like having their individuality dismissed or having to justify that they are 'really' ill

Seeing a GP who I don't know that well in order to talk to my psychologist who I do trust makes it really hard. I wish it was easier; if I need help, I'm feeling vulnerable. I don't always have it in me to jump hoops. Just turning up to see someone is really hard.

Person with lived experience and support person, Queensland

I have received support from three different Disability Employment Service Providers. There is too much focus on ticking the boxes for the government and not actually assisting people to find work. With one of the DESPs I visited, all my appointment time was spent updating my Employment Pathway Plan and no time was ever spent actually supporting me in getting a job. [...] Over a period of at least a few months I was told at every appointment how busy they were completing their tender application for the next round of government funding. It made me feel like they didn't really have the capacity to help me find a job.

Person with lived experience, Queensland

Professionals and people with lived experience gave examples of regulatory and reporting requirements obscuring the purpose of services and programmes and getting in the way of face-to-face therapeutic interaction.

There is so much paperwork to complete within mental health services that over half the time each day is spent on this compared to 1:1 work with clients. A lot of this is repetitive e.g., needing to re-do risk assessments every 24hrs for highly risky clients despite their level of risk remaining this high throughout the commencement of treatment.

Clinical psychologist, Australian Capital Territory

The increase in daily reporting has been incredible. We now input our daily activities into the computer service (this is an inefficient program that takes up to 30 mins a day to account for your activities); fill forms including: treatment plans - recovery plans - family care plans - care review summary - relapse prevention plans- crisis intervention plans, and outcome. This is on top of the very important reports: Clinical Assessments documents; letters to GPs; risk reviews; ITO reports, and in my case psychological and cognitive specific reports. Service managers judge us by our computer input rather than our clinical work—this skews the way services operate. Solid documentation and communication is very important, but at some stage the relentless introduction of new paperwork and computer-based reporting needs to stop or we will have little time for clients. My biggest concern is that no-one even looks at half of this stuff once it's done—it's done to meet service requirements rather than to assist clients. I am aware of some services whose stats and service levels are amazing—but they see far less clients—this is crazy stuff.

Clinical psychologist, Queensland

Referral pathways in Commonwealth programmes can delay access to helpful interventions, create clinically harmful pauses in treatment, or cause people to give up seeking treatment altogether.

There is too much paperwork once the initial sessions have been used. My psychologist asked me to get my psychiatrist to complete paperwork; can't, has to be GP, wait 4 days for doctor appointment, he doesn't have psychologist report, go back to psychologist, he can't get on to doctor. I'm left with no support for weeks and gave up. Request for additional sessions needs to be simpler.

Person with lived experience and support person, Victoria

A core aspect of clinical psychology practice is a succinct précis to the referrer once assessment, case formulation and diagnosis have been conducted. Then at the conclusion of treatment. Informal case consultations are the norm. This has always been a part of practice. However, recent mental health programs (ATAPS, Better Access etc.) have increased reporting to the point where regulation increases the costs of mental health care and creates high risk pauses to treatments (e.g. reporting after six then four sessions; GP reviews; GP mental health care plans).

APS College of Clinical Psychologists

5.3.4 Suggestions for increasing the utility and efficiency of reporting

Enable the reporting of experiences and outcomes—not just activity

Although it may be useful to funding and regulatory authorities, the reporting of activity information (such as 'occasions of service' reported by professionals in public mental health services) is not seen as useful to the improvement of the quality and safety of services. Many respondents suggested that there is a need to develop an outcomes-focused reporting system which has the experiences of people, their family members and supporters at its core.

PHaMs reporting is very user-friendly and allows for client stories to be heard through the medium of case studies.

Merri Community Health Services

Such demands for experience-based reporting are reflected in respondents' comments that present reporting systems do not account for the complexity of mental health interventions and their impacts on a person's life.

How do you report on the complexity of peoples' lives and situations with numbers and by ticking boxes? It is hugely inadequate and presents a very simplistic view of an incredibly complex picture.

Allied health professional, Queensland

If reporting is to be useful to the organisation required to undertake it, there needs to be sufficient flexibility in the reporting system to accommodate what a 'good' or meaningful outcome entails for the people receiving the service or support.

What you report and the way you report it reflects your paradigm and your world view. We would think that Minimum Data Set is only the answer if you already subscribe to a world view predicated upon western European individual clinical therapeutic case management and individualised service delivery model.

Kimberley Aboriginal Law and Cultural Centre (KALACC)

Long-term follow-up and longitudinal evaluations of the outcomes of interventions and programmes also is seen as a desirable aspect of meaningful reporting by many respondents.

A much bigger problem for all mental health care programs is long-term follow-up. To properly evaluate all of our programs we would require follow-up data about people who exit systems of care, at the 3 month, 6 month, 12-month and 3 year interval. From a psychological standpoint, it would be worthwhile to have long-term symptom severity data for most of our treatment programs.

Alliance for Better Access

Remove Better Access Mental Health Care Plan requirements

Two suggestions were made to decrease red tape associated with Better Access: either removing the Mental Health Care Plan requirement (and associated MBS item) altogether, allowing GPs to refer with a letter in the way they refer to other professionals, or to only remove the review requirement after the initial six sessions.

Many respondents doubted the usefulness of Mental Health Care Plan requirements, regarding them as documentation which the GP does not have the time to complete, which impose extra expense on people and on Medicare, and which are duplicative of work done as part of Better Access providers' normal practice.

A red-tape problem is the need for a patient to return to a doctor to get a re-referral to continue treatment with the psychologist. In a number of cases this is an unnecessary waste of time and expense to all concerned. Some patients, often busy farmers, have had to travel over 100 or more kilometres simply to get this re-referral.

Administrator, Western Australia

Streamline reporting requirements

According to providers of services, reporting currently happens in two main ways for two main purposes. First, providers often create their own localised reporting mechanisms (e.g. bespoke software for client records) which they use to inform in-house monitoring and improvements. Second, they use multiple systems of reporting required of them by funders, in which they must enter similar information multiple times, in order to demonstrate compliance and accountability. While many respondents valued the ability to report against a national minimum data set (e.g. for ATAPS reporting online) and to access that data to benchmark their

own performance, there evidently also is a widespread need for data collection and reporting systems which are tailored to local circumstances.

Our own Client Information System allows us to gather a wide range of data not only that is required by Departments but also our own data, such as screening and risk assessments that inform our practice and policies.

De-identified service provider

One way to simplify this situation might be to develop, using online technology, a reporting system which has mandatory modules (i.e. a national minimum data set) for reporting performance to funding bodies, with a variety of (linked) optional modules which can be used by organisations and practitioners for their own purposes. The mandatory reporting modules would satisfy the requirements of multiple funders (i.e. Commonwealth and states) and the information would only need to be entered once by providers but could be accessed by multiple funding and regulatory authorities. Mandatory reporting would be focused on client and experiences—because these would be of interest to all funders, whatever the particular supports or interventions they are funding.

Reporting in Mental Health could be made more efficient if minimum data sets, and reporting portals or lodgement mechanisms, were unified and systemised across Commonwealth-funded contracts, and with state-funded contracts, if possible.

The Richmond Fellowship of WA

State and federal governments working more closely together—aligning their capacity and resources to enable nationally used systems and outcomes and tools to get a clear idea of where we've been, where we are and where we should be going.

Grow

Examples of such streamlined reporting do exist; these would merit further study to determine whether such approaches could be scaled up.

In 2012 RFDS Queensland signed an agreement with the (then) Department of Health and Ageing to combine funding streams into a single set of comprehensive reports across four program areas. This has been implemented and is widely regarded as a highly successful example of efficiency in reporting. The process has highlighted and rectified deficiencies in data reporting that were previously unrecognised by the RFDS and the funding body alike. It has generated a range of system improvements leading to better work flows for clinicians and better data production for use in managing the service operation and direction.

Royal Flying Doctor Service

Reporting requirements are burdensome; however, they are also necessary. Using electronic systems similar to that of the National Health Service (UK) would cut down enormous amounts of time. Unfortunately, until then, this means long unpaid hours for committed health professionals.

Clinical psychologist, South Australia

Allowing individual professionals more self-regulation opportunities was another option to streamline reporting burden on providers:

Clinical audits violate client confidentiality and place clinicians in professional and ethical dilemmas. Expensive audits of the clinical notes in files do not ensure or relate to quality of treatment. Supervision, Peer review and Professional Development are better means of promoting treatment quality and have been traditionally used to ensure clinical standards by professional bodies such as the APS.

Clinical psychologist, Western Australia

5.4 Promising practice examples

5.4.1 Promising examples of appropriate and effective reporting mechanisms

The Private Mental Health Alliance ... provides private psychiatric hospitals with the opportunity to contribute to the Centralised Data Management Service (CDMS). This service provides a national data collection which meets the needs of hospitals and health funds for annual reporting and benchmarking purposes. This data collection also provides a valuable resource for government agencies and other stakeholders. It has been designed with the specific needs of the private hospital sector in mind.

Australian Private Hospitals Association

The following example we received is sensitive to the needs and preferences of recently arrived culturally and linguistically diverse (CALD) communities from overseas and settled generations of multicultural communities as well. It is aligned to relevant policies, legislation and accreditation requirements in Australia.

MHiMA has launched an online self-assessment and annual reporting tool entitled the 'Framework for Mental Health in Multicultural Australia' with support from the Commonwealth. A number of state government and non-government mental health services have taken up and used the framework across Australia.

Development of the framework has received positive feedback from a number of public mental health services in some of the most culturally and linguistically diverse communities in Australia, such as Western Sydney, Dandenong, Perth, Gold Coast and the Metro South Hospital & Health Service in Brisbane. Based on initial feedback there is merit in exploring whether the framework could be formally integrated into accreditation requirements as set out in the 'National Safety and Quality Health Service (NSQHS) Standards', thereby enabling uptake and utilisation across all states and territories in Australia. Utilisation of the framework to drive quality improvement could also form the basis for effective, efficient and transparent allocation and better targeted commissioning of resources to meet the needs of CALD populations.

Mental Health in Multicultural Australia (MHiMA)

6. Gaps in services and programmes

6.1 Key findings

There was a high level of consensus across all groups of respondents about the gaps in the mental health system at present. Respondents (particularly individuals) are limited in their ability to assess system-wide gaps as they can only speak from personal or professional experience, and therefore could be prone to suggesting that their own area of residence or expertise is underserved. However, the regularity with which particular gaps were mentioned across the groups of respondents gives confidence in the findings presented below.

The major gaps mentioned in submissions can be categorised as either an overall *lack* of certain supports, or gaps *between* services, sectors, or professionals.

Gaps were cited in relation to:

- gaps between services, sectors or professionals
- lack of service provision in particular geographical areas, especially in regional, rural and remote areas
- availability of specific types or modalities of support
- availability of appropriate treatments for specific diagnoses
- lack of services catering to needs of particular life stages, life experiences and backgrounds.

The existence of these gaps commonly was attributed to:

- a mental health system set up to react to crisis rather than prevent crisis
- a focus on time-limited rather than ongoing support
- a mental health system where access to appropriate support is often based on ability to pay
- uneven rollout and inflexible implementation of Commonwealth programmes
- a failure to structure services around a recognition of the intertwined nature of mental health and social and economic circumstances
- workforce shortages or gaps in expertise.

Some of the **problematic consequences** of these gaps include the following:

- Lack of consistent, ongoing support which is flexibly tailored to a person's needs makes it more likely that a person will continue in a vicious cycle of deteriorating to crisis point, being admitted to an inpatient unit, and then discharged without follow-up
- There is a lack of continuity of care for people experiencing a mental illness.

6.2 Overview

Term of reference 5 asked the National Mental Health Commission to assess:

Funding priorities and gaps in mental health services and programmes, given the current fiscal circumstances

In this chapter, we focus on the gaps in mental health services and programmes which were mentioned most frequently by respondents. The issues of balance of funding and funding priorities have been incorporated with ToR 1 in chapter 2 of this document, especially in section 2.3.5.

Many respondents emphasised that addressing gaps in services and programmes would not necessarily equate to funding new services, but would likely entail encouraging existing services to work in a more collaborative way, or to work differently (for example, harnessing technologies to deliver support in rural and remote areas). This issue of improving service delivery through collaborative or innovative ways of working is addressed in chapters 7 and 8 under ToR 6.

6.2.1 Survey question

Organisations and professionals were asked to give examples of:

- a. an area, state or territory where there are gaps in services and programmes

People with lived experience, family members and support people were not asked specifically about gaps, but elements of their responses to other questions which identified gaps were included in analysis for this ToR.

6.2.2 Survey responses

For question (a), 58.5 per cent of organisations (n=138) and 38.6 per cent of professionals (n=332) provided a response.

Analysis for this chapter considered three sources of evidence—responses to this particular survey question, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

6.3 Thematic findings

6.3.1 Overall

Respondents interpreted gaps in services and programmes in two ways:

- a total absence of a particular service or programme for a certain population or nationwide
- a gap between two services, professionals or sectors caused by lack of collaborative working and communication between them and resulting in poor experiences or outcomes of support for people with lived experience.

6.3.2 Types of gaps in programmes and services

Gaps between services or sectors

All stakeholders reflected an overall perception that Australia's mental health systems and services are fragmented, not only at a national level (in terms of gaps between jurisdictions) but also at the level of the individual client's experience. Organisational respondents were more likely to indicate higher level gaps—such as between private and public sectors—while individual professionals and people with lived experience provided more localised examples of multiple services operating in isolation from one another.

Gap between public hospital and private psychology services

The most concerning gap identified by many respondents was a perceived absence of support for people living with moderate to severe mental illness between clinical services in the form of hospital treatment on the one hand, and private psychology services on the other. For many, there appears to be no service or programme between these two which can provide ongoing clinical and non-clinical support in the community to prevent return to hospital.

For people, especially teenagers, identified as high risk or having emerging serious mental health services their only resource is often CAMHS [public child and adolescent mental health services]. However, the waiting list can be three months or longer and in the meantime real and lasting harm can be done to the family dynamic and make meaningful recovery even more difficult. There's nothing in between 10 Medicare rebateable sessions with a psychologist and complete hospitalisation or removal from the home.

Clinical psychologist, Victoria

In many cases, this 'stop-start' availability of support, which is accessible only at points of crisis or for a limited number of sessions, leaves people for long periods vulnerable to deterioration. For those who cannot afford the gap payment for private psychology and psychiatry consultation, and cannot find a bulk-billing practitioner, there appears to be little community-based ongoing support across many areas of the country.

Policies directed towards the outsourcing of rehabilitation and community support services to NGOs demonstrate a gap in service delivery. NGOs are funded on a time-limited basis, but are often dealing with lifelong or chronic problems. Community teams tend to fade by attrition in current funding conditions and financial constraints lead to a lack of cover for active staff, a lack of replacements for staff on leave, and indefinite delays in replacement of staff that have resigned or retired.

Royal Australian and New Zealand College of Psychiatrists

I am currently undergoing intense sessions with a Psychologist due to the acute nature of my condition, and I have quickly reached the limit of my 6 sessions. I am now left alone to fend for myself for a month until I can see my GP again and get my remaining 4 sessions underway.

Person with lived experience and support person, Victoria

Characteristic of comments both about inpatient treatment and private psychology (in the form of Better Access) was the feeling of being 'dropped' and left to cope with problems alone after a short period of support is provided. In the case of inpatient hospital care, we received many stories of people with lived experience who were discharged from hospital before they felt ready or without any form of follow-up support. Many others reported that they could not access public hospital inpatient care, being told that they were not considered sufficiently at risk to need such intervention.

The access in public hospitals to their mental health wards is terrible. If you are in a really bad state mentally and need to be hospitalised you pretty much have to have attempted to harm yourself as they will try to turn you away and suggest that you are better off at home.

Person with lived experience, Queensland

The gap in continuity of care presented to the many people who complete their ten session allocation under Better Access frequently was mentioned as contributing to adverse experiences for people with a mental illness. This gap is dealt with in detail in Chapter 4 of this document (against ToR 3)—but the point to emphasise is that for many, the end of Better Access appears to mean the end of any support at all until the new calendar year comes around. This can create perverse consequences, as the following quotes show.

... there were constant references to the countdown of my six sessions, and this created much pressure on me, and prevented me from actually getting anywhere, because I was too scared to open up to my issues of trauma, and then potentially be left without support. I am frustrated because my inability to get adequate treatment for my PTSD means that I am unable to hold down a job or study, when I know I do have the potential.

Person with lived experience, Victoria

[What doesn't work for consumers is] after the completion of the 10 sessions, and seeing their improvement over this period, then all of a sudden either being left out in the cold, forced to see a psychiatrist (or GP) and start all over again (i.e. developing rapport, explaining their story), and then having to wait until January to be able to return to the ONLY person who seems to make a difference to their mental health!

Support person, Victoria

The absence of ongoing community-based support means that Better Access becomes the only option for many people with severe illness (if they can afford it), with professionals reporting that they are trying to deal with complex and entrenched difficulties, including personality disorders and often tied up with histories of abuse and trauma, under a programme which was designed for less severe problems.

Better Access was for mild/moderate (as I understand it) and state/territory to manage moderate/severe. This is not borne out in reality now, as except for acute/crisis presentation and consumers with psychosis dx, the severe depression, anxiety, trauma, personality disorders are being turned away. These people are often impaired environmentally, socially, developmentally and financially (loss of productivity etc.). The flow-on effect is a waste to public resources (e.g. management in ED, short-stays in hospital to manage a crisis, multigenerational effect on children) and does not provide adequate treatment, according to evidence base.

Clinical psychologist, Australian Capital Territory

Gap between clinical and non-clinical services

Failure to recognise a person's interrelated needs—where mental, physical, social and economic health are recognised as interdependent—is reflected in a scenario commonly mentioned in submissions. This scenario involves a person being discharged from an inpatient unit, only to encounter difficulties to do with housing, family, or finances which then impact negatively on their mental health. Such difficulties might range from returning to an empty house where there is no food to being discharged to unstable accommodation or a harmful family or social situation characterised by violence or drug-taking.

I live alone and have no real family support. Therefore the three visits I have had to hospital have left me without food and supports when I go home. A lot could be done in this space to speed up recovery and to avoid readmissions.

Person with lived experience, New South Wales

Clinical services in these scenarios have failed to liaise with available non-clinical supports such as housing services, which in turn leads to a greater likelihood of readmission to hospital. The quote below shows that even if clinical services are available, if they are not backed up by and linked with non-clinical supports such as employment services, a person may find it hard to sustain any mental health gains made.

Despite significant focus in the areas of men, youth, mums with children under two years, elderly, there is insufficient support specific to mums/females with depression and other mental illness in the form of support groups and therapies.

It is recommended as part of recovery for mental illness that you should undergo paid work or volunteer work; however, there are no strategies, support mechanisms that can support someone with mental illness to manage both their illness and their employment.

Person with lived experience, Victoria

The fragmented nature of the mental health system at present means that it is difficult for services and programmes to holistically assess and address a person's family context and to use whole-of-family therapeutic interventions. This is especially important when a parent is experiencing a mental illness which in turn may affect their children, or when a child is experiencing a mental health difficulty which affects (or is affected by) their siblings and parents.

