MENTAL HEALTH DEEP DIVE

Strategic context and problem definition report

May 2021

Report prepared by Aurora Elmes, Lisette Kaleveld, Aleksandra Olekalns and Kelly Clark

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ACKNOWLEDGEMENTS

Acknowledgement of Country

We collectively acknowledge and pay respects to the Traditional Owners, and Country on which we work – the Wurundjeri People of the Kulin Nation, who are the Traditional Custodians of the lands on which Swinburne's Australian campuses are located in Melbourne's east and outer-east; the Whadjuk Noongar people, who are the Traditional Custodians of the lands on which UWA is situated; and the Bedegal and Gadigal People, both of the Eora Nation, and the Ngunnawal People, who are the Traditional Custodians of the lands on which UNSW is based. We pay respects to the Country and Peoples, and to their Elders, past and present.

Acknowledgement of Lived Experience

We acknowledge the individual and collective expertise of those with a living or lived experience of mental health, alcohol, and other drug issues. We recognise their vital contribution and value the courage of those who have shared their perspectives and personal experiences for the purpose of learning and growing together to achieve better outcomes for all.

REPORT STRUCTURE

This report has been divided into ten main sections, as follows:

1. Executive summary
2. Introduction
3. An overview of policy settings and the Australian mental health system
4. Prevention and early help
5. Improving psychosocial and community-based supports
6. Improving experiences of mental health services
7. Conclusion of evidence review
8. Problem statements based on evidence review findings
9. References
10. Appendix

1. EXECUTIVE SUMMARY

This report provides findings from a review of key mental health frameworks and evidence, drawing from: lived experience reports, grey literature (policy documents and government plans and frameworks) and academic sources. The objectives of this review are:

1. To understand the strategic context, systems, settings and factors influencing mental health in Australia

2. To identify the main issues and gaps within existing systems and settings in order to define a series of core problem statements[1] for further exploration in the next stage of this project

Figure 1– Progress against project plan
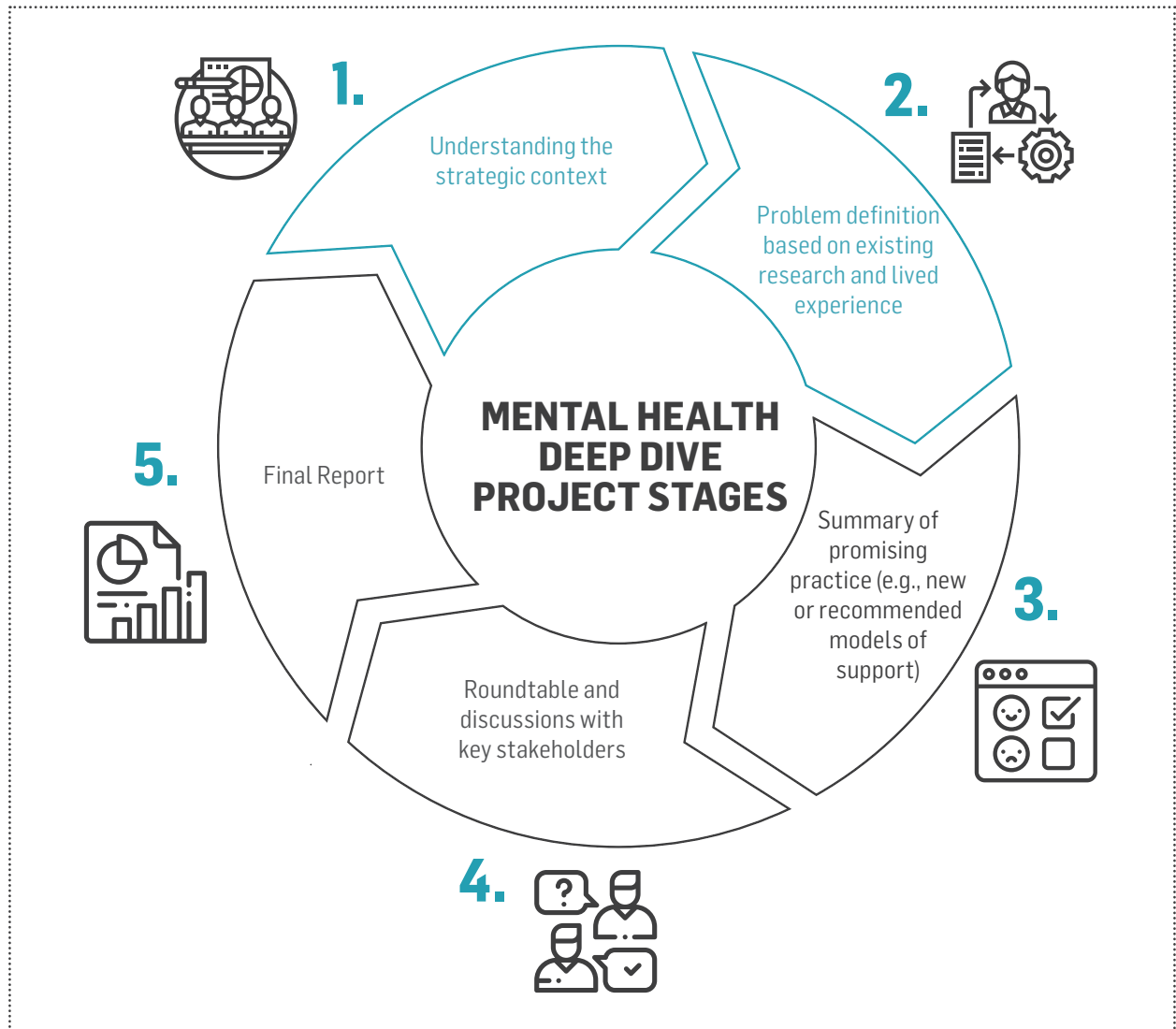
Areas of promising practice or policy reform will be covered in the next stage of this project, with a particular focus on the agreed problem statements arising out of this report. Together, this body of work will support the overall project objective of understanding how to support mental health frameworks in Australia.