In most areas of Australia, there is significant disconnect between adult mental health and child and family services. The interdependence of outcomes of adults experiencing mental illness and outcomes for children have been well demonstrated, yet services for adults and children are rarely integrated and do not routinely address the parenting needs of adults with mental illness, the needs of the whole family, or the individual needs of their children. Improved integration, collaboration and pathways of support and information sharing needs to occur across the range of adult, child and family services.

Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA)

No services in a geographical area

Regional, rural and remote areas of Australia

By far the most common gap identified by respondents was the lack of particular (or in some cases, any) mental health supports in outer-metropolitan, regional, rural and remote areas of Australia. Long waiting lists, requirements to travel long distances, or simply a complete lack of access to support, were all identified as problems in these parts of the country. These gaps have been addressed in detail under ToR 8 in Chapter 11 of this document.

The first quote below illustrates the shortage of services even where a person is able to pay for private treatment, while the second lists the multiple gaps in mental health related supports in a particular geographical area. Some areas lack whole systems of support, while others lack appropriate support for particular difficulties.

My daughter was unable to access the headspace service on return to her university studies in [a regional town] after having taken a year leave due to her hospitalisation and ongoing treatment because she had already used the 10 psychology appointments covered under her mental health plan. She was unable to gain any support apart from regular monitoring from the GP and had to travel [many] hours home to Sydney every few weeks to visit a private psychologist. The ability to access support in [the regional town] is very difficult with only 1 psychiatrist with expertise in [my daughter's problem] who I was told had a 4 month waiting list.

Support person, New South Wales

[A regional area in Queensland] has more gaps than services:

- No high care service.
- No crisis accommodation for Men.
- No rehab services.
- No child psychologist
- No LGBTI services
- No family and carer support groups.
- No MH support group run by people with MH issues.
- No dementia diagnostician or services for mod / high care.
- No bulk billing
- No MH beds
- No effective access to psychiatrist (QHealth—good luck; Private—every six weeks if funding renewed).
- No ASD [autistic spectrum disorders] trained clinician
- Limited DV [domestic violence victim support]

Psychologist, Queensland

The significant gaps in provision of mental health supports in regional, rural and remote Australia could be said to result from decisions about prioritisation of funding, as argued in the following extract:

The distribution of mental health funding in South Australia between Rural and Metropolitan service is inappropriately balanced [...] A prime example is the funding allocation for mental health services for older persons, Rural SA has approximately 10 to 12 clinicians to provide this service across a population of 395,000 people and a geographical spread of approximately 1,000 sq. km in comparison to Adelaide with well over 120 Clinicians.

Researcher, South Australia

Programmes unevenly distributed

Geographical disparities often were cited in relation to uneven distribution or rollout of Commonwealth mental health programmes, especially Partners in Recovery and the Mental Health Nurse Incentive Programme.

While the evaluation of the MHNIP has reported significant client outcomes it also identifies the limited uptake in some jurisdictions such as WA and SA and no uptake in the NT. There are a range of factors for this; however, a significant factor has been a lack of investment in the program. The investment in supporting the uptake and implementation of general practice nurses has been significant compared to the MHNIP. From the DoH (DoHA) there has been little promotion of the program, or support for organisations and services that want to use the program.

Australian College of Mental Health Nurses

Eleven Medicare Local regions [have] yet to be provided Partners in Recovery funding. This has left [them] lacking a service which would provide consumers and their family and carers with a personalised approach to identifying their health, mental health, vocational and recreational goals and would ensure access to relevant services and supports is streamlined and coordinated. PIR would enable consumers to receive wrap- around supports and coordinated access to services to prioritise their needs. [...] The absence of Partners in Recovery has also resulted in a lack of resources to support the development of systemic partnership enhancement across the region which would facilitate service system integration, coordination and care pathway improvements.

De-identified Medicare Local

Gaps due to service closures

Many individual respondents cited concerns about services which had closed recently or which potentially faced imminent closure. Concerns were raised that they were not being replaced by an equivalent service and that therefore gaps in support would result in that town or community.

The Newcastle and Hunter area has recently been informed that our community health counselling service will close. They stopped taking clients on 3rd March, and already the impact of this terrible decision has been felt. The community health counselling service employed some of the most highly skilled psychologists in the area, treating some of the most complex and vulnerable community members. Its closure leaves a tremendous gap. Already most private practices are full, and even if clients could get in, 10 sessions is not adequate for the complexity of these presentations.

Clinical psychologist, New South Wales

Lack of appropriate services for particular types of mental health problems

Two diagnoses frequently mentioned as receiving inadequate specialist care were personality disorders (especially borderline personality disorder) and eating disorders.

In terms of personality disorders, it was widely felt that there is insufficient attention paid to making therapies available which are considered particularly effective for such difficulties, including dialectical behaviour therapy for borderline personality disorder. People experiencing a personality disorder frequently have complex histories, often including experience of trauma and abuse, and many professionals feel that the existing limit of ten subsidised psychology sessions under Better Access is insufficient to effect meaningful change. Establishing trust can be an issue with people with such complex needs, and of itself can take considerable time. Insufficient therapeutic intervention can lead to a revolving door effect where crisis after crisis is dealt with reactively by inpatient services—ultimately an inefficient situation.

[There are] too many examples to list of overloaded emergency care services leaving distressed and injured people with BPD [borderline personality disorder] waiting hours for treatment or being sent home without being seen. In one case a young woman who had self-harmed was treated with band aids, a tranquiliser tablet and sent home alone on a bus. The young woman later died at another hospital following further similar injuries.

Former psychiatric nurse, South Australia

People with experience of an eating disorder and those who support them find that, in most areas of Australia, expertise and service capacity are lacking. A common complaint is that even where specialist eating disorder services do exist, they focus on physical parameters including weight gain as evidence of recovery, without supporting someone to achieve broader quality of life outcomes or psychological recovery.

[A woman with anorexia nervosa] deteriorated to the point where her psychiatrist required her to present to emergency at a large public teaching hospital in a major city. She spent two days in emergency before being admitted to a ward. A dietician not experienced in eating disorders was assigned to her—she ate no food. Her weight continued to fall but it took a number of days before her treating team agreed to a nasogastric tube. No one on her team had any experience in treating eating disorders, nor were they inclined to consult with those with experience (at another hospital). No psychological services were provided ... The family did not feel safe leaving her without someone by her bedside to insist on care. There was no multi-disciplinary approach and a lack of willingness to understand and treat the illness.

Butterfly Foundation

Many respondents referred to gaps in mental health expertise among staff in primary healthcare and emergency departments (EDs). Because these services are usually the first place people turn for help when experiencing mental health problems for the first time, this is concerning. Respondents told us that stigmatising and dismissive attitudes are a common problem for people seeking help. One emergency department nurse attributed this to a failure to consider emergency service workers as part of mainstream mental health services, leading to a failure to train them in how to deal appropriately with someone experiencing a mental health crisis.

There exists in EDs a tension due to conflicting cultures of practice where recovery-orientated practice is not (rarely) understood in EDs and as such clients may experience care that reinforces stigma and undermines the person-centred nature of contemporary mental health care ... I believe that the general trained nurses who assess and initially manage clients with a mental illness [in the ED] are in fact part of the mental health workforce—their needs are poorly considered and rarely met.

Nurse, Queensland

Lack of appropriate services for particular life stages and population groups

Respondents from different parts of Australia reported gaps in services catering to the particular mental health challenges of young people, of pregnant women and new mothers, and of older people. Although the gaps vary from place to place, there was a common perception of being cut off from services because of reaching a life milestone.

For example, young people who had been supported through headspace find that when they turn 25 they may not be able to receive the same level of support from adult services. Parents report that they have found it difficult to find appropriate support for their child who is going through difficulties. The quote below illustrates how age-appropriate support or treatment is particularly hard to find when a child is going through phases of transition.

There are minimal psychiatric inpatient services available for children under 12. I was told the only option for my child was the [name removed] child psychiatric unit, but the unit wouldn't admit her due to the mix of patients there at the time (oppositional defiant boys). I was told once she turned 13 there would be more options as there are several adolescent psych units; however, I also had mental health professionals tell me it was not a good environment for a 13-year-old girl as there were often patients in there with substance abuse issues and a culture encouraging self-harm.

Support person, Victoria

Appropriately tailored support for older people with mental health difficulties who are not experiencing dementia appears to be scarce.

In NSW, there is a lack of appropriate mental health care for older people. Aged care services typically do not actively identify or respond to the needs of older people with mental illness, and there is a poor understanding of mental health issues in the aged care sector. While there are specialist mental health services for older people in NSW, their availability is limited to people with the more severe symptoms.

NSW Consumer Advisory Group - Mental Health Inc. (now trading as BEING)

Lack of appropriate services for interrelated needs

Many submissions referred to the seeming inadequacy of current support arrangements in addressing interrelated needs in a way that ensures the needs of the whole person are met. Respondents told us that this is especially the case where mental illness occurs at the same time as other social, health and economic problems, or in the context of particular life experiences. For example, people who experience a substance abuse issue or a physical or intellectual disability as well as their mental health problem may find that the mutually influencing nature of these difficulties is not recognised and that different problems are either not addressed or are addressed in piecemeal fashion. There is also the risk that the person will be considered as another agency's business and fall through the gaps between services.

In a similar way, people whose mental health can be affected by their life experiences, background, or circumstances can have their clinical symptoms treated without consideration of how such contextual factors can either support or adversely affect their mental health. For example, we heard stories of young people discovering their sexuality and not being able to find support services where they felt comfortable discussing this—especially in rural areas.

These deficiencies in support for interrelated needs are discussed more extensively in Chapter 8 of this document in relation to integrated care.

7. Emerging approaches: technologies and e-mental health

7.1 Key findings

Respondents identified four key aspects of using technology effectively in mental health service delivery. These were:

- service accessibility for people with lived experience
- social support for people with lived experience, family members and support people
- dissemination of information and knowledge sharing
- aids to professional networking, training and continuing professional development
- increased efficiency and effectiveness in provider roles.

Challenges of using technology in delivery of mental health services included:

- integration and coordination with existing services
- ethical issues and accountability in service delivery
- universal accessibility and availability.

Suggestions to improve the use of technologies in mental health services were:

- incorporate alternative service delivery technologies
- increase access to service providers through telephone and internet sessions
- improve existing technological infrastructure.

Promising practice examples include the innovative use of technology within existing services and mental health programmes. The Australian Government's Teleweb initiative also was identified as contributing to positive outcomes and innovative mental health service delivery online.

7.2 Overview

Term of reference 6 asked the National Mental Health Commission to assess:

Existing and alternative approaches to supporting and funding mental health care

We selected two issues to highlight as alternative approaches to service organisation and delivery in response to this ToR. These two stood out as prominent themes across responses from all respondent groups. While Chapter 8 will deal with the role of innovative models of collaborative working and integrated care delivery in improving mental health support, the current chapter explores the potential of technologies to improve the delivery of existing models of mental health support and to be the basis of new models of care delivery in the future.

7.2.1 Survey questions

Analysis for use of technology was based on two surveys—one completed by people with lived experience and the other by organisations and professionals.

Professionals and organisations were asked to provide:

- a. an example of the use of technology to improve the experience or effectiveness services

Although this was the only question directly related to the use of technology, references to technology were also found throughout responses to other questions in the survey and were coded appropriately.

People with lived experience and support people were not specifically asked to provide examples regarding use of technology, but references to technology were found and coded accordingly for use in this analysis.

7.2.2 Survey responses

For question (a), 57.2 per cent of organisations (n=135) and 39.5 per cent of professionals (n=340) provided a response.

7.2.3 Note on interpretation

It should be noted that the only question directly related to technology asked professionals and organisations to provide an example of effective use. Therefore, as might be expected, there were a greater number of comments about technology being effectively used in comparison to where technology was thought to be ineffective. Although some responses identified examples of ineffective use of technologies, these responses were comparatively limited.

In our analysis, we found that respondents defined ‘technology’ primarily in terms of information and communication technologies—including electronic patient records, remote professional consultations via videoconference, and online peer support.

7.3 Thematic findings

7.3.1 Aspects of effective use of technology in mental health services

Respondents from all groups provided numerous examples of how the effective use of technology has contributed to improved delivery of mental health services. Responses from people with lived experience identified that online technology was useful for them to access mental health information, services and support. Professionals also reported that technology can improve their knowledge, efficiency and effectiveness in performing their roles and supporting positive people with lived experience outcomes.

Service accessibility for people with lived experience

A key benefit of communication technologies identified by respondents is the increased reach and accessibility of services to people with lived experience. Where barriers to accessing traditional mental health services might exist, online or phone-based alternatives were viewed positively.

For example, the anonymity of online and telephone services encouraged those who would otherwise feel uncomfortable (especially because of stigma issues) to gain access to services and support. It was often mentioned that the availability of online and telephone services increased access for youth in particular.

Having an anonymous outlet can be very helpful, especially for first point of contact. Also, for me, when I felt embarrassed and ashamed about something I was going through, an anonymous outlet was the only means which I felt comfortable using. I chose to use the eHeadspace service.

Person with lived experience, Victoria

Internet and telephone support services were also frequently mentioned as an effective means to deliver professional services to those who ordinarily experience barriers to accessing face-to-face sessions. Telemedicine, telepsychiatry, telehealth, e-health and online support were perceived to offer increased convenience and access to people, most notably in regional, rural or remote areas.

The use of telehealth is a prominent example of an innovation and government investment that has enabled rural and remote patients to access care. The government incentive, which has provided up-front payments for practices to be involved in telehealth, offered patients in outer metro, rural and remote regions of Australia the opportunity to visit their GP in order to conduct a consultation with a specialist via video-link, rather than having the patient travel long distances to a large city for the appointment.

Royal Australian College of General Practitioners (RACGP)

Social support for people with lived experience, family members and support people

Online mechanisms such as discussion forums were commonly cited as an effective way to increase informal social and peer support for people with lived experience and also for their families and supporters. This was frequently mentioned as one of the benefits of using technology to connect with others and receive support that may not be available from traditional mental health services.

I think there are some fantastic online resources that young people can access for support with mental health problems. Sites like ReachOut, eHeadspace, Kids Helpline Online, beyondblue and the Butterfly Foundation, which provide information, referrals and services such as online counselling. I have used all of these services when I didn't feel able to speak to anyone in person. They were a great help to me, and meant I didn't need to disclose my mental health condition to friends and family until I was ready.

Person with lived experience, Victoria

Websites such as Reachout.com and beyondblue are invaluable in their ability to provide this sort of affirmation and validation in circumstances where individuals are unable to access such support. This support enables them to reduce the sense of shame and self-blame associated with mental health problems, and focus on constructively approaching solutions.

Person with lived experience, New South Wales

Examples were also provided of increased support for care providers and other support people.

The Support After Suicide website, online community and Facebook presence have enabled people to access information and support at any time, and from any location. Importantly, they facilitate access to information and support in a non-judgmental and non-stigmatising way, and can preserve anonymity. This may be particularly helpful for some people who are suicide bereaved.

Jesuit Social Services

Peer Support Groups and our 24/7 Peer Grief Telephone Support Line have proved efficient and effective resulting in good outcomes to bereaved parents and siblings. Frequently we receive written expressions of the fact that the connections with these services 'saves' people's lives and sanity, and ability to rebuild their lives.

De-identified provider organisation

Dissemination of information, knowledge sharing

The capacity of information technology to disseminate mental health information widely to people with lived experience, professionals and the public is felt to be of benefit to mental health coping and outcomes, as the information is readily available and easily accessible.

Online information, like what is provided on ReachOut.com, is really helpful. Fact sheets on how I am feeling, tips and advice on a range of issues, forums to talk to other young people about mental health is so valuable. I never really wanted to see a counsellor all the time, sometimes I feel awful, and I just turn to the internet to cheer me up or to get more information.

Person with lived experience, New South Wales

Online resources that increase the connectivity between providers and clients were often mentioned as contributing increased knowledge sharing and dissemination of mental health information. Many examples were provided of successful online platforms.

[Name removed] is a single digital social media and information platform for all things health [in our geographical area]. It includes a web-based information repository, Facebook, Twitter and You Tube channel. The platform is designed to provide two-way information for the community and clinicians. The site provides a professional networking platform for a variety of professional groups, including mental health professionals.

North Coast NSW Medicare Local

Aids to professional networking, training and continuing professional development

From the perspective of both professionals and organisations, examples were provided of the use of technology to aid in professional networking, training and continuing professional development. Online virtual training courses and video seminars were commonly mentioned as examples of where technology had been used to enhance professional development.

I recently completed a webinar for ATAPS providers that was organised by the Australian Psychological Society. This seems like a really good way to make this information accessible to a large number of people.

Clinical psychologist, Victoria

Common examples included the use of these technologies in regional, rural and remote areas where added benefits were perceived for enhancing workforce development.

APAS [Australian Psychoanalytical Society] runs Skype training for clinicians in rural areas. A recent programme run by the Sydney branch taught a wide range of mental health workers in rural and remote Australia the fundamentals of understanding and treatment of autism and related disorders.

Australian Psychoanalytical Society (APAS)

Increased efficiency and effectiveness in provider roles

The integration of technology into mental health service delivery has in several ways increased the efficiency and effectiveness of services provided. For example, professionals identified how the supplementation of traditional face-to-face therapies with alternative methods and tools helped to improve client outcomes. The use of e-therapies (such as computerised cognitive behavioural therapy) and mobile phone applications were some of the specific tools that professionals reported integrating into their practice.

Online cognitive behavioural therapy for adult anxiety disorders and depression has been an invaluable adjunctive tool in my work as a clinical psychologist in private practice. These courses provide a means for patients to access relevant, complementary information to that which we cover in session. It also allows excellent ongoing monitoring of patient symptoms via automated online questionnaires. Adjunctive use of these online programmes enables me to deliver more specialised and personalised instruction when meeting with private patients.

Clinical psychologist, New South Wales

Professionals also report that they use simple communication technologies to improve the service they provide to clients. For example, email and text messaging was perceived to improve compliance (such as appointment attendance) and to assist with building the therapeutic relationship.

I have also found that between-session contact with clients (e.g. in the form of a quick email or text message) is well received by clients, aids in the therapeutic relationship and helps to keep clients motivated in therapy.

Clinical psychologist, South Australia

7.3.2 Challenges of using technologies for mental health support

Integration and coordination with existing services

A number of challenges were identified by respondents in the integration of new technologies into existing service models. Examples were provided of difficulties in ensuring consistency and continuity in care with the variety of technologies being introduced and used by people with a mental illness and service providers. Some mentioned that the continual use of emerging technologies caused services to become “fragmented” and resulted in confusion and lack of coordination among service providers.

The current offering online has evolved in parallel with the offline service offering and there is little or no integration across or between services. This is a missed opportunity and one that should be addressed immediately.

Young and Well Cooperative Research Centre

One example of this is the use of online services and self-guided web based therapies by people with lived experience. Many respondents identified the challenges of incorporating these services into mainstream service provision. There remains considerable uncertainty about how these services could be most usefully employed to connect people with existing service providers and to ensure continuity of care.

There have been rapid developments in online platforms for the identification, prevention and treatment of mental health problems, with e-mental health services shown to be highly effective, efficient and cost-effective. However, e-mental health services largely exist independently of traditional service settings. Health care providers rarely utilise e-mental health systems in their practice.

Black Dog Institute

Ethical issues and accountability in service delivery

A number of ethical issues and lack of service accountability in the use of certain technologies were also mentioned by respondents. In the delivery of mental health services outside of traditional settings, an inability to discern whether services have been effective, and a lack of accountability for service providers, were concerning to some.

It's hard when a young person logs on and shares their story and people respond with great advice and the young person is involved in that moment but when they don't come back to share the rest of their story it's hard to not worry about that one person.

Moderator, mental health website

Universal accessibility and availability of services

Respondents identified a lack of universality in the availability and accessibility of some technologies for mental health support. Examples illustrated limited access to online services and similar technologies for disadvantaged populations and those living in rural, remote and regional areas.

Internet-based health initiatives are only as useful as their accessibility and a lack of reliable internet available to Aboriginal and Torres Strait Islander and rural communities is a significant disadvantage to these groups.

Doctor, Victoria

7.3.3 Suggestions to improve use of technologies in mental health services

Incorporate alternative service delivery technologies

The need to incorporate technologies and alternative mental health therapies into existing and “traditional” models of mental health service delivery was expressed by many respondents. Although many identified the challenges that this can produce, respondents frequently recommended that these services be incorporated as an adjunct to complement and work alongside existing models.

Mental health is definitely not a 'one-size-fits-all' model, so it is essential we ensure the support available for those suffering with mental health problems remains diverse. This includes maintaining a balance of face-to-face and alternative services. I think online services are an excellent resource for both people who are not ready/comfortable to seek help and rural Australians. E-health can also provide care and support outside office hours, which I know, from personal experience, is quite often when young people need help the most.

Person with lived experience, Tasmania

Many respondents provided examples of how online services by themselves are ineffective, and vice versa. Recommendations highlighted the need to have an effective balance of services accessible through various avenues.

Technologies simply cannot replace therapy, particularly for young people with complex, severe and enduring mental health problems such as major depression, drug and alcohol addictions, eating disorders, psychosis and personality disorders. That said, used effectively and as a part of a comprehensive and integrated mental health system, technologies have the potential to reach a large number of people at lower cost to treat high prevalence disorders like anxiety and depression, thereby freeing up professionals and services to focus on those with more complex needs.

Young and Well Cooperative Research Centre

Increase access to service providers through telephone and internet sessions

The use of telephone counselling and internet sessions to increase access to service providers was mentioned frequently as an effective use of technology that should be prioritised and expanded to improve accessibility of mental health services.

If I could request anything I would ask for more serious online and hotline services, not just crisis hotlines, but 6–10 sessions of phone counselling. I have looked for these services before (both for my own mental health and for the young people I work with as a youth worker) and haven't found any other than crisis lines. I want a personal counselling session over the phone with a trained professional, who I can speak to for several sessions, or a one-off.

Person with lived experience, Western Australia

Multiple respondents perceived the provision of psychological services through telephone or online services to be an effective use of resources. However, the need to address existing constraints in availability and affordability of these services for people with lived experience was frequently cited.

Phone consultations with a trusted psychologist who has been successful in the past for treating me and who knows my entire mental health history were more beneficial than face-to-face consults with another professional. I had to cease my phone consultations due to financial reasons which has set my recovery back considerably and even though I have found another care provider, I do not feel as comfortable and feel this is jeopardising my recovery.

Person with lived experience, Australian Capital Territory

Multiple professionals, organisations and people with lived experience recommended the expansion of Medicare rebates for consultations that occur via this method to professionals other than psychiatrists.

People in rural areas often want to receive my services but are not covered by Medicare for phone consultations. I have worked in EAP programmes in the private sector providing clinical psychology treatment via telephone and it was as effective as my face-to-face work. It would make the world of difference if Medicare could provide phone treatment to people in rural settings as they would have a far wider choice of service providers.

Clinical psychologist, South Australia

Improve existing technological infrastructure

Respondents provided a number of examples of how the existing technological infrastructure could be strengthened to improve the efficiency and effectiveness of mental health services. Many professionals indicated a number of areas where technology could be better integrated into the everyday provision of services with clients. Examples were provided in the existing systems to access Medicare rebates, perform referrals and record, collect and share client information.

The need to expand use of shared electronic patient records, and the potential benefits including time saving, improved continuity of care and patient safety, were commonly mentioned.

A key enabler for coordinated care is e-health, including an e-health record. The personally controlled e-health record might be a solution but the roll out has been slow and there has been few “drivers” for state-funded organisations to get involved. The e-health record has the capacity to work well and improve informed, available and cohesive care and improve the effectiveness of services for consumers. More work should be done to support uptake amongst mental health clinicians and with states to push uptake in hospitals, community health services and not for profit organisations.

De-identified mental health planning organisation

Better integration of mental health care with physical health care also was indicated as a potential benefit.

Integration of electronic patient files across services would clearly offer greater opportunities for care that bridges current mental and physical health divides, and integration of selected e-mental health programmes and services with electronic patient files would offer even greater efficiencies, effectiveness and safety.

Clinical psychologist, Queensland

7.4 Promising practice examples in using technology

7.4.1 Innovative uses of technology in existing programmes

Multiple examples were provided of the innovative use of technologies in mental health services and programmes.

Technology has been used to improve data collection in existing programmes.

The use of technology at headspace, as an example, has improved the effectiveness of gathering minimum data from young people attending the service. Headspace Lismore uses iPads which electronically collect the data and are linked to online scoring and interpretation. The iPad also collects information on the client experience of services at headspace, which provides valuable data for the service improvement and timeliness of service provision. The use of iPads and electronic data collection has enabled staff to access data, reports, trends in client outcomes and service information more easily.

North Coast NSW Medicare Local

Innovative use of social media also has been indicated to successfully link people with lived experience with mental health services and improve outcomes especially with youth.

The PSY [Preventing Suicide in Youth] Facebook Group has now approximately, 20,000 members from both Australia and New Zealand (gated community), and is governed strictly by 'duty of care' and ethical guidelines and policies for dealing with crisis management and response situations. A difficult and challenging medium for provision of such support, this PSY Facebook Group is also balanced by a positive, resilience-based approach to increasing help-seeking behaviour in youth and young adults, providing mentoring and education for members via well-trained and supervised volunteers.

An average of 400 requests for support are made each month and an average of 2 emergency services call-outs are made each week to the PSY Facebook Group. This data points clearly to a need within the youth and young adult community for help-seeking responses and support in the arena of suicidality and mental health. With the future prospect of rigorous evaluation of the website already in the planning stages, I have no doubt that this invaluable service will become even more critical and essential for meeting the future needs of our young people at risk.

Researcher, Queensland

7.4.2 Teleweb initiative programmes and services

The Australian Government's Teleweb initiative was mentioned as contributing to a number of successful online interventions and the use of innovative and effective mental health services.

The SANE Online Forums (a Teleweb project funded by the Australian Government) will come online in mid-2014, for the first time providing mutual support via online forums for carers as well as adult consumers, for people affected by any mental health condition, and concerned about any related issue—anywhere in Australia, 24/7.

The volume of users will ensure a rich and empathetic resource for people concerned about their own mental health or that of a person they care for—promoting guided self-care, mutual support and referral to local support services as needed. In addition to utilising a sophisticated technology platform, The SANE Online Forums will use an innovative distributed service model, in partnership with local consumer and carer support organisations all around Australia. Instead of solely expecting users to come to the SANE website to access the service, the service will go to them—embedded in the websites of their local mental health support organisations. This unparalleled level of support using peer-to-peer mutual support would be impossible without the use of technology and our syndicated service model, to provide a safe and effective environment for promoting recovery.

SANE Australia

8. Emerging approaches: integrated care

8.1 Key findings

Integrated care is not just about making sure that professionals communicate with each other about a person they are supporting (although this is an important aspect). In order to deliver a system of supports which recognises the needs of the whole person, meets interrelated needs and ensures that people do not fall into gaps between siloed services, multiple levels of integration are required.

These include:

- integrated governance and planning
- models of care recognising the person as an integrated whole
- infrastructure to support integration such as buildings and technology
- collaborative ways of working.

This chapter examines examples of each of these levels of integrated practice cited by respondents, and shows the consequences of the current failure to address these complementary aspects of integration. The key message is that integration is not just about structural change—it is about cultural change too. Providing and accessing an integrated system of supports was such a central concern of respondents to our call for submissions that it appears to be a prerequisite for improving outcomes for people experiencing mental illness.

8.2 Overview

Term of reference 6 asked the National Mental Health Commission to assess:

Existing and alternative approaches to supporting and funding mental health care

We selected two issues to highlight as alternative approaches to service delivery in response to this ToR. These stood out as prominent themes across responses from all respondent groups. Chapter 7 dealt with the potential of technologies to improve the delivery of existing models of mental health support and to be the basis of new models of care delivery in the future. This chapter discusses the role of innovative models of collaborative working and integrated care delivery in improving the outcomes and experiences of people with lived experience, family members and support people.

8.2.1 Survey questions

Professionals and organisations were asked to provide an example of different services, policies, programmes or initiatives which:

- a. demonstrate good integration, joint working, or collaboration with other services, programmes or initiatives
- b. are not well integrated or don't communicate with each other.

Although these were the only specific references to integration in the survey questions, responses relevant to this issue also were found throughout responses to other questions in the survey and were coded and used in this analysis.

People with lived experience, family members and support people were not asked to provide specific examples of integration, but references to integration, collaboration and communication were coded appropriately and used as the basis of analysis for this chapter.

8.2.2 Survey responses

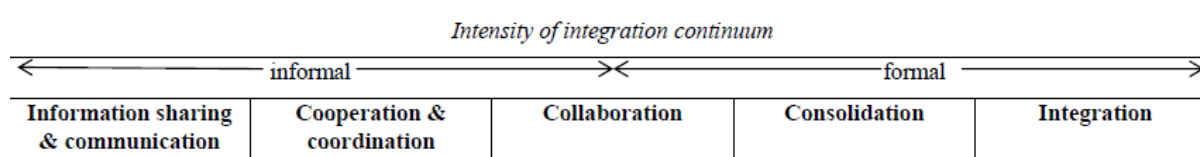
For question (a), 79.2 per cent of organisations (n=187) and 69.0 per cent of professionals (n=594) provided a response.

For question (b), 63.8 per cent of organisations (n=150) and 47.7 per cent of professionals (n=411) provided a response.

8.2.3 Note on interpretation

The term ‘integrated care’ is commonly used in health and welfare policy. However, what it actually means is seldom properly defined. For the analysis underpinning this chapter, we have elected to be inclusive, and have adopted Konrad’s continuum of integration which incorporates a range of types of integration according to formality of the joint working arrangements.

Figure 2 Konrad’s continuum of integration



Source: Konrad, E. L., A multidimensional framework for conceptualizing human services integration initiatives. In Marquart, J. M., and Konrad, E. L. (eds.), *Evaluating Initiatives to Integrate Human Services*, Jossey-Bass, San Francisco, 1996.

The definitions along this spectrum are diverse, but all share the implication that some agent (a person, organisation, group) is engaged in a sustained way in a joint endeavour with another agent across some divide (such as a boundary between professional disciplines, organisations or sectors). In the case of mental health supports, agents may be working towards a shared goal to improve the life experiences or health outcomes of an individual or of a defined group of people.

8.3 Thematic findings

8.3.1 Overall

Improving the way professionals, people with lived experience, family members and support people, organisations, sectors and jurisdictions work together across traditional boundaries was one of all groups of respondents’ most commonly mentioned concerns about mental health services and programmes.

This is perhaps because improving the integration of services and programmes at multiple levels of the mental health system is seen as a basic mechanism to effect mental health reform. Many of the problems with the quality, effectiveness and efficiency of mental health support cited by respondents are attributed to the ‘system’ being fragmented. This fragmentation extends from the highest levels of governance (such as confusion about state and federal responsibilities) to the poor experiences of people with lived experience whose support professionals do not talk to one another.

This chapter examines what people told us about evidence of insufficient integration, collaboration and communication within and between programmes and services, and the consequences of this for people with lived experience, family members, support people, professionals and taxpayers. We also received many examples of pockets of effective

collaboration and integration, and from these examples we have developed a picture of the types of integration that are possible and the benefits which can accrue.

While not proposing that increased collaboration and integration is a panacea, our analysis shows that these are considered by many stakeholders to be both structural and cultural prerequisites for reform.

8.3.2 Consequences of failure to achieve joint working and integration

Evidence of lack of collaboration and integration appears in many other parts of this document, and this lack is frequently perceived as contributing to poor experiences and outcomes for people with lived experience, family members and support people, as well as inefficiencies in the system. In particular, the analysis of gaps in programmes and services presented in Chapter 6 of this document (ToR 5) is a catalogue of evidence for such a lack.

Many of these failures reflect a system that is not set up to see the whole person or to tackle interrelated needs in a coordinated way. In responses from people with lived experience, family members and support people it became clear that where people do receive effective support for complex or multiple needs, this is the result of an ad-hoc process whereby the initiative and energy of individual clinicians and other professionals is the glue holding the system of support together. It also was common for people with lived experience, family members and support people to report that they themselves had become default care coordinators in the absence of any other mechanism to achieve this.

For many, this task proves difficult or impossible because they have no way of knowing what support was available or what different support organisations are supposed to do. Therefore, where a person did have a good experience of multiple supports working together, this seemed often to be despite the 'system' rather than because of it.

There was a common thread to many of the stories we received about poor experiences of mental health services and programmes. This was a failure of continuity and consistency of support resulting from the failure of different sectors (such as health, education, or housing), different organisations and individual professionals to communicate with each other about the individual person's support. People with lived experiences reported having to repeat their story multiple times to multiple providers, and sometimes to the same provider.

Educate peripheral service providers, e.g. housing, education, rehabilitation, Centrelink to become involved in and communicate with psychological and medical providers, to facilitate holistic interventions and treatments that address every aspect of a mentally ill person's needs. Otherwise everyone's efforts are often wasted, don't last, or result in a situation where one problem is addressed only to have another arise, which causes deterioration in the first etc. etc.

Clinical psychologist, Western Australia

As we noted in relation to ToR 5 (gaps in services and programmes), people with lived experience report commonly being left without ongoing support after a short episode of care (such as an inpatient admission or a series of Better Access sessions), or after a visit to an emergency department.

My friend recently attempted suicide twice. [In] both cases she was admitted to [the emergency department] but in the second case they had no idea about the first time she had

been admitted which was only [a few] weeks prior. So she was very traumatised about speaking about her experience over and over again to the many different health professionals ... There was no communication between them internally or across the incidents.

Person with lived experience, Victoria

The absence of a well-integrated system of supports, whether at a national or local level or around an individual person, means that people experiencing mental illness receive a sub-optimal level of care unless they are able to self-advocate or have tireless personal or professional advocacy to find and receive the combinations of supports they need.

There is a wider implication of this absence, however, which is overall inefficiency of investment in mental health services and programmes. Wherever a person has one difficulty addressed but another is ignored, wherever they have to repeat their story, wherever a professional does not know a person's history, quality of support is compromised and a cycle of deterioration, crisis and inpatient treatment is more likely. The burnout of personal support people and secondary social and economic impacts also are more likely to happen with repeated experiences of this type.

I had a team of doctors for several different injuries after a car accident. A neurologist diagnosed my migraines as being caused by depression/anxiety, then prescribed me medication—without consulting with my psychiatrist to see if these meds would clash with what I was prescribed by the psychiatrist. The end result was an increase of my psychological issues, leading to my last suicide attempt.

Person with lived experience, New South Wales

The consequences of the current failure to adopt integrated service models, sustained inter-professional communication, collaborative ways of working or the governance and infrastructure to support these, are perceived to be damaging for people and governments alike.

8.3.3 Levels of integration and collaboration

It is difficult to talk about 'integrated care' (as in service delivery) in isolation. Respondents reflected the interdependence of different levels of integrated working, from high-level governance to how individual professionals work together. It seems from the responses we received that so-called 'integrated care' is not just achieved at the 'coalface' of support and treatment, but that it must be supported by infrastructure which encourages boundary-crossing, and by a culture of collaborative working which infuses the whole mental health system.

Findings for the remainder of this chapter are presented according to the different aspects of integration and collaboration identified in submissions. The levels of integration mentioned by respondents were:

- Integrated governance and planning
- Integrated philosophy and model of care
- Infrastructure to support integration (finance, technology, buildings)
- Collaborative ways of working.

For each type, the following are identified:

- Rationale and proposed benefits of this type of integration
- Proposed mechanisms to achieve this type of integration
- Barriers to this type of integration
- Examples of this aspect of integration at work.

Integrated governance and planning

Joint governance and planning of mental health supports was thought by many respondents to be a necessary foundation to underpin the delivery of integrated services and programmes. The following excerpt summarises the case for integrated governance.

In our experience, mental health clients require an array of physical, social and psychological services. The biggest challenge is lack of coordination of this care. This coordination does not require an additional layer of services, but greater integration of services. For the majority of clients, this can be achieved through the 'Medical Home' or 'Wrapped-Around' model of care. ... What is required is a reconceptualisation of funding and service design guidelines to achieve this care coordination.

North Coast NSW Medicare Local

Different forms of joint governance were mentioned by respondents. Shared structures may be set up, such as a centralised triage or intake point which acts as a hub for referral to a range of agencies, programmes or services. Agreements may be made between agencies sharing similar goals to tackle those goals in a collaborative rather than competitive way.

WentWest has partnered with the Western Sydney Local Health District (WSLHD) and the Aboriginal Medical Service Western Sydney (AMSWS) to address the so-called Common Health Priorities within the region, of which mental health is one. This is undertaken through joint planning, capacity-building, programmes and strategies. This work is critical to building a better primary health care system and better equity. The evidence shows that this is fundamental if we are to reduce this burden of disease and keep people well and out of hospital.

WentWest

Another form of this type of governance entails setting up formal structures for sustained and regular involvement of people with lived experience, family members, support people and communities in the design, operation and evaluation of particular mental health supports.

The key to mental health service reform is true collaborative partnerships based on trust and mutual respect. These partnerships need to occur on many levels, between and among services and service providers, but most importantly with consumers. They should be seen as the real leaders of mental health service reform and health care professionals should adopt a 'leadership of service' to mental health consumers.

Faculty of Health, University of Technology Sydney

A concrete example of this philosophy in practice can be seen in the following quote.

The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) administers the COPMI initiative. The association's aim is to actively promote the mental health and wellbeing of infants, children, adolescents and their families and/or carers in Australia. The meaningful involvement of people living with mental health problems and their families/supporters is a key philosophy and practice of the organisation and is evident at all levels. COPMI's consultation group, the COPMI National Lived Experience Forum, meets on a quarterly basis and is involved in the development of all the initiative's materials and resources as well as recruitment of staff.

AICAFMHA

Integrated governance also may involve a collaboration of multiple agencies jointly conducting a needs assessment and setting out a plan for how they will cooperate to meet the needs of their local population. This may then be followed by a long-term commitment to a joint approach to service delivery. Multiple agencies may come from the same sector (e.g. health agencies funded by state and Commonwealth source, or health agencies at primary and secondary care level) or may originate in traditionally separate sectors.