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1 A problem definition process is used in design thinking methods to allow a disciplined focus on an issue, before solutions can be developed.

1.1   Findings of this review

- We need to recognise and reduce current social inequities that affect mental health. Currently, the people our society places most at risk of mental health conditions are also the least likely to receive access to safe and responsive healthcare. Reducing mental health stigma is also important for decreasing health inequities and removing barriers to support.

- We need an increased focus on, and more resources towards, prevention of mental health conditions across the lifespan, from early childhood through to education and workplace settings and beyond – including training and resources for people working across these settings to be able to better support mental health within the community.

1.1.2   Improving psychosocial and community-based supports

- Social factors such as safe, affordable housing, access to employment and connection to community can all contribute to good mental health, and to recovery from a mental health condition. Supporting recovery is critical if we are to prevent people cycling continuously through the mental health system. Non-clinical psychosocial supports delivered in community settings can help people establish connection to others, strengthen skills and find secure housing and employment. There is evidence that these supports are greatly lacking and underfunded.

1.1.3   Improving experiences of mental health services

- Australia's mental health system is challenging to navigate, and the levels of care provided across the spectrum from early help-seeking to crisis care are mismatched with demand, meaning many people are missing out on the support they need. Suicide prevention remains a vital focus area, alongside appropriate postvention for people affected by suicide attempts. We need to provide equitable, flexible and inclusive access to person/family/community-centred prevention, early help programs, healthcare and non-clinical supports.

- The mental health workforce is currently under-resourced and at risk of staffing short-falls. There are also gaps in provision of culturally safe and responsive care for Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, and other marginalised groups. We need to support and resource a diverse, skilled and sustainable mental health workforce.

1.2   What are the core problems?

- Waiting for people to be in crisis and access acute care is not working.

- Social inequalities are exacerbated by access barriers and system design.

- Care is fragmented/not coordinated well, it is difficult to support people where they are at, and to help them move through their experience to a holistic recovery.

- The mental health crisis in Australia is not improving despite investments.

2. INTRODUCTION

2.1   Definition of concepts

This report provides an overview of Australia's mental health system and current frameworks relating to the promotion of mental health, and support for people experiencing a mental health condition. The World Health Organization defines mental health as a state of wellbeing that enables people to cope with stress, reach their potential, and live a meaningful, fulfilling life (World Health Organization and Calouste Gulbenkian Foundation, 2014). A mental health condition is commonly defined as as a health problem that significantly affects how a person thinks, feels, or behaves (Manderscheid et al., 2009). Mental health is a broader descriptor and is relevant for everyone at population level, while a mental health condition is a more specific descriptor related to the presence