Integrated or collaborative governance is seen in a variety of contexts, not just service delivery. Often, a project or initiative to improve mental health support—such as guideline development or investigation of new technologies—is developed in partnership between different types of stakeholders including service providers and universities. The idea of leveraging combined expertise and integrating theory and practice is important here.

The National Centre for Farmer Health (NCFH) [is] one of the most exciting initiatives in agricultural healthcare in more than a generation. It is a new university research, service delivery and education centre that provides national leadership to improve the health and wellbeing of farmers, farm workers and their families across Australia. It is a partnership between Deakin University and Western District Health Service.

National Farmers' Federation (NFF)

Barriers to integrated governance and joint planning primarily appear to stem from disparate funding streams (for Commonwealth programmes, philanthropic sources, state government funding and so on) and competition for funding at local or regional level. These can act as disincentives for collaboration between agencies, sectors and organisations.

The process of tendering to multiple NGOs encourages competition among participants and reduces inter-agency cooperation. Often those agencies are not locally managed and this impacts on service provision, costs of service and their ability to coordinate with other local services.

Broken Hill Department of Rural Health, University of Sydney

Integrated philosophy and model of care

The benefits of joint governance and planning which cross organisational or sector boundaries include the increased ability to implement a 'no wrong door' policy. If a combination of services and programmes are designed on a regional level to work together to meet the needs of that region, it should not matter which programme or service a person goes to first. The

idea is that a person accessing any service will have their whole-of-life needs jointly assessed by the relevant agencies, which, together with the person, decide which of their service offerings will, in combination, meet these needs. This is more user-friendly for people with lived experience, family members and support people, who do not need to act as their own care coordinators across a fragmented system.

The idea of integrated governance, therefore, is that it will make it easier for local services and programmes to be implemented in a way which recognises and attempts to meet the needs of the whole person, in their family and community context, rather than as a collection of isolated symptoms and needs. In other words, 'integrated care' presumes that the person with lived experience is seen as an integrated whole with interdependent needs, strengths and preferences.

Respondents gave us many isolated examples of services and programmes which they felt were guided by such an integrated view of the person. Commonly, these demonstrate a 'client pathway' approach to delivering support, where the goal is that the person experiences a seamless continuity of care, however many service or programme boundaries they may cross.

One mechanism for achieving this cited by respondents is to orientate mental health supports around primary healthcare. Increasingly, for example, psychologists are working within primary healthcare practices alongside GPs. Other examples of primary healthcare-oriented integrated service models are seen in some rural and remote primary health care services which, out of necessity, pool expertise and limited workforce to deliver a wide range of services.

Primary care psychology involving the co-location of appropriately trained psychologists in the primary care setting with GPs enables optimal (effective and efficient) reporting and team-based integration of knowledge about the patient. Use of "Medical Director" or "Best Practice" software systems in the general practice setting enable both the doctor and psychologist to share (from session to session) approved but confidential information in a way that serves patient best interest and outcomes. Given delays in the e-health initiative, this integrated note-taking is not available between professionals working in their own separate "silos"—such as psychiatrists and psychologists who work autonomously in their private practice settings. Shared notes, co-location enabling effective and timely (often informal) verbal interchanges (again in confidence) enhances patient care. Research evidence also indicates that such multi-disciplinary team-based care and communication results in better treatment outcomes.

Clinical and health psychologist, New South Wales

Infrastructure to support integration

The above example shows that an important aspect of providing an integrated service model is that it requires the participating agencies or professionals to share information, to ensure continuity of care and to reduce duplication of effort. Respondents mentioned that a shared care record, hosted on an IT platform which is accessible by all agencies and professionals, can significantly aid this process.

Infrastructure may come in the form of introducing new workforce roles to actively coordinate services around a person. This is an alternative to top-down mechanisms of integrated governance where organisations routinely work together. Instead, active coordination requires that particular professionals or organisations work together on an ad-hoc basis where the needs of a particular person demand it. These already exist in many places in the form of care

coordination professionals and most recently in the form of Partners in Recovery support facilitators, but it appears that the availability of such supports is confined to people with the most complex needs and even then only in certain places.

A third type of infrastructure to support integrated care is the provision of buildings where collocation can occur. This is where multiple agencies, organisations and professionals house their services in the same or nearby buildings, theoretically increasing their ability to work together to meet interrelated needs, and increasing convenience for the client.

Collaborative ways of working

The idea of setting up joint governance, infrastructure and whole-person models of care is to make it easier for those working in support services to implement collaborative ways of working during their everyday practice. In theory, working collaboratively 'at the coalface' is increasingly being achieved through multi-disciplinary teams within health services, which sometimes have housing, vocational and drug and alcohol specialists embedded within the team. Better Access was mentioned by people with lived experience and professionals alike as facilitating communication between professionals who usually work in isolation. Having what feels like a network of informal and professional supports around them who communicate with one another can be important to some people with lived experience (while raising privacy concerns for others).

Having a "safety net" of connected people that I can rely on in periods/moments of crisis to take action if required. This includes my wife, GP, counsellor, psychiatrist, close friends. During some episodes of depression and suicidality in the past months, it was important that they knew they had my prior permission to escalate concern over my wellbeing and, if required, intervene on my behalf.

Person with lived experience and support person, Victoria

However, collaborative whole-person integrated care is about more than crossing inter-disciplinary boundaries—it also is about crossing traditional organisational and sectoral boundaries. The following is an example of mental health supports in a rural area which worked collaboratively to improve whole-of-life outcomes for a person who had previously been in and out of hospital in a far distant metropolitan area. According to the excerpt below, a new intermediate care service (ICS) was able to intervene in this cycle by working with existing community professionals.

The consumer was homeless, with a history of not being able to maintain their living environment, physical, financial and own wellbeing, not compliant with medication or keeping of appointments. A relationship was established with clinician and psychosocial support worker while in hospital. The local mental health clinician had an excellent relationship with the local hospital, enabling the consumer to stay in hospital for 30 days with escorted day leave to establish a sustainable community living environment. Result in consumer now living in rented accommodation, with ongoing psychosocial support, paying rent, cooking for self, maintaining daily living requirements etc. This outcome was possible due to the flexibility of the ICS program across the community, local general hospital and government and non-government organisations.

National Alliance for Rural Mental Health

People with lived experience, family members and support people often reported that it is important to feel they are a part of a collaborative arrangement where all parties are committed to working towards their goals.

[What is effective in terms of mental health supports?] Patients and doctors/therapists working together through setting and working to achieve the patient's goals. In addition, the therapist exercising patience with the patient. My psychiatrist is patient with me and together, we set ways for me to get better sooner.

Person with lived experience and support person, Western Australia

8.4 Promising practice example of collaborative working and integrated services

Integration of education and health and wellbeing supports were seen by many respondents as a desirable way to ensure that school achievement and attendance is not affected by mental health difficulties. This was one of the more common inter-sectoral integration opportunities identified.

The benefits of having mental health supports working as part of the school community, under partnership arrangements between health and education authorities, are thought to include: a reduced sense of stigma for young people and for parents if supports can be accessed in school settings; an opportunity for widespread early intervention in emerging mental health difficulties; and the ability to meet the young person in their own life context. The following example describes such a partnership which is underpinned not only by a shared vision and governance, but a whole-of-community, whole-of-family approach to children's wellbeing in recognition of their interdependent needs.

Doveton College is a community focused school in the City of Casey in south-east Melbourne catering for families and children, prenatal to early adulthood by offering a fully integrated wrap-around service, including early learning, family support, and mental health support services. Doveton also provides a range of community development initiatives. The model is strongly supported by research recommending school and community services are needed to be woven together to overcome barriers for children's learning and development. Within this initiative Family Life provides access to the Family Mental Health Support Services ([SHINE](#)), and has delivered our Creating Capable Leaders program in 2013, developing skills for local leadership and volunteering. The eight-week program achieved more than 20 parent graduates in 2013 alone, who are now actively leading local initiatives such as a food cooperative to improve child and community wellbeing.

The Family Mental Support staff work closely with other service providers at the college such as general practitioners, allied health, early childhood intervention services, family support services and teachers. All the services contribute and subscribe to a shared vision, use one family file, establish partnerships and create effective referral pathways between each participating agency. All participating agencies sign a Memorandum of Understanding (MoU) with Doveton College for the services they provide.

Family Life (Southern Family Life Service Association Inc.)

9. Mental health research

9.1 Key findings

Responses identified a number of perceived problems with the current mental health research agenda in Australia. The most prominent were:

- gaps in existing research activity in terms of both topic and methodology
- misaligned priorities in mental health research
- research evidence not translated into practice.

To address these problems, a number of improvements and changes to mental health research were suggested. Most commonly these were:

- increased funding for mental health research
- integration of service priorities and research activity
- partnerships between researchers and service providers
- research coordination and information sharing.

Promising practice examples of research initiatives in mental health include recent initiatives by the National Health and Medical Research Council (NHMRC) to improve translation of research evidence. The formation of groups such as the Alliance for the Prevention of Mental Disorders also is contributing to more informed mental health policy decision-making and a shift from treatment to prevention research.

9.2 Overview

Term of reference 7 asked the National Mental Health Commission to assess:

Mental health research, workforce development and training

The research aspect of ToR 7 is dealt with in this chapter. The ‘workforce development and training’ aspect is the subject of a separate analysis in Chapter 10.

9.2.1 Survey questions

Professionals and organisations were asked to provide an example of a service, policy, programme or initiative which demonstrated:

- a. regular and effective use of evaluation or research to inform evidence-based practice
- b. poorly prioritised, funded or organised research activities.

All respondents, including people with lived experience and support people, were asked:

- c. What is your view about the current funding, organisation and prioritisation of mental health research?
- d. What specific action or strategy do you think could improve this situation?

9.2.2 Survey responses

For question (a) 62.7 per cent of organisations (n=148) and 43.1 per cent of professionals (n=371) provided a response.

For question (b) 41.1 per cent of organisations (n=97) and 26.7 per cent of professionals (n=230) provided a response.

For question (c) 32.6 per cent of organisations (n=77), 18.9 per cent of professionals (n=163), and 16.4 per cent of people with lived experience and support people (n=102) provided a response.

For question (d) 30.5 per cent of organisations (n=72), 16.1 per cent of professionals (n=139) and 13.5 per cent of people with lived experience and support people (n=84) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

9.2.3 Note on interpretation

It should be noted that although service and programme evaluation are often seen as distinct activities from formal academic research, respondents to our survey commonly interpreted 'research' to include service evaluation as a sub-category. We have therefore included comment on service and programme evaluation in our analysis for this ToR, but have also considered the use of evaluation for accountability purposes as part of ToR 10 on transparency and accountability.

9.3 Thematic findings

9.3.1 Perceived problems with current research in mental health

Gaps in existing research activity

Respondents from all backgrounds listed a multitude of research gaps spanning a wide variety of mental health topics, conditions, interventions and services. Research regarding the effectiveness of existing services was more commonly identified as being of potential use but currently under-resourced in comparison to research into new treatments, interventions and practices. All categories of respondent provided examples of research gaps in assessing the effectiveness of mental health services and programmes currently being delivered across Australia.

There would be benefits to both clinicians and policy makers if the funding priorities for mental health research included studies on the effectiveness of mental health interventions and service delivery models, including programme evaluations. Efficacy and effectiveness studies serve different purposes, although funding for the latter is increasingly scarce in Australia.

Australian Psychological Society

A key research gap in such applied research was identified as being investigation of effective preventive approaches to mental health support. Within prevention research, the need to research approaches to improve mental health awareness among the general public, assist with suicide prevention and address environmental and other socio-economic risk factors for mental illness were specifically cited.

We need to fund research into evidence-based preventative approaches to reduce the reliance on 'medical model' approaches. There needs to be a lot more research into early intervention strategies. For example, empowering people in how to support themselves and what to do to alleviate a crisis; low-security support residential retreat services should be trialled to see

whether it significantly alleviates the course of illness and prevents in-patient unit care and emergency transport.

Researcher, New South Wales

The consensus from a large body of evidence supports the contention that interventions to prevent mental disorders across the lifespan can be both effective and cost-effective. However, funding for research in the area of prevention of common mental disorders is considerably lower than that for research in the areas of treatment, epidemiology and neurobiology. Thus, there is a clear imperative to direct funding towards prevention research to redress this imbalance.

The Benevolent Society

Research into addressing existing service gaps and mental health disparities among disadvantaged groups and populations also was felt to be under-prioritised. Research into the specific support needs and effective service responses for children and youth, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups, marginalised and at-risk populations, individuals living in rural and remote communities, LGBTI groups and ageing populations were all cited as being in need of attention.

The lack of translational CALD mental health research is an inhibitor for services which are interested in addressing service gaps through utilisation of contemporary evidence-based research practice. Better coordination and governance around evaluation and research would assist in supporting creativity and innovation in terms of CALD mental health service planning, allocation of resources and routine review of service delivery outcomes.

Mental Health in Multicultural Australia (MHIMA)

Misaligned priorities in mental health research

Existing priorities in mental health research appear to many respondents to be poorly aligned with the existing service needs, and with gaps in knowledge about what works within mental health services. Respondents often cited current funding arrangements and prioritisation of research as ineffective in ensuring the most beneficial mental health outcomes.

For example, over-prioritisation of clinically focused research was thought to lead to decreased funding availability for mental health research outside the realm of a medical model.

The funding, organisation and prioritisation of mental health research in Australia tends to have a focus on scientific research to facilitate an improvement in the outcomes of clinical intervention. By comparison, research in the psychosocial, including vocational, recovery field is relatively under-resourced and undeveloped in Australia, compared to what has been achieved in the rest of the developed world.

The Richmond Fellowship of WA

Such a clinical focus was perceived to be exemplified by the distribution of funding under grants given by the National Health and Medical Research Council (NHMRC).

There is a lack of interest in funding research which is to evaluate and implement mental health projects. NHMRC has a particular focus on the biomedical model of health and as such mental health lacks the intensity of research required to alleviate the burden of mental health on families, communities and peak service providers along with governments.

Centre for Rural and Remote Mental Health, University of Newcastle

A variation on this theme was a perceived prioritisation of basic or experimental research in preference to applied mental health research to solve existing problems. Examples were provided of funding being disproportionately awarded to studies that are conducted under controlled conditions and which therefore are seen to lack immediate 'real world' applications.

We have argued that mental health research funding is heavily biased in favour of RCTs, and against meaningful 'real world' research, which may often be much more cost-effective and immediate in its impact. We note that "major" funding bodies such as the NHMRC typically privilege efficacy and basic science research, usually conducted in city-based university settings. We draw attention to the dearth of translational and implementation research in mental health; we suggest that Australia is lagging behind some other countries in its approach to implementation research; and in terms of 'real world impact,' we question whether government and research funders have currently got the balance right.

University Centre for Rural Health North Coast (NSW)

Research evidence not translated into practice

People with lived experience, professionals and organisations provided a number of examples where it was perceived that mental health research findings had not been effectively integrated into existing mental health policies, services and programmes. Often, existing evidence regarding effective therapies, treatment models and methods of service delivery were seen as not being incorporated into policies, service models and programmes.

There was frustration that research regarding the effective number of therapy sessions with clinical psychologists appeared to have been overlooked—along with positive evaluations of the scheme—in the move to change Medicare-supported consultations for psychological services under *Better Access*. Many thought that policy makers were ignoring the evidence.

We wouldn't dream of providing half a treatment for physical health problems, like a half dose of antibiotics, so why do we do this for mental health? Research evidence clearly shows some patients require longer-term psychological therapy, and that clinical psychologists are the most highly trained professionals and produce cost-effective outcomes.

Clinical psychologist, Victoria

9.3.2 Suggested improvements and changes to mental health research

Increased funding for mental health research

Respondents often mentioned the need for increased overall funding for mental health research. In addition to providing a number of examples where further funding in mental

research is needed, respondents often perceived that funding for mental health was not equally distributed in comparison to “physical” health research.

More globally, funding for research into mental health, which constitutes the third largest burden of disease, lags a long way behind funding for most physical disorders.

De-identified research organisation

Research activity is underfunded throughout Australia and the NHMRC or ARC do not prioritise it. Every year very small percentage (usually about 4–5 per cent) of the national medical research budget is spent on mental health.

Researcher, Victoria

Integration of service priorities and research activity

Many respondents identified that under existing funding arrangements, strategic prioritisation of mental health research is necessary to ensure the greatest potential benefit to the community. Many examples were provided which identified a need for organisations that fund and conduct research to ensure research activities address existing service gaps, improve delivery and access to services and contribute to positive mental health outcomes.

Research funding and prioritisation is seen to be removed from service needs and priorities.

The NHMRC uses a peer review process which seeks to ensure that the highest quality research proposals are funded. While this focus on excellence is, of course, important, it provides little opportunity to consider the strategic importance of particular areas of research or particular approaches.

While the NHMRC has the capacity to make a targeted call for research, it does so only rarely, relying instead on researchers to propose research topics. Better use of research funds could come from closer links between the research and mental healthcare sectors.

Research Australia

A promising example of how this has been achieved within cancer research also was provided by Research Australia.

Cancer Australia’s primary research funding program is the Priority driven Collaborative Cancer Research Scheme (PCCRS) to support research that reduces the impact of cancer on the community and improves outcomes for people affected by cancer. The scheme brings together the government funding administered by Cancer Australia with funding provided by other cancer research fundraising bodies in the philanthropic sector. It seeks to better coordinate the funding of cancer research across the whole sector, and seeks submissions for investigator-initiated research for specific research priorities in relation to cancer, covering the spectrum from primary to translational and public health research.

Research Australia

Partnerships between researchers and service providers

Strengthening the partnerships between researchers and service providers was another strategy for mental health research often mentioned by respondents. Examples were provided of how increased collaboration between researchers and service providers can contribute to a number of added benefits in providing evidence-based practice and ensuring effectiveness.

A more collaborative environment would be beneficial so all stakeholders are aware of research being conducted, and researchers improve their 'on-the-ground' knowledge of mental health treatment. This collaboration may operate to reduce research costs, by facilitating completion of programmes within services, which would increase sample sizes and reduce costs of payment to clinicians. Effectively this increases the likelihood of best practice being applied, and also had the potential to reduce funds required for research.

Hunter Medicare Local

A number of factors in the current approach to research, including funding arrangements, were also perceived to restrict collaboration. It was mentioned that an adjustment to how research is funded and incorporated is needed to increase collaboration.

Linkage and partnership research should encourage and support high-quality integration between services and researchers but often fails to do so. Project-based funding often results in episodic engagement rather than long-term collaboration. Services often have inadequate resources to make a genuine contribution and policy and funding settings are inadequate to promote strong commitment to research and evaluation. Benefits of participation in research and evaluation are often intangible. In the absence of a clear R&D culture framework, services understandably prioritise service delivery.

Faculty of Health, Queensland University of Technology

Research coordination and information sharing

In addition to building partnerships, respondents identified a need to improve research coordination and dissemination of findings in a 'digestible' format for practitioners. Examples were provided of how multiple research studies and service and programme evaluations fail to share findings of 'best practice' and to relay information in a systematic and useful way.

There are some fantastic innovations in rural mental health. However, due to lack of research infrastructure and coordinated knowledge translation, pockets of excellence remain virtually unknown and unrecognised. This is a tragic loss of valuable applied knowledge.

Broken Hill University Department of Rural Health, University of Sydney

Many respondents mentioned that there was a lack of information sharing between researchers and providers.

I just did a PhD. I received an OK scholarship. I finished my PhD and not one person in the university asked how my work could be applied in practice. This highlights my comment about the poor translation of research into practice. My PhD was on improving practice.

Respondents identified a need to increase information sharing between providers to ensure the most effective delivery of mental health services is achieved.

Currently funding is spread across multiple organisations running programmes and campaigns which have little evidence to support their use, and without built-in evaluation strategies to measure impact on the target audience. A large number of campaigns attempting to address stigma, suicide prevention and other areas of mental health promotion are often being run simultaneously with little coordination between agencies or sectors, resulting in the public receiving confusing and sometimes contradictory messaging.

headspace

9.4 Promising examples of research in practice

9.4.1 Initiatives from the National Health and Medical Research Council (NHMRC)

NHMRC Call for Action NHMRC has established a Research Translation Faculty to support expediting the translation of research evidence. The faculty, which comprises around 2,900 Chief Investigators and Fellows funded by NHMRC, has been asked to identify areas where research outcomes have not been taken up in policy and practice, and put together a written case proposing actions to address this. Mental health is one of 14 areas of focus for the faculty. These 'Cases for Action' will initially be considered by the Council of NHMRC. The mental health Case for Action is expected to be considered in the first half of 2015.

NHMRC's Prevention and Community Health Committee (PCHC) provides evidence-based health advice to the Council of NHMRC on a range of matters in community and population health, prevention and environmental health. PCHC is examining effective parenting practices and their role in promoting resilience and mental wellbeing in children and later on as adults. PCHC is aiming to develop advice for parents, including those in high risk and disadvantaged groups.

National Health and Medical Research Council

9.4.2 Information and support to policy makers

The new Alliance for the Prevention of Mental Disorders (APMD.org.au), which represents many of the most senior mental health researchers in Australia, has been set up to provide information and support to policy makers. Our aim is to support the realignment of mental health research and services from a predominant emphasis on treatment to prevention and mental health promotion. This approach recognises the centrality of mental health to the physical and economic health of the population, and prevention and promotion as the most effective and cost-effective approaches to the considerable global burden of disease imposed by mental disorders.

Researcher, Victoria

10. Mental health workforce planning, development and training

10.1 Key findings

Respondents identified three key elements of **effective use** of the mental health workforce, incorporating planning, training and development. These were:

1. Strategic alignment of workforce planning and distribution priorities with changing policy and provision priorities including identified gaps and unmet need.
2. Using development and training to promote and enable collaborative working within multi-disciplinary teams and between different health and welfare agencies.
3. Ensuring adequate emotional support for staff in order to improve staff retention and prevent burnout.

Current workforce **barriers** to optimal outcomes for people with lived experience, family members and support people included:

1. Inequitable geographic distribution of professionals.
2. Inequitable recognition of disciplinary groups under Commonwealth programmes.
3. Imbalance between medical and allied health rebates under Better Access creating a skew towards a medical model of care.
4. Stigmatising, dismissive or judgemental attitudes among service providers.

Options for **improving** workforce planning, training and development include a 'back to basics' approach which:

1. Prioritises the person with lived experience, family member and support person experience of their interaction with services.
2. Addresses attitudes among professionals which are detrimental to the person with lived experience.
3. Acknowledges the basic importance of the professional-client relationship in the effective practice of mental health care.

10.2 Overview

Term of reference 7 asked the National Mental Health Commission to assess:

Mental health research, workforce development and training

This analysis deals only with the workforce aspect of ToR 7. The research aspect is the subject of a separate analysis in Chapter 9 of this document.

10.2.1 Survey questions

Professionals and organisations were asked to provide an example of a service, policy, programme or initiative which demonstrated:

- a. effective workforce planning, development or training
- b. poor use or planning of workforce/human resources.

All respondents, including people with lived experience and support people, were asked:

- c. What is your view about the current way mental health workforce development and training is carried out in Australia; and
- d. What specific action or strategy do you think could improve this situation?

10.2.2 Survey responses

For question (a) 58.5 per cent of organisations (n=138) and 34.6 per cent of professionals (n=298) provided a response.

For question (b) 44.1 per cent of organisations (n=104) and 27.1 per cent of professionals (n=233) provided a response.

For question (c) 45.3 per cent of organisations (n=107), 27.2 per cent of professionals (n=234), and 15.9 per cent of people with lived experience and support people (n=99) provided a response.

For question (d) 40.7 per cent of organisations (n=96), 23.6 per cent of professionals (n=203) and 13.7 per cent of people with lived experience and support people (n=85) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

10.2.3 Note on interpretation

It should be noted that responses from professionals are not representative of the entire mental health workforce. A high number of respondents identified as psychologists, while there was limited representation from nursing and medical fields, including psychiatry and general practice. It should also be noted that there is an uneven distribution of responses between states, rural and metropolitan areas, as well as between workers from acute care and community care settings. Respondents working in the private sector far outnumber not-for-profit and public sector employees.

10.3 Thematic Findings

10.3.1 Overall

Workforce issues identified by survey respondents highlighted the multiple layers and complexity of workforce development within mental health services. Respondents provided examples from an organisational level to an individual level, and identified challenges across education, ongoing professional development and training, regulation, supervision and management, recruitment and retention within a number of disciplines. Workforce planning issues also were raised regarding appropriate and optimal use of human resources and ensuring roles and responsibilities of professionals are well aligned to the needs of people. Respondents identified a number of areas across and between disciplines where improved workforce planning could be used to strengthen the delivery of mental health services.

10.3.2 Elements of effective planning and use of the workforce

Strategic alignment of workforce development priorities with identified service gaps

Respondents identified a wide range of examples of how effective workforce strategies are being used to address current service gaps within mental health services. There were two primary examples of successful workforce strategies proposed to address these needs—the delivery of targeted professional development, education and training of existing mental health professionals, and coordination and collaboration with educational institutions to increase workforce numbers in specialties where high needs exist.

We received evidence that professionals across disciplines are being provided with additional training and professional development to meet current or anticipated mental health needs within the community. As a result of the wide variety of mental health professionals and organisations represented, a range of successful professional development and training programmes being implemented at a number of levels was identified. These ranged from innovative and unique internal training programmes in a single organisation, to national workforce education programmes that have been implemented across a number of settings. In general, opportunities to participate in or deliver staff training were viewed favourably by organisations and professionals.

A commonly cited example of a successful national intervention involved the up-skilling of mental health professionals to address an existing service gap in the delivery of children's mental health services. The provision of children's mental health training through the Tier 2 ATAPS programme was mentioned frequently as contributing to positive service outcomes.

The use of workforce planning principles to identify a potential gap in training has enabled the anticipated workforce challenges to be addressed 'upfront' in a rapid, accessible and cost-effective manner. The recipients of the CMHS [Children's Mental Health Service] now have access to clinicians with up-to-date training and able to deliver evidence-based practice suitable to the developmental age of the consumer.

Australian Psychological Society

Further mental health training for GPs and new accreditation standards set by the General Practice Mental Health Standards Collaboration (GPMHSC) were also mentioned as positive developments by some respondents. Such training was seen as particularly valuable in rural areas.

A GP from a rural Queensland town with a population of 4,500 explained how her advanced focused psychological skills in mental health were vital when her town became severely affected by drought. With waiting times of several weeks to access mental health services through headspace, the Divisions of General Practice and hospital-based mental health teams, this GP was able to provide timely and local treatment to individuals with chronic mental health issues. The town did not have a resident psychiatrist or psychologist, so the GP was able to address this service gap and play an integral part in mental health service delivery in her rural area.

Royal Australian College of General Practitioners (RACGP)

Another common example of where workforce training was used successfully to address service gaps was in the delivery of mental health services for ageing populations. Not only was this identified as a strategy to address current needs, but also as an example of how service planning can anticipate future workforce demands.

By having a 10-year plan, public mental health services for older people in NSW have been able to link service development priorities to workforce information and training. As community services were planned to expand significantly, a significant proportion of clinicians were expected to have limited experience. Therefore 'beginner competencies' for older persons mental health clinicians were developed, then cooperation with the NSW Institute of Psychiatry, both their older persons mental health training adapted to support this, and training developed to assist managers to use the competencies constructively.

Psychiatrist, New South Wales

The second most commonly identified workforce strategy for filling service gaps was through links with educational institutions and targeted training pathways to meet current needs. Numerous responses from both professionals and organisations identified how strategic planning and coordination between academic institutions and service providers can help leverage the existing workforce for better outcomes. This was achieved in a number of ways, including the provision of scholarships, and targeted recruitment and training within final placements. Numerous benefits were identified, including improved staffing ratios, cost-effective service delivery and higher staff retention.

Respondents mentioned successful programmes where students are recruited into high-needs areas. The most common examples highlighted the benefits of targeted training programmes in remote and rural areas.

The Commonwealth Government-funded Specialist Training Programme provides funding for training positions to enable medical specialist trainees to rotate through an expanded range of settings beyond traditional public teaching hospitals is an example of effective planning in the field of both workforce and training.

An example of such a successful programme is the Hunter New England Training in Psychiatry programme, which is a well-resourced rural specialist training programme that delivers care to a region of around 850,000. Models of specialist training such as this should be replicated in other regional centres if the Government is to ensure the supply of psychiatrists into the future.

Royal Australian and New Zealand College of Psychiatrists

Smaller organisations also find that training placements offered in high-needs areas can successfully address service delivery gaps.

Workforce development opportunities are informed by regional needs, workforce capacity and demands. For example, a developing workforce shortage in geropsychology services is being addressed through a psychologist placement programme in line with the region's ageing population, ageing workforce and shortage of state health services.

North Sydney Medicare Local

The provision of scholarships also was perceived to be a highly effective workforce strategy from both the professional and organisation perspective. Examples of numerous scholarship programmes and resulting benefits were provided.

There is no strategic development of a rural and remote mental health workforce other than current University Departments of Rural Health (UDRH) support (0.5 FTE) for students and mental health workers. A concerted effort with scholarship programs that are targeted—through UDRH, for example—would greatly improve the rural and remote mental health workforce.

Mount Isa Centre for Rural & Remote Health, James Cook University

Developing a collaborative mental health workforce

One of the most commonly identified examples of an effective mental health workforce was where a high level of collaboration existed within multi-disciplinary or multi-agency teams. Mental health professionals working closely with or alongside other service providers frequently was associated with positive service experiences and outcomes for those experiencing mental health issues. Respondents identified a number of benefits including improved communication, shared knowledge and expertise, increased understanding of clients' needs and experiences and improved continuity of care.

For example:

- Psychology services in primary care:

Primary care psychology (the provision of quality controlled psychological services in the general practice setting, involving collaborative care between GPs and psychologists) enables effective and timely feedback between clinical psychologists and the GPs they are working directly with—both via shared notes and formal and informal discussions and evaluations of patient outcomes together. This results in ongoing effective monitoring of shared patient outcomes, and ongoing solutions re: patient treatment. Effective communication between practitioners is the key and co-location definitely facilitates this—ensuring effective monitoring and motivation of service improvement.

Clinical and health psychologist, New South Wales

- Online collaboration:

The Mental Health Professionals Network Webinars provide an excellent resource and consultative forum for professionals across health and community sectors to work collaboratively and improve delivery and quality of services & outcomes for mental health clients and carers.

De-identified rural health research organisation

- Multi-agency collaboration; including education, housing and social services and drug and alcohol services among others.

As a Principal of a special school I am called to work with the GAP Clinic [mental health assessment service] and we find this a successful approach to a complex issue as when all aspects of the child's life are considered then a full picture emerges.

Teacher/educator, South Australia

Responses from people with lived experience, support people and family members identified positive experiences when various disciplines worked collaboratively to provide optimal mental health outcomes for both those with lived experience of mental illness and their families.

Mental health issues are not resolved by medication alone or psychological assistance alone. A good outcome isn't really reached without the collaboration of medical and allied health specialist supported by appropriate housing, employment or education. When we got more collaboration (through the involvement of the Department of Human Services) things started to come together for us. As a parent I was unable to make that collaboration happen.

Support person, Victoria

[Partners in Recovery Programme] partnerships have given rise to an unprecedented level of inter-sectoral and inter-agency collaboration, spanning the health, housing, welfare, disability, education and employment sectors. The key advantages of this are that (a) people with complex mental health needs now have access to a single integrated package of mental health support; (b) consortium members are aligning their organisational goals and programmes to reduce service duplication and make system level improvements; and (c) long-standing service gaps in rural and remote Australia are being filled for the very first time.

De-identified organisation

Providing emotional support for mental health professionals

Both professional and organisation respondents identified the unique emotional needs and workplace stressors experienced by mental health professionals. Strategies to address these needs were regarded highly, and were perceived to contribute to positive workforce outcomes, including improved staff satisfaction and retention.

We recognise that mental health work is emotionally demanding and that mental health work presents problems for staff over and above those encountered in other organisations. Mental health workers have poorer job satisfaction and higher job burnout and turnover compared with established norms for other occupational groups.

De-identified provider organisation

Early intervention for staff mental health was mentioned by respondents as a successful strategy for emotional support.

The use of the Early Intervention Programme (EIP) which resulted in early identification of employees with mental health problems, direction to appropriate treatment options and also early resolution of problems in the workplace. This mitigated the risk of absenteeism, performance issues and potential workers compensation claims.

Allied health professional, Queensland

ATAPS/Better Access training

Workforce training programmes funded through ATAPS and Better Access were mentioned multiple times as being successful initiatives. These included online suicide prevention training, child mental health training and Aboriginal mental health and perinatal streams of training for ATAPS providers. Mandatory training as required by ATAPS was viewed very positively and was often perceived to contribute to improved service outcomes, including mandatory training for ATAPS providers to conduct cognitive behavioural therapy.

10.3.3 Current barriers to effective use of the mental health workforce

Uneven workforce distribution and use of professional skills

Concerns were expressed by professionals, organisations and people with lived experience alike that current workforce distribution and professional services were unmatched to mental health service delivery needs. In terms of the current distribution of the mental health workforce, service providers were noted to be in high demand, especially in remote and rural areas. Accessibility and utilisation of the mental health workforce not only was influenced by physical location, but also by availability within the existing benefit scheme. Many respondents indicated that current Medicare benefits eligibility requirements prevent people with lived experience from accessing a number of alternative professional services, and results in negative service outcomes.

Limited availability of professionals in remote and rural areas

In terms of workforce distribution, many respondents provided examples of uneven service availability and high workforce needs across remote and rural areas.

Service coverage and quality are quite variable between areas, depending on service creativity and a relatively small number of professionals providing services, who are difficult to replace upon illness, retirement or relocation.

Clinical psychologist, Victoria

Multiple examples were provided by both professionals and organisations of the consequences of inadequate human resources on service delivery, including limited accessibility of services, staff burnout and poor staff retention. Some examples also highlighted the impacts of temporary workers and that long-term solutions are needed to address mental health workforce needs within individual communities.

Rural and remote communities are significantly disadvantaged by variable resourcing of mental health and other support services, and significant workforce supply issues. There is a lack of specialist mental health professionals in remote and rural communities across NSW. The reliance on 'fly-in and fly-out' service providers is ineffective. Many people in such communities are also sceptical of professionals coming from outside of the community.

NSW Consumer Advisory Group - Mental Health Inc. (now trading as BEING)

In practice, there is an endless succession of inexperienced people cycling through these important roles with no development of their practice. It probably has a "burn out" effect on the staff attempting to deliver such services, which have the odds stacked against them through the service delivery model. It also means investment in services is not targeted at the community, meaning no local capacity is developed.

De-identified service provider

Many people with lived experience also provided examples of limited access to mental health professionals in rural areas and how this may contribute to poorer service outcomes.

Having been admitted to hospital in a rural area is a nightmare. The psychiatrists have to fly in each day, which means, you see them once a week whilst in hospital and as they are the ones that have the final say in your treatment you are required to see them before being discharged. They are available for maybe a few hours a day (togglng between community and hospital whilst in town) ... And in winter, if foggy, they may get delayed or not get to town at all, which delays everything and causes frustration! The system is so stretched in rural areas that sometimes you can be waiting to see the mental health services for weeks even if in crisis.

Person with lived experience, New South Wales

Inequitable recognition and treatment of professional groups under Better Access

Many examples from mental health professionals, organisations and people with lived experience identified the negative aspects of having no more than ten sessions with a psychologist (or other approved allied health professional) under *Better Access*. Although psychiatric treatments can be funded for up to 50 sessions per year, many respondents across all groups felt that this provided a barrier to the effective use of non-psychiatric human resources.

There are some clients who would benefit from more than 10 sessions a year, and thus they fill up psychiatrists' waiting rooms. Whereas a counselling or clinical psychologist would be just as suitable, provide more practical therapies and be far less expensive.

Counselling psychologist, Victoria

Clients of mental health services provided many examples of how limited financial resources have prevented access to preferred mental health care providers, and resulted in poorer service outcomes and experiences.

50 sessions with a psychiatrist per year is absolutely meaningless to me. In the regional city where I live, psychiatrists do not have the time or interest in helping someone like me. They do not offer or have the expertise to work with someone who has complex trauma-related mental health issues. The reason I have been caught in the mental health system for so long is that psychiatrists simply medicated me. That has never helped; in fact it made my life worse due to medication side-effects.

Person with lived experience, Victoria

Some clinical psychologists described why they believe the current system of workforce planning is not cost-effective or conducive to positive client outcomes.

Clinical Psychologists have received the ideal training for working with mental illness: a single and comprehensive focus within an eight-year training in the evidence-based prevention, early identification, assessment, case formulation, diagnosis, treatment and evaluation of mental illness and cognitive problems across the entire lifespan and range of complexity and severity, particularly in the moderate to high range. It would seem more sensible, therefore, to allocate 50 sessions per year to clinical psychologists to work with high needs patients and who can work in partnership with psychiatrists when medication is required. This would provide a considerable saving to the Government and free up the small psychiatric workforce to more adequately deal with very severe cases.

Clinical psychologist, New South Wales

Under Better Access, it is also perceived that other qualified mental health professionals are being overlooked in terms of their capability and capacity to deliver mental health services. Numerous examples were provided by counselling psychologists, counsellors, psychotherapists and mental health nurse specialists.

We need a system of mental health care that provides due respect for the diverse skills each mental health professional brings to each patient and values each person's right to seek care from a professional they trust. Our system also needs to encourage skilled mental health care practitioners from every discipline to help members of the public recover from mental health conditions.

Alliance for Better Access

Clients miss out on the professional services of a diversified group of Counsellors and psychotherapists who presently cannot get a Medicare rebate for their clients. Doctors also miss out on knowing of and referring to perhaps better qualified professionals who are not just a psychologist. Doctors would have a wider range for referral.

Counsellor/psychotherapist, New South Wales

The existing higher Medicare rebate for clinical psychologists is poor use of the workforce of psychologists and unjustifiably favours one group of specialists within the profession. It skews the financial incentives for students to choose clinical psychology in preference to other specialist streams such as counselling psychology and rewards clinical psychologists more than other psychology specialties such as counselling psychologists. In NGOs such as Medicare Locals, it provides an incentive to employ clinical psychologists with Medicare provider numbers because when clients are billed the ML receives a higher rebate per session than when other psychologists employed by the ML bill Medicare.

Psychologist, Western Australia

10.3.4 Options to improve workforce training, planning and development: back to basics

People with lived experience, professionals and organisations identified a number of areas where professional service delivery was not conducive to positive service outcomes. Through interactions with clients, multiple examples were provided where mental health professionals' delivery of services and resulting client outcomes could be strengthened.

The improvements suggested by respondents often related to the most basic of workforce principles. The primary aspects of professional service delivery that commonly were mentioned as detrimental to clients were negative attitudes and behaviours from staff, a lack of knowledge and understanding of mental health issues, and utilisation of inappropriate or ineffective treatment pathways.

Need to improve staff attitudes

Numerous examples were provided by people with lived experience of negative attitudes and behaviours of professional staff. These attitudes and behaviours not only create negative perceptions of mental health services in general, but also have negative consequences on the development of a therapeutic relationship and result in poor individual outcomes.

My personal view is that many doctors still get away with treating people who present with mental health problems as dirt under their shoes. The amount of discourtesy, disrespect, ignorance and stupidity is egregiously bad.

Person with lived experience, Western Australia

The way that somebody with mental health problems is judged by staff at services (particularly public hospitals). My husband was treated badly. He was humiliated and made to feel insignificant.

Support person, New South Wales

Responses from people with lived experience also identified examples of how staff attitudes and behaviours can contribute to positive outcomes. Common examples included experiences where respondents felt they were listened to, respected and not judged for their condition. People identified caring, compassionate, patient and empathetic behaviours as most positive, and valued services that were individually focused.

Need to address gaps in professional knowledge

A further example of problems with staff training and development identified by people with lived experience was a lack of knowledge and understanding of mental health issues from professionals. Many examples were provided where respondents perceived that health care providers and, in particular, general practitioners, lacked understanding and adequate knowledge about mental health issues.

Even though they are the first port of call for families seeking help and diagnosis, it seems most GPs are not adequately trained in youth mental health, lack knowledge to confidently make decisions regarding appropriate medication, may have limited knowledge of local mental health services & private psychiatrists and psychologists to whom they can refer patients, and may not know how to discuss mental health issues appropriately with their young patients.

Support person, Victoria

Primary care clinicians are generally not fully trained to diagnose or treat mental health problems, yet people with these conditions typically are seen in primary care more than any other setting and referrals to community-based mental health providers are relatively low. Studies show that well over half of primary care docs are not successful in referring patients to mental health professionals in the community for a variety of reasons.

Central Adelaide and Hills Medicare Local

A number of positive examples also were provided where primary care providers contributed to service outcomes through improved knowledge and active involvement mental health outcomes.

Having a GP who was sensitive to mental health issues was great. I know some GPs focus more on physical symptoms but my GP assessed all of my symptoms, was sensitive and not dismissive of the psychological symptoms. She referred me to a psychologist and also pointed me in the direction of support groups and group therapy programmes.

Person with lived experience, Victoria

Seeing a GP who was happy to have long consults with me to just let me talk about what I was feeling when I was in a crisis, was incredibly helpful. GPs who care about the mentally ill as WELL as the physically ill, that have a proper amount of experience with disorders and won't stigmatise you for 'looking' well when you very well might not be, are rare in my experience however. Only finding two who were able to help me and properly listen to me.

Person with lived experience, Western Australia

Respondents also provided a number of examples where providers' underlying treatment philosophies and lack of focus on recovery were perceived to impact on outcomes for clients. Many examples were provided where an emphasis on medication management was perceived negatively.

While drugs have a role, the medical model under which we operate emphasises medication rather than psychotherapy for many mental disorders. The more severe the problem, the more reliance is placed on drugs. This needs to change. We need to spend more time and more care/love on those with more 'severe' mental disorder as that is what they lack.

Person with lived experience, Victoria

Professionals and organisations have also recognised the importance of engagement with people with lived experience and holistic recovery philosophies in delivering the most effective service outcomes.

Programmes don't provide support, people do. There is a need to get away from the 'treatment motif' and look more at the 'connection and engagement motif'. Practitioners want to treat rather than relate.

NGO manager, Victoria

The evidence increasingly shows that while accommodation, employment and social connection services are central to the mental health recovery journey, it's also the recovery philosophy and relationship skills that mental health workers bring to their roles that help instil a sense of belonging, connection, empowerment and hope in those experiencing mental illness.

Psychiatric Disability Services of Victoria (VICSERV)

10.4 Promising examples of effective workforce interventions

The Mental Health First Aid Programme was identified multiple times as a successful programme for increasing mental health awareness to providers, not only within mental health but elsewhere.

The Mental Health Professionals Network also was identified as a successful initiative encouraging coordination and collaboration between mental health providers through multi-disciplinary/collaborative training.

Innovative internal training programmes are being delivered to professional service providers in an effort to improve therapeutic relationship development with people with lived experience.

A Local Health Network project called 'Safety for All' was identified as an excellent example of an innovative programme which looks to transform traditional mandatory aggression training to a course co-delivered by peer workers that focuses on building therapeutic relationships, trauma informed care and recovery oriented services.

Under the Better Access initiative, further training and improved mental health credentials are seen as having the potential to improve service delivery and mental health outcomes.

The RACGP is continuously committed to ensuring GPs are well equipped with the appropriate skills and knowledge to detect, diagnose and treat mental health issues. This is particularly evident through its management of the Commonwealth's General Practice Mental Health Standards Collaboration (GPMHSC) project, which ensures that GPs are skilled to a certain standard of education before enabling them access to MBS item numbers under the Better Access initiative. Since its establishment, more than 22,000 GPs have completed a mental health training activity accredited by the standards set by the GPMHSC.

Royal Australian College of General Practitioners (RACGP)

11. Specific challenges for regional, rural and remote Australia

11.1 Key findings

Responses highlighted a number of significant challenges to provision of adequate and appropriate mental health programmes and services in regional, rural and remote (RRR) areas. The most prominent were:

- lack of accessible supports for mental health difficulties
- workforce shortages
- high prevalence of mental illness and suicide
- Stigma and lack of anonymity.

Characteristics of ineffective programme and service provision included:

- funding not reflecting the additional demands of service delivery in RRR areas
- failure to adapt service models for the particular needs of RRR areas
- transient services, initiatives, and workforce.

Characteristics of currently effective programmes and services in RRR areas included:

- small or no out of pocket expense
- flexible service delivery models.

Suggestions to improve the effectiveness of services and programmes in RRR areas were:

- capacity building and incentives for the mental health workforce
- greater use of innovative delivery mechanisms including e-health.

11.2 Overview

Term of reference 8 asked the National Mental Health Commission to assess:

Specific mental health challenges for regional, rural and remote Australia

11.2.1 Survey questions

Analysis for this term of reference was primarily based on answers to two questions which appeared in all surveys.

- a. What is your/your organisation's view about the current provision of mental health support in remote and rural Australia?
- b. What specific action or strategy do you think could improve this situation?

11.2.2 Survey responses

For question (a) 45.8 per cent of organisations (n=108), 21.7 per cent of professionals (n=187), and 14.5 per cent of people with lived experience and support people (n=90) provided a response.

For question (b) 42.8 per cent of organisations (n=101), 20.1 per cent of professionals (n=173) and 12.7 per cent of people with lived experience and support people (n=79) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

11.2.3 Note on interpretation

It should be noted that respondents living in a regional town or a rural/remote area represented one-third of the total responses from people with a lived experience, providing accurate representation of this group as per Australian population distribution. One-third of professionals also identified as living in a regional town or in a rural/remote area, allowing for a good representation of this workforce. There was a strong representation from organisations whose primary interest is in rural and remote health and mental health, perhaps indicating the strength of feeling about the need for change and improvement in these areas. Of the 65 regional, rural and remote related organisations which responded, 52 per cent (n=34) were advocacy/peak bodies and 18 per cent (n= 10) were research departments specifically for rural and remote health.

11.3 Thematic findings

11.3.1 Types of challenges in providing effective mental health support in regional, rural and remote Australia

Mental health services unavailable and/or gaps in service provision

Respondents from all groups expressed concern that mental health services often are unavailable across regional, remote and rural areas.

As a psychologist living and working in a rural community, it has been my experience that many service gaps exist. People who live in these communities are disadvantaged in many ways, including few (sometimes non-existent) specialist services which they can access; the need to travel very long distances to access such services and the enormous expense involved.

Clinical psychologist, Queensland

Common examples where service needs are greatest included a number of speciality services. Some respondents identified service needs for groups that may be at high risk of developing mental health problems, including Aboriginal and Torres Strait Islander populations and individuals working in agriculture. Services for culturally and linguistically diverse populations also were perceived to be needed in rural areas. Effective services for people with chronic mental health concerns and for people requiring support to recover from a crisis or acute episode of illness were both perceived to be lacking.

There are many gaps nationally in rural/remote areas, but one significant gap is in appropriate treatment for people with chronic and severe mental health problems. Due to the severity and type of illness this patient group experiences, they require longer-term psychological treatment (above typical 6/10/12 session or 4–6 month limits), and so present intermittently but repeatedly to short-term services, which provide a 'stop-gap' service but are not capable of fully meeting the needs of this group.

Clinical psychologist, Victoria

In some examples, limited service availability had resulted in devastating consequences for those with critical mental health needs.

It is also possible that due to my brother's rural place of residence that he was denied this assessment that probably would have treated his acute symptoms and saved his life. He had a problem that was completely solvable—he was 19 and was struggling to come out as gay. This struggle is unsurprising given his lack of exposure to other gay men in the small farming community he lived in, and also given the fact that there are absolutely no support services for LGBT youth in this part of country Victoria. The closest headspace centre is 1hr 20mins away, and my brother did not have his driver's license. Ultimately, there was no support for his specific issue anywhere near him, and there was no support for him when he faced crisis.

Support person, Victoria

Qualified mental health professionals unavailable

Another challenge frequently mentioned in the delivery of rural and remote mental health services, and a primary cause of lack of service availability, was the availability of qualified mental health professionals. Limited access to mental health professionals such as psychiatrists, psychologists and other allied health providers was often listed as a barrier to effective service delivery in rural areas. Frequent staff shortages and high turnover of staff were also mentioned as contributing to irregular and unreliable mental health service delivery.

Multiple examples were provided which identify the lack of mental health professionals as a cause of decreased access to mental health services.

Access to quality healthcare providers is strongly linked with improved health outcomes. Australians living in rural and remote areas have significantly reduced levels of access to mental health professionals such as psychiatrists and psychologists compared with those living in major cities. One of the most important ways to improve mental health outcomes for rural and remote Australians is to improve their access to quality mental health professionals.

Rural Health Workforce Australia

Mental health professionals provided many examples of how existing working conditions contribute to poor staff satisfaction and poor staff retention in remote areas.

I live in a remote area in Far North Queensland where support services and counselling are extremely limited. The services that are on offer to the public are utilised to the absolute fullest and maximum; because of this, staff exhaustion and the 'burnout' rate is high.

Counsellor, Queensland

Poor mental health and high rates of mental illness in regional, rural and remote areas

Respondents often mentioned high rates of mental illness and suicide in regional, rural and remote areas. A number of examples provided descriptions of the unique mental health needs in these areas, including many examples where livelihoods such as involvement in agriculture lead to high levels of stress and high risk of mental illness.

There are particular factors that contribute to poor mental health or mental illness in rural and remote areas. This includes those commonly recognised, such as the challenges and hardships associated with drought and other climatic conditions, but also broader challenges such as isolation, loneliness, and lack of engagement with other people due to low population numbers, the distances between residences and limitations in technology.

Royal Flying Doctor Service

Issues with stigma, and a lack of anonymity in small communities

In small and remote communities, an additional barrier to service access was the fear of stigma due to a lack of anonymity, as well as associated confidentiality issues.

It is recognised that the stigma associated with mental illness is even more pronounced in regional and rural areas of the country. Services are frequently staffed by neighbours and friends and consumers are concerned about their anonymity, privacy and confidentiality.

Women's Mental Health Network Victoria Inc.

11.3.2 Characteristics of ineffective services and programmes in RRR areas

Funding

Both professionals and organisations commented that existing funding arrangements fail to differentiate between the needs of urban and rural areas, as well as between different regional, rural and remote communities. Even though extra weighted funding for initiatives delivered in rural and remote areas was recognised, this was often perceived to be inadequate. Complaints were made by individual professionals that their travel time was not paid for under programmes such as Better Access, for example.

There are also additional costs for services providing mental health programs to rural and remote communities in relation to car leasing, car maintenance and travel and accommodation costs to have MHPs provide services on an outreach basis to towns where it is not feasible to have a MHP to be situated or where there are no MHP living locally. Such costs are not currently adequately factored in to the funding allocations for programs like ATAPS where funding is allocated on a per-session basis.

Goldfields Midwest Medicare Local

My view is that funding should be reprioritised toward Remote communities, and a distinction made between 'rural' and 'regional' locations. Some 'regional' locations are in fact within 60 km of a major city or town of over 250,000 people. Truly remote or regional locations are often 1,000 km from a city or town. The difference in resource provision between these locations is profound, leading to undetected mental health problems in remote communities, without access to highly qualified treatment services.

Clinical psychologist, South Australia

Service models

Respondents expressed concerns about the translation of programmes perceived to be suited to an urban environment into rural areas. Despite the programme's explicit goal of targeting disadvantaged communities, existing services provided through ATAPS and/or Better Access sometimes were seen as ineffective in improving access to affordable services for those living in rural, remote and regional areas.

Providing mental health services to rural and remote Australia is also very different to implementing services in metropolitan areas as the fabric of rural communities is different to urban ones. However, specific rural and remote issues are seldom considered in funding agreements and are rarely, if ever, simple adaptations of an urban model to a rural area.

De-identified representative organisation

Reasons that were commonly listed by people with lived experience, professionals and organisations included a decreased number of providers and specifically general practitioners (who are required to gain access to the scheme in the first place), psychiatrists and other mental health professionals who bulk bill. High waiting times for access to referrals and inability to receive coverage for services delivered through alternate means such as on the telephone and online sessions.

I offer my services in one of these communities (an Indigenous community), for an extremely reduced rate so that the members of this community may receive much needed support. I am not in position to offer counselling for free, but I have recognised the catastrophic need and offer this much needed and utilised service.

Counsellor, Queensland

Transient services, programmes and workers

Although some respondents mentioned how drive-in or fly-in (DIDO and FIFO) mental health services helped to fill some needs within communities, many examples from professionals in particular indicated that high costs and inconsistencies of temporary programmes and workers were an ineffective (and expensive) solution to existing service needs.

Community engagement, relationship development and experience and knowledge of unique community context were mentioned frequently as lacking where temporary programmes and transient workers were utilised in rural areas.

Many of the drive in/drive out services have no long-term connection to the communities they are attempting to service, and [our organisation] has often seen such services disappear once the contract is lost, taking with them any corporate knowledge developed over time with government funding. This endless loss of experience means services never have the chance to develop over time. In practice, there is an endless succession of inexperienced people cycling through these important roles with no development of their practice. It probably has a “burn out” effect on the staff attempting to deliver such services, which have the odds stacked against them through the service delivery model. It also means investment in services is not targeted at the community, meaning no local capacity is developed.

De-identified service provider

While the principal problem in RRR areas was lack of services, we heard from several respondents about some communities where there was a perverse duplication of services from many different providers. In some small communities perceived as having high levels of need, we heard of cases where many providers arrive unannounced and with no consultation, while communities up the road receive nothing. This can result in a situation where providers leave the community when they discover they cannot survive there.

As a volunteer with Headspace [in a regional town], it was regularly noted that there are many diverse and varied groups in the community that in some instances duplicated their services. There were also many examples of times that each organisation was competing for funding from the same source at the detriment to another organisation. In a rural setting this type of duplication and competition is creating some animosities between organisations.

This lack of coordination has resulted in some programs only being conducted for a short period of time and not really being effective. Mental health clients need continuity and constant support, all too often the client gets a few months aid then is left to look elsewhere as the funding for the current program has ended.

Allied health professional, South Australia

Respondents often mentioned how temporary and impermanent solutions for mental health services were not cost-effective and did not lead to long-term solutions for service provision.

Although the lack of infrastructure in remote communities makes drive in/drive out servicing seem attractive, and such services seem to be proliferating, these do not represent good value for money and have a long-term negative effect on the region’s capacity.

De-identified service provider

11.3.3 Characteristics of effective services and programmes in RRR areas

Affordable services

Providing affordable services through existing programmes such as MHSRRA [Mental Health Services in Rural and Remote Australia] often was mentioned as an effective means of providing increased coverage and improved access to services in rural and remote communities. Both ATAPS and MHSRRA programmes were seen as useful in filling gaps where the availability of Medicare-subsidised services is lacking.

MHSRRA funding is flexible and less rigid in its operational guidelines than ATAPS and enables MLs to provide mental health services to areas not well serviced by general practice, specialists or state services. MLs rely on MHSRRA funding to deliver mental health services to rural/remote catchments which the inflexibility in ATAPS funding makes it difficult to do.

De-identified representative organisation

MHSRRA and ATAPS programmes both have their place in the Kimberley and represent effective programmes for people with high prevalence mental health issues from a psychological treatment perspective. Without these programmes in the Kimberley there would be no psychological treatment services that were affordable for the majority of the population.

There are very few private providers and all charge gap fees that encourage only those with high incomes to be able to afford such initiatives as the Better Access incentives. The MHSRRA and ATAPS programmes allow access to some of the most socially and economically disadvantaged individuals in Western Australia.

Mental health nurse, Western Australia

Flexible service delivery models

People with lived experience, professionals and organisations perceived access to mental health services through alternative service models to be an effective means of service delivery in regional, rural and remote areas. Although many also identified that there are difficulties in ensuring reliable access to internet and phone services, when available they were perceived as making positive contributions to mental health services.

I am really surprised how effective Skype is to continue to see clients when they find it difficult to attend in person. Given that I have people referred to our practice from lengthy distances away and in this area adverse weather conditions often cut roads, this is a good option to continue with the therapy. I also have many clients who at times cannot afford the petrol to drive into the regional town I work from; they can call me and let me know and I can Skype them. It is also useful when clients relocate further away and we have agreed to continue the therapy.

Mental health nurse, New South Wales

Examples identified a number of benefits to these services including easy access, no cost and anonymity.

I believe online and hotline (phone call) services are the most accessible for young people, especially in remote areas. I believe these services work best as you can seek the support you need without having to face someone. Sometimes facing a real person is just too hard, and on the phone you can deal with the issue, then hang up and get on with life knowing you won't run into your counsellor at the local shops in a small town.

Person with lived experience, Western Australia

11.3.4 Strategies to improve mental health services in regional, rural and remote areas

Strengthening the mental health workforce in regional, rural and remote areas

A common recommendation for the improvement of mental health service delivery in regional, rural and remote areas was to strengthen the mental health workforce in these areas. Many examples of how this should be done included up-skilling existing generalist service providers to better meet mental health needs, and increasing recruitment and retention of mental health practitioners in regional, rural and remote areas.

Mental health services in rural Australia have long experienced difficulties staffing much-needed services in the absence of suitably qualified clinicians. Strategies used successfully in other health professions include one-off payments for professionals relocating from metropolitan to rural areas, annual incentives to remain in a rural area of need and new graduate HECS debt reduction incentives if they work in rural and remote areas post-graduation. These strategies need to be adopted and applied to address mental health workforce shortages in psychology, social work, occupational therapy and mental health nursing. Furthermore, GPs and other allied health professionals need incentives to participate in mental health CPD and postgraduate mental health qualifications.

Murrumbidgee Medicare Local

There should be a focus on providing additional support to the service providers who already provide mental health services in rural and remote areas, including those providing more general health services. It is unlikely that in the foreseeable future, every remote community will have regular access to specialist mental health services, and instead GPs and other primary health service providers should be supported to enhance their knowledge and expertise.

Royal Flying Doctor Service

Greater use of technology and innovative ways to increase access to services

Another strategy suggested for improving access to mental health support was to increase the use of technology and develop innovative solutions. People with lived experience provided many examples of how access to mental health services through online and telephone delivery models has contributed to positive mental health outcomes. Many professionals and organisations also identified a strong need to continue to develop these interventions and to prioritise research into how services can be more effectively delivered using technology.

For example, increasing the use of telemedicine and telepsychiatry was suggested.

The application of telemedicine to psychological services for individuals who are housebound or live in rural and remote areas would enable services to reach those people in need of treatment for mental health problems who would otherwise miss out.

Clinical psychologist, South Australia

Many responses also identified a need for increased funding and coverage of these services to enable increased delivery and access through these means.

The barriers presented by distance and limited health workforce can be ameliorated through improved access to telehealth options for doctors, patients and allied health professionals. This will require the establishment of necessary infrastructure and development of an MBS item for telehealth consultations directly with patients.

Australian Medical Association

With the development of evidence-based e-mental health interventions, funding support for these modalities to be used extensively by MLs in providing primary mental health care to the appropriate populations in these areas is extremely important.

Hunter Medicare Local

11.4 Promising practice for regional, rural and remote areas

Multiple online and telephone-based services were mentioned as valuable and effective in providing mental health services and support to those living in regional, rural and remote areas. ReachOut.com, eHeadspace, Lifeline and Kids Helpline online were mentioned often, in addition to other online information and counselling services.

I find ReachOut.com an excellent site for me, with advice given in everyday language for my problems I experience. The forums on the site are excellent for me in particular to give advice as someone who truly understands what the [other] person is going through from my own experience, and I can give advice from what has worked for me. Telephone numbers, in particular those that are 24/7 are vital services as problems and emergencies do not keep work hours only. For example Lifeline and Youth Lines as well. Another Organisation for all Mental illnesses that has been preventive for me and helped to keep me well and out of Hospital is the NSW Schizophrenia Fellowship. They have a telephone outreach service where someone rings up regularly to support so you can cope with what you have to deal with. It I have found very supportive and helpful in keeping me well.

Person with lived experience, New South Wales

Many examples of successful telepsychiatry programmes were also identified by respondents.

In South Australia, the SA Rural and Remote Mental Health Unit Tele-Psychiatry outreach programme has been running for more than 10 years, and provides effective 'between visits' support to people who live a distance from health services. Similarly, in NSW telephone, email, and Skype are all used between face-to-face appointments.

Royal Flying Doctor Service

12. Specific challenges for Aboriginal and Torres Strait Islander peoples

12.1 Key findings

Respondents identified three key challenges to mental health service delivery for Aboriginal and Torres Strait Islander people. These were:

1. Marginalisation and social and economic disadvantage resulting in poor mental health outcomes for Aboriginal and Torres Strait Islander peoples.
2. Disconnect between mainstream mental health services and Aboriginal and Torres Strait Islander communities.
3. Limited mental health services and support for Aboriginal and Torres Strait Islander peoples.

Some aspects of mental health service delivery that were perceived to be inappropriate or ineffective included:

1. Culturally inappropriate provision.
2. Funding restrictions and barriers.
3. Limited coordination, partnerships and consultation between service providers and with local Indigenous communities.

Some aspects of mental health services that were perceived to be most effective included:

1. Targeted financial investment in Aboriginal and Torres Strait Islander mental health.
2. Community-based programmes.

Some key strategies and recommendations for improving Aboriginal and Torres Strait mental health services were:

1. Strengthen the Aboriginal and Torres Strait Islander mental health workforce.
2. Improve delivery of primary and preventive mental health services.

12.2 Overview

Term of reference 9 asked the National Mental Health Commission to assess:

Specific challenges for Aboriginal and Torres Strait Islander people

12.2.1 Survey questions

Analysis for this term of reference was primarily based on answers to two questions which appeared in all surveys.

- a. What is your/your organisation's view about the current provision of support for Aboriginal and Torres Strait Islander people's mental health?
- b. What specific action or strategy do you think could improve this situation?

12.2.2 Survey responses

For question (a) 38.1 per cent of organisations (n=90), 13.8 per cent of professionals (n=119), and 6.9 per cent of people with lived experience and support people (n=43) provided a response.

For question (b) 34.3 per cent of organisations (n=81), 10.8 per cent of professionals (n=93) and 5.5 per cent of people with lived experience and support people (n=34) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

12.2.3 Note on interpretation

It should be noted that demographic data on Indigenous status was not collected from respondents, and that professional and people with lived experience/family member/support person representation from the Aboriginal and Torres Strait Islander population is unknown. However, nine Aboriginal and Torres Strait Islander organisations and interest groups provided comprehensive responses, which form the majority of the material used for this analysis.

12.3 Thematic findings

12.3.1 Barriers to appropriate mental health support for Aboriginal and Torres Strait Islander peoples

Respondents identified a number of unique and specific challenges in the delivery of mental health services to Aboriginal and Torres Strait Islander peoples. People with lived experience, professionals and organisations identified many examples of where poor social and economic circumstances are leading to negative mental health outcomes. Examples also pointed to stigma surrounding mental health within Aboriginal and Torres Strait Islander communities, and where traditional beliefs and practices are not well aligned to 'mainstream' mental health services. Many responses indicated that access to mental health services and support for Aboriginal and Torres Strait Islander people is lacking, and provided a number of examples where services are needed.

Marginalisation and social and economic disadvantage result in poor mental health outcomes for Aboriginal and Torres Strait Islander people

Responses from all groups identified the complex and unique challenges facing mental health providers when providing services to Aboriginal and Torres Strait Islander people. Many respondents highlight the underlying social and political issues, as well as historical legacies of trauma, which place Aboriginal and Torres Strait Islander peoples at higher risk of mental illness, and which mean that 'Western' models of mental health intervention may not be appropriate or effective.

The long history of marginalisation and underprivilege for Indigenous people and communities and the complex, multi-generational history of trauma and the disrupted cultural context mean that mental health problems in these groups present unique challenges, and it is not surprising that many mental health initiatives do not produce the results hoped for.

The Australasian Confederation of Psychoanalytic Psychotherapies

Aboriginal peoples' preference to referring not to 'mental health' but to 'social and emotional wellbeing' reflects my perspective that the large majority of mental health problems are caused by factors in the social, political and physical environment

Researcher, Australian Capital Territory

Disconnect between mainstream mental health services and Aboriginal and Torres Strait Islander communities

Respondents cited the fact that access to 'mainstream' mental health services is relatively poor among Indigenous communities. Some framed this in terms of stigma surrounding mental illness or distrust of services preventing people seeking formal help, while others acknowledged that access might be low because many services do not appear relevant or appropriate to Indigenous conceptualisations of mental distress.

There are very few services equipped to deal with Aboriginal and Torres Islander mental health issues and they generally do not feel trusting of the regular services available that are not specific to their culture. I have certainly had some patients from these cultures that have been happy to use the general services. However, the low numbers referred to the organisation I worked for leads me to suspect that there are many more who may not.

Mental health services manager, South Australia

Poor mental health often still carries the negative stigma for Aboriginal and Torres Strait Islander people. Within the pervasive 'medical model' of mental health service delivery and care there can be limited opportunity to work with an individual's sense of reality; for example, their traditional beliefs about their mental health issue/illness and the western diagnosis.

Indigenous Allied Health Australia

Limited mental health services and support for Aboriginal and Torres Strait Islander peoples

Limited access to mental health services for Aboriginal and Torres Strait Islander people was commonly mentioned by respondents. In particular, communities in regional, remote and rural areas commonly were identified as lacking appropriate mental health services.

Aboriginal and Torres Strait Islander peoples, historically and today, enjoy significantly less access to mental health and related services and programmes than other Australians. By 'accessible services', we mean by location and cost; services that do not discriminate; and services that are culturally acceptable to Aboriginal and Torres Strait Islander peoples (or 'culturally competent').

National Aboriginal and Torres Strait Islander Leaders in Mental Health

A lack of resources also was commonly mentioned as contributing to limited mental health support and services for Aboriginal and Torres Strait Islander communities.

Whilst the Aboriginal community-controlled health sector has historically played a major role in responding to people displaying high levels of social and emotional distress and high levels of disturbance and self-destructive behaviour, it has lacked the resources and trained staff to adequately deal with these complex issues.

Western Australian Association for Mental Health

Respondents provided examples of the consequences of limited availability of appropriate mental health services. Common examples included frequent deterioration to crisis point resulting in hospitalisation and high rates of suicide.

We have so many deaths from suicide, mostly young people, we have a community in a constant state of grief. We cannot seem to attract funding for these services (there is no funding programme that we can identify) and yet the risks are so high.

South Coastal Women's Health Services

Obviously Aboriginal and Torres Strait Islander people are not receiving effective mental health services. They continue to be over represented at MH services, usually at the point of crisis. There is tragedy happening amongst our Indigenous populations.

Allied health professional, Queensland

12.3.2 Aspects of services and programmes perceived as ineffective for Aboriginal and Torres Strait Islander peoples

In the provision of mental health services to Aboriginal and Torres Strait Islander people, a number of examples were provided of ineffective approaches to service delivery. The three main issues identified were:

- cultural inappropriateness
- funding restrictions and barriers
- limited coordination, partnerships and consultation between service providers and with local Indigenous communities.

The Aboriginal community of Victoria carries a significant burden of social and emotional wellbeing and mental health issues. Services for Aboriginal people with mental health challenges are often fragmented, uncoordinated, discontinuous, poorly integrated, culturally inappropriate and hard to sustain and access.

Victorian Aboriginal Community Controlled Health Organisation

Culturally inappropriate provision

Examples of how existing mental health service delivery models are poorly aligned with cultural beliefs and practices within the Aboriginal and Torres Strait Islander community were commonly mentioned by respondents.

Our mainstream mental health services struggle to provide culturally responsive care to our Aboriginal community as they do not understand the holistic concept of health that Aboriginal people have. Without understanding this model of health then the mainstream is unable to provide proper care and services

Credentialed mental health nurse, Victoria

Aboriginal people are forced to conform to "white ways" of mental health support (i.e.: doctors, referrals, assessment forms, clinics, offices and waiting rooms, appointments etc...). Even when Aboriginal people specifically request to sit and talk, or go fishing to build rapport with workers, the workers are often confined by organisational/funding guidelines. Service delivery needs to be tailored to and cantered around the client.

Allied health professional, Western Australia

Funding restrictions and barriers

Existing funding arrangements can prove challenging and restrictive in the delivery of appropriate mental health services to Aboriginal and Torres Strait Islander populations.

As an example of this, respondents cited an inability to provide appropriate, sustainable, long-term solutions with Aboriginal and Torres Strait Islander communities through short-term funding.

Short-term funding cycles create significant barriers to sustainable service provision, particularly in rural and remote regions and ATSI populations/communities where relationship development, community consultation, joint planning and cultural respect is essential. Short-term funding results in service provision that is unsustainable, not cost-effective, lacking consultation and often poorly planned.

Northern Territory Medicare Local

Respondents also identify a lack of flexibility in specific Commonwealth programme requirements and funding guidelines. This is perceived to be ill-suited to the needs of Aboriginal and Torres Strait Islander communities.

The prescriptive nature of the funding guidelines severely limits the ability of our service to respond with flexibility to the needs of Aboriginal and Torres Strait Islander peoples; for example, the requirement of a GP Mental Health Treatment Plan, the prescriptive 6+6 service delivery model and the restrictions placed on therapeutic approaches that may be used.

New England Medicare Local

The ATAPS ATSI and ATAPS ATSI Suicide Prevention programmes can deliver valuable services to the ATSI community; however, the requirements under the programmes for a GP referral and structure of the ATAPS programme often do not fit with the ATSI community's needs. The requirement from a GP referral is often prohibitive for clients for several reasons, including that they are either not linked in with a GP, they are unable to afford to go to a GP or there is limited access to GPs in the local community.

Goldfields Midwest Medicare Local

Limited coordination, partnerships and consultation between service providers and local Indigenous communities

Another commonly identified aspect of ineffective service delivery was a lack of collaboration and partnerships between relevant Aboriginal and Torres Strait Islander organisations, mental health providers and Aboriginal and Torres Strait Islander communities. Many respondents referred to current mental health services as operating in “silos” and identified examples of where collaboration could be improved.

In remote locations it is common to hear of a duplication of services with no coordinating body or network to ensure efficiencies and cost-effectiveness. In some remote Aboriginal communities, for example, it is not unusual to have multiple organisations (including NGOs and government organisations) visiting these communities to provide mental health services. With different organisations visiting the same communities, however, it also means that other communities get no services at all.

Centre for Remote Health, Northern Territory

Strategies that target Aboriginal and Torres Strait Islander emotional and social wellbeing need to be collaborative in their approach and complement one another, rather than working in silos. For example, the Closing the Gap Program and Aboriginal and Torres Strait Islander ATAPS programs

De-identified representative organisation

12.3.3 Aspects of mental health services and programmes perceived to be effective for Aboriginal and Torres Strait Islander peoples

There were two main aspects of mental health services and programmes perceived to be effective for Aboriginal and Torres Strait Islander peoples.

Investment in Aboriginal and Torres Strait Islander mental health through existing funding arrangements

Increased and targeted investment for Aboriginal and Torres Strait Islander people through the ATAPS Tier 2 service was mentioned frequently as a step in the right direction in recognition of the mental health needs for this population. In particular, many responses from professionals identified existing ATAPS arrangements as contributing to improved access to mental health services for Aboriginal and Torres Strait Islander people that did not previously exist. Other common examples of benefits to the programme included employment of Aboriginal health workers and development of cultural competencies.

Funding under ATAPS Tier 2 has improved service delivery to Aboriginal community members. Additional benefits include the scope to employ Aboriginal health workers and utilise culturally appropriate therapies (e.g., narrative therapy). Furthermore, an investment by the Commonwealth in training ensured that all clinicians working with the target group received training in culturally competent practice.

Murrumbidgee Medicare Local

Mental Health Services for Rural and Remote Australia (MHSRRA) also was identified by organisations as an effective funding model which has enabled improved mental health service delivery to Aboriginal and Torres Strait Islander communities in regional, remote and rural areas.

Mental Health Services for Rural and Remote Australia (MHSRRA) provides funding to eligible NGOs such as MLs, Aboriginal Medical Services (AMSs) and Rural Flying Doctor Services (RFDS) to deliver mental health services to rural and remote Australia. MHSRRA funding is flexible and less rigid in its operational guidelines than ATAPS and enables MLs to provide mental health services to areas not well serviced by general practice, specialists or state services. MLs rely on MHSRRA funding to deliver mental health services to rural/remote catchments which the inflexibility in ATAPS funding makes it difficult to do.

De-identified representative organisation

Community-based programmes

Multiple examples were provided by people with lived experience, professionals and organisations of successful local and community-based mental health outreach and engagement programmes directed towards Aboriginal and Torres Strait Islander people. These programmes were perceived to result in very positive mental health outcomes, and were viewed as highly effective in their ability to provide tailored, culturally appropriate services to address mental health issues. A 'community-based' approach to mental health issues was frequently identified as resulting in the most positive mental health outcomes for Aboriginal and Torres Strait Islander populations as opposed to individualised approaches.

The success of the health gains that have been provided by ACCHSs [Aboriginal Community-Controlled Health Organisations] is due to the model of service which is initiated by local Aboriginal community, governed by the local Aboriginal community and implemented by local Aboriginal community.

National Aboriginal Community Controlled Health Organisation

12.3.4 Suggested strategies to improve existing mental health services for Aboriginal and Torres Strait Islander community members

There were two main strategies identified to improve mental health services for Aboriginal and Torres Strait Islander peoples, namely capacity building in the Aboriginal and Torres Strait Islander professional workforce and orienting care delivery around primary care.

Strengthen the Aboriginal and Torres Strait Islander mental health workforce

The development of the Aboriginal and Torres Strait Islander workforce to address mental health needs was commonly mentioned as a successful and important strategy for improving mental health outcomes. Common responses identified the importance of workforce development to ensure sustainable and appropriate interventions.

The approach of engaging local Aboriginal mental health workers ensures a range of positive benefits and outcomes for individuals and communities including capacity building, continuity of care and sustainability. Aboriginal mental health workers have been critical enablers of effective, innovative, culturally appropriate delivering of mental health support that also supports community control, self-determination and empowerment.

Northern Territory Medicare Local

Aboriginal people benefit most from health care provided by Aboriginal people. This will particularly be the case in relation to their mental and social and emotional health. The AMA believes, and research shows, that Aboriginal community-controlled health services have a strong capacity to provide comprehensive care that can address drivers of poor mental health.

Australian Medical Association

Improve delivery of primary and preventive mental health services

Many respondents from all groups highlighted the need to prioritise preventive and primary mental health services for Aboriginal and Torres Strait Islander populations. The greater mental health needs within the Aboriginal and Torres Strait Islander community, added to current service inefficiencies, conveyed a sense of urgency to address these issues and prevent emergency service encounters once people reach a state of crisis.

Effective prevention initiatives are urgently needed to reduce the impact of both mental ill-health and suicide. It should remain a priority and investment made in partnerships and approaches that build sector and community capacity.

Hunter Institute of Mental Health

There needs to be more awareness, education, promotion and detection for mental illness and we need to keep on 'closing the gap' in terms of mental and physical states of illness for Aboriginal and Torres Strait Islander communities. It's shameful to know that for those of Aboriginal and Torres Strait Islander descent, the suicide rate is 2.5 times higher for males and 3.4 times higher for females (Lifeline)

Educator, Victoria

12.4 Promising practice examples of effective Aboriginal and Torres Strait Islander peoples' supports

In addition to a number of innovative locally developed and delivered community mental health outreach programmes, Aboriginal Community-Controlled Health Services (ACCHS) were commonly mentioned as contributing to positive mental health outcomes.

AHCRA believes that good examples of cost-effective services can be found in many Aboriginal Community-Controlled Health Services (ACCHS), such as Wurli-Wurlinjang Health Service in Katherine. It is also evident in some Victorian community health services, e.g. Inner South Community Health. This latter service provides a wide range of mental health, alcohol and drug and primary health and support services in an integrated manner, avoiding the need for many clients of a disjointed system of care among multiple providers, ultimately a more expensive option for funders.

Australian Healthcare Reform Alliance

Another national awareness programme that was positively perceived was mental health first aid training which has been tailored to Aboriginal and Torres Strait Islander populations. It was perceived that the program was successful in delivering culturally appropriate mental health awareness and promoting the wellbeing of Indigenous Australians.

Mental Health First Aid Australia runs an Aboriginal and Torres Strait Islander Mental Health First Aid training program. There are over 160 Aboriginal instructors teaching the program and they have trained over 13,500 people. Evaluation of the program has found that it is culturally appropriate and acceptable to Aboriginal people. A recent review recognised Mental Health First Aid training as one of the most promising interventions for improving the social and emotional wellbeing of Indigenous Australians

Researcher, Victoria

13. Accountability for the outcomes of investment

13.1 Key findings

True accountability for investment was interpreted by respondents as being wider than just accountability to funding bodies; accountability to people with lived experience and to the community also is vital.

However, true accountability for the outcomes of investment is hampered by a number of factors including:

- lack of agreement on mandatory outcome indicators
- lack of data infrastructure and tools for collecting outcome information
- current focus on activity and activity based funding.

Mechanisms which respondents view as promoting proper accountability for outcomes include:

- allowing time and funds for proper evaluation
- involvement of people with lived experience, family member and support people in service planning and evaluation
- being conscious of accountability to stakeholders and the community
- collecting longitudinal and experiential outcome information
- scale up existing tools for effective evaluation.

Promising practice examples of attempts to provide transparent accountability for outcomes include organisations receiving Commonwealth funding which organise their own independent evaluations from universities; whole-of-community commitment to monitor and improve outcomes; and public reporting of client outcomes.

13.2 Overview

Term of Reference 10 asked the National Mental Health Commission to assess:

Transparency and accountability for the outcomes of investment

13.2.1 Survey question

Organisations and professionals were asked the questions:

Please give an example of a service, programme, policy or initiative which:

- a. demonstrates transparent accountability
- b. demonstrates effective monitoring of outcomes
- c. fails to demonstrate transparent accountability
- d. fails to demonstrate effective monitoring of outcomes

While people with lived experience, family members and support people were not asked specifically about accountability, we have included in our analysis references made by those respondents to this issue.

13.2.2 Survey responses

For question (a) 43.6 per cent of organisations (n=103) and 32.2 per cent of professionals (n=277) provided a response.

For question (b) 64.0 per cent of organisations (n=151) and 46.1 per cent of professionals (n=397) provided a response.

For question (c) 33.1 per cent of organisations (n=78) and 23.2 per cent of professionals (n=200) provided a response.

For question (d) 41.1 per cent of organisations (n=97) and 27.8 per cent of professionals (n=239) provided a response.

Analysis for this chapter considered three sources of evidence—responses to these particular survey questions, plus material from unsolicited submissions, and answers to other survey questions which addressed issues relevant to the chapter.

13.3 Thematic findings

13.3.1 Overall

Accountability for outcomes was strongly linked by respondents to the need for independent evaluation of services and programmes. Without such evaluation, it is difficult for providers to show accountability for their use of taxpayer dollars.

The evaluation of HASI ('HASI One Evaluation'), which involved substantial qualitative and quantitative data analysis including significant consumer and carer input, is an example of public accountability for the outcomes of investment.

Australian Association of Social Workers

The issue of accountability is strongly linked to ToR 4 regarding regulation and reporting, because accountability is achieved through reporting to governments, stakeholders and to the public. Therefore, there is some overlap in our findings for ToR 4 and ToR 10.

However, our emphases in analysis were different. In this summary of thematic findings on ToR 10, we have focused specifically on whether the outcomes of investment in mental health services and programmes are transparent or not, and on the extent to which mechanisms for public accountability exist or are implemented. In contrast, ToR 4 carried more of an emphasis on the use and usefulness of all types of reported information for multiple purposes, including accountability.

13.3.2 Factors hampering transparent accountability for outcomes

Respondents highlighted a variety of barriers to the achievement of transparency and accountability for the outcomes of investment in the mental health system. The following excerpt shows the extent of the difficulties, which range from a failure to collect meaningful outcomes, to a lack of analysis capability and infrastructure to use outcome data, to a lack of routine public reporting.

The most significant gap in this space is the effectiveness of the outcome monitoring. Across both Commonwealth and state-provided and funded services, there is a failure to capture meaningful data and measures (including consumer feedback). Furthermore, there is minimal intelligence capability across agencies and few opportunities to benchmark. Finally, very few providers have practices in place that ensure transparent reporting to the community (e.g., scorecards, report cards, or publicly available independent evaluations/reports).

Murrumbidgee Medicare Local

Lack of consistent outcome measurement across services and programmes

A basic problem with demonstrating accountability for the outcomes of investment is perceived to be the fragmentation of responsibility for direct service funding between Commonwealth and states/territories. When service providers are accountable to multiple funders, each of which has their own outcome measures and funding terms, it is difficult for them to demonstrate the benefits of a service or programme to the population over the long term.

The monitoring of benefits and population health outcomes requires an ongoing commitment to a comprehensive mental health strategy with service development and funding sustained over the long term to be able to measure any discernible change in population health ... a joined-up approach to population needs assessment, joint and sustained strategic planning across a 5–10 year period, population health outcome measures and monitoring is required. Due to the fragmentation across the current mental health service system (e.g.: funding, responsibilities, accountabilities, jurisdictions etc.) it is unclear how whole system and population health outcomes can be monitored and utilised to inform quality improvement in the short term.

De-identified Medicare Local

Lack of a national agreement on appropriate mandatory outcome indicators for mental health services is perceived as a barrier to accountability for the outcomes of government investments. Some respondents highlighted the difference in levels of accountability for outcomes between Commonwealth-funded programmes. For example, Better Access and the Mental Health Nurse Incentive Programme often are seen as demonstrating low levels of

public accountability because reporting is minimal and mostly occurs only between the private provider and Medicare. In contrast, Medicare Local-administered programmes such as ATAPS often are perceived as providing a more comprehensive set of outcome information via National Minimum Data Sets.

Some respondents highlighted the danger that with a focus on activity-based reporting (and activity-based funding), accountability for outcomes may become confused with accountability for outputs, meaning that accountability does not rest on whether a service or intervention actually helped a person with lived experience.

Statistics can be manipulated—e.g. number of clients versus number of sessions booked, versus number of sessions delivered (outputs vs. outcomes). Outcomes may not be known for some time after interventions, but it's the small increments that can have a big difference on day-to-day life of individuals with mental illness/ill health.

Allied health professional, Victoria

Lack of adequate tools for meaningful outcome measurement

Many professional respondents argued that it is difficult to prove accountability for outcomes when the outcome measurement required by programmes and services is inappropriate or cursory.

Existing outcome measurement practices are thought to be deficient because:

- They are not designed for accountability to people with lived experience:

Everywhere, outcomes monitoring is for government purposes and rarely is used to respond to the emerging and ongoing needs of the clients of services. Embed this phrase in your minds 'I have no mouth and I want to scream'; that is pretty much how most people I know, including myself, feel about their experience with mental health services in South Australia.

Person with lived experience, South Australia

- They do not measure whole-of-life outcomes:

Eating disorder treatment only uses weight gain as an outcome measure. Weight has nothing to do with recovery.

Person with lived experience, New South Wales

The biggest indicator of success of a mental health program is not HONOS or DASS21 or K10. It's when the individual tells you they have a job or a relationship, and when they have something more important in their life they no longer need mental health services. The biggest indicator of a successful mental health service is that when an individual experiences a crisis they have a secure therapeutic relationship to return to if they need it (GP and MHNIP).

Genesis Medical Centre, Victoria

- They do not account for the unique nature of improvement and recovery from mental illness:

It is a complete furphy to think that clinical psychological treatment can be subjected to the same treatment outcome measures as other areas of medicine. It's not the same as performing an operation or fixing a broken leg. Patients can find benefits up to five years after treatment, but may not recognise benefits immediately upon completion of treatment. Further, dealing with patients who suffer chronic and/or serious acute mental illness means gains can be small, particularly over a brief period of intervention.

Clinical psychologist, Western Australia

- Self-reporting is sometimes difficult for people with lived experience:

It's often very difficult for people who are experiencing significant mental health difficulties to complete questionnaires (pre and post treatment measures), or to return them.

Clinical psychologist, South Australia

- Professionals do not complete measures:

Several different outcome measures were required to be reported at [public] mental health services. That a colleague of mine managed to get away with not doing these for her 30+ case-load for 12 months without it being noticed would suggest that the outcome measures were not being used in any meaningful way.

Clinical psychologist, Queensland

Outcomes measurement does not affect policy or practice

Like other types of reporting, outcomes monitoring was perceived by some professionals as not being useful to their everyday practice.

Outcomes monitoring so frequently fails to measure anything other than being 'seen' to do something. Little is actually reaching the ground.

Allied health professional, South Australia

The use of HONOS [Health of the Nation Outcome Scale]. All the data is collected nationally. No feedback is ever given back to health practitioners as to what this data indicates re practice. It therefore has become just red tape and its collection consumes massive resources.

Clinical psychologist, Victoria

SDQs [Strengths and Difficulties Questionnaires] are routinely completed, but the online form has some mistakes in it and most clinicians do not use them to feed back to clients or to monitor progress. In a previous service we chose our own outcome measures that were applicable to individuals and picked our review points. While this was not as rigorous, it was much more appropriate for our client group and also meant we were more likely to use outcome measures as useful therapeutic tools.

Clinical psychologist, Australian Capital Territory

Some professionals (particularly psychologists) were frustrated that policy decisions, particularly around the number of sessions under Better Access, seemed to be made without regard for outcomes-based research. Evidence was cited by these respondents supporting the argument that for many mental health problems, ten sessions of psychological therapy is insufficient to affect positive clinical outcomes for clients.

Measuring outcomes on periods of therapy which are not aligned with research regarding necessary length of treatment for specific presenting concerns is ineffective.

Clinical psychologist, Queensland

Lack of time and funding dedicated to outcomes monitoring and evaluation

Independent evaluation is considered a vital component of accountability because it allows services and professionals to demonstrate their worth to funders and the wider public. However, there is widespread concern that time and resources for evaluation are not built into funding agreements routinely.

MIC was funded under the TATS [Taking Action to Tackle Suicide] program and was specifically required not to include evaluation of the program in the funding. From MIC industry revenue MIC has engaged in several evaluation processes to ensure the programs are best practice.

Mates in Construction

A related difficulty in demonstrating accountability for outcomes is when evaluations are carried out before initiatives have had time to 'bed in'—giving poor results when the benefits of an intervention may take a long time to accrue.

AHCRA is concerned that the resources provided to carry out service provision in the mental health sector seldom have sufficient or allocated funds for evaluation, especially given that many of the outcomes can only be measured several years from initiation of a program. Often the tools to appropriately evaluate a specific program have not been developed when the program is implemented, often because of a lack of funds for the research required. This undermines accountability for mental health funding and makes it difficult to know whether or not funds are being used to achieve maximum outcomes.

Australian Health Care Reform Alliance

Even where outcome monitoring tools do exist, some respondents report that there is insufficient infrastructure or user support to ensure the potential benefits of using the tools are realised.

... there is an increasing focus on outcomes rather than outputs, which our members rate as positive. However, there are still improvements that need to be made. For example, use of the Psychiatric Outcomes Measurement Tool has been highly variable, largely due to the absence of suitable and affordable software, lack of user support, and inconsistent use of the tool across the sector.

St Vincent de Paul Society

13.3.3 Factors facilitating transparent accountability for outcomes

People with lived experience, family member and support person involvement as an accountability mechanism

When asked about accountability for the outcomes of investment, many organisations reported that involving people with lived experience, family members and support people in the planning and scrutiny of their activity was a powerful mechanism to keep them 'honest'.

The headspace Youth Reference Groups were mentioned multiple times as a method of ensuring accountability to the young people targeted by the service. The public and media attention often attracted by the opening of a headspace centre was felt by some to heighten the sense of accountability to the community.

The headspace Wagga centre is accountable not only to the funding body (via the reporting and evaluation framework) but to the public and young people. A consortium of stakeholders, consumer and parent representatives and the MML Board jointly govern the headspace Wagga centre ... the centre also facilitates a Youth Reference Group, which is a critical part of the service delivery model and aids accountability. The centre is transparent about its programs and activities and is frequently featured in the media—indicative of a sense of responsibility for being in the public eye and ensuring that the public have a positive perception of the service. We also understand the reputation of the centre is the most important asset; if young people lose trust in the brand or the service provided, they will stop seeking our help.

Murrumbidgee Medicare Local

St Vincent's Health Sydney has established an "Urban Partnership for Health, Social Inclusion and Well-being" (UP). UP is a wider forum including service providers, consumers and carers for the community to be fed back the results of surveys, to workshop solutions to specific service issues and for the Inner City service provider network to jointly plan services around areas chosen by the UP for attention e.g. the upcoming Acute Services Symposium.

St Vincent's Health Australia

A different mechanism for community involvement in ensuring accountability for outcomes is the District Health Advisory Council model run in Western Australia.

Whilst transparency with regard to informing the general public regarding spending and outcomes can seem to be lacking, there are some clear examples. Across Western Australia there are District Health Councils comprised of hospital, Aboriginal community health, private allied health practitioners, Medicare Local, GPs and community representatives. Matters of priority funding and resources put into implementation of policies & procedures (such as the four-hour rule in hospital ED) are reported upon and reviewed.

De-identified rural health research provider

Being accountable to local stakeholders and the local community

Direct communication with the public was mentioned by many organisations as being a way in which they tried to ensure they could be held accountable for the work they do and the outcomes they achieve. Mechanisms for such direct communication were regular newsletters, website news updates, and public meetings.

The Annual General Meeting, Report Back Meeting and Annual Report are the formal mechanisms used to report to our stakeholders, whilst ... a summarised annual report [is] sent to all clients, families, carers and stakeholders. These include information about our work throughout the year, financial and operational performance as well as client profile data. The ... website is a key communication tool and provides a platform for disseminating information about our governance structures, services, research and outcomes for clients. This is supported by a quarterly newsletter (distributed to 25,000 people) as well as a client newsletter.

Mind Australia

Improved transparency sometimes is achieved through governance mechanisms which ensure that an organisation's work develops in consultation with, and under scrutiny of, local stakeholders.

Eastern Melbourne PIR is one of EMMML's programs governed by a consortium made up of service providers across the region. This group is afforded complete transparency to all data accumulated by the project including consumer and stakeholder satisfaction. The consortium will be the authorising group of any applications for the use of flexible funding above \$5,000, with the Recovery Focused Advisory Committee (see above) being the authorising group for expenditure between \$500 and \$4,999. This is a clear indication that the accountability for the use of PIR Flexible Funding is not dominated by EMMML as the lead agency of the project but instead shared with its major stakeholders.

Eastern Melbourne Medicare Local

Somewhat different models of accountability are considered effective by individual professionals, especially those in private practice. These professionals often cite the importance of choice for people with lived experience and the 'vote with their feet' model of accountability—if a practitioner is not known for achieving positive outcomes, no-one will refer to them.

The Medicare model of psychological care offers accountability through the patient reporting of outcomes to their GP at review appointments and at ongoing medical visits after psychological care has concluded. In most cases, those providers who are performing poorly simply do not get ongoing referrals, due to negative client feedback or a backlog of disappointing case reports. Conversely, GPs and psychiatrists tend to refer to trusted psychologists who they see a pattern of positive outcomes with prior referrals made.

Alliance for Better Access

Mechanisms for ensuring financial accountability and due diligence were mentioned frequently in relation to private practitioner audits by Medicare.

In providing Medicare-funded psychology services, psychologists are required to comply with Medicare Australia's auditing arrangements. The focus of the Medicare Australia compliance audits is to determine that billing for services is legitimate. Compliance audits of retrospective services, for up to two years previous, are conducted with Medicare service providers either by telephone, letter or through a face-to-face interview. These audits work to detect and prevent fraudulent claims and other inappropriate practices by providers and are an example of clear public accountability.

Australian Psychological Society

13.4 Promising practice examples of transparency and accountability for outcomes

13.4.1 Transparent accountability to the whole community

The concept of partnership governance and joint accountability is extended in an example provided by SANE Australia of a US programme called *StriveTogether*. This is a framework for individual communities to use to commit to the improvement of developmental and educational outcomes among its youth population. It involves baseline measurement and then regular reporting on a series of key indicators. The programme is jointly governed and committed to by multiple community organisations (not limited to schools), to represent whole-of-community commitment to improved youth outcomes.

A good example of clear public accountability for the outcomes of an investment can be found by looking overseas to the StriveTogether 'cradle to career' vision for education in the US. This 'collective impact model' has a very strong framework, which underpins its work. The StriveTogether framework includes roadmaps with key benchmarks and understands the importance of ensuring the processes, mechanisms and relationships are in place to effectively assess and share the data to measure and report impact. Identification of key levers is critical, along with the development of a Community Report Card, which identifies the baselines and highlights changes against these annually.

SANE Australia

13.4.2 StandBy Response evaluation

We also have heard about many examples of organisations involved in delivering Commonwealth-funded programmes using evaluations to increase their public accountability for taxpayer dollars. Commonly, they partner with university-based evaluation teams. Cost-effectiveness evaluations are emerging piecemeal as a result of this. For example, the StandBy Response initiative is a national suicide bereavement support service funded under the National Suicide Prevention Programme; it has undergone an economic evaluation and had its outcomes published in the peer-reviewed literature (Comans, Visser & Scuffham, 2013).

13.4.3 Comprehensive accountability at RFDS

In 2012–13 RFDS Queensland took part in a trial of streamlined Commonwealth funding and reporting called the ‘Single Desk Report’. This was an attempt by the then Department of Health and Ageing to find a way to reduce red tape for NGOs which results from multiple funding streams. RFDS’ submission to us indicates that the trial has had a positive impact on its activities and on the public accountability it is able to provide.

In the experience of RFDS Queensland, the outcome measures and the Single Desk Report are clear examples of a service under public scrutiny like no other. The Single Desk reports deliver outcome measures statistically analysed to provide evidence of efficacy of service across a broad range of social reform areas. Outcome measures are broken down to analyse changes in behaviour, social cohesiveness, mental health and a range of substance use issues. The remainder of the reports reflect service activity including individual counselling, non-client contact activity that nonetheless relates to specific clients, group activities with a breakdown on type of activity, target group of activity, numbers of attendees and psycho-educational components (the nature of the message contained within an activity—e.g. parenting, cannabis use), community networking and planning and meeting activity.

Royal Flying Doctor Service

13.4.4 Feedback Informed Treatment

Individual professionals (particularly psychologists) frequently mention the usefulness of a tool called ‘Feedback Informed Treatment’ (FIT). This tool is a way for practitioners to collect information about clients and outcomes in order to monitor trends in their practice over time and to inform client care planning. Some psychology practices publish the de-identified results of this data collection on their websites—see for example [JumpStart Psychology’s Feedback Informed Treatment Outcomes](#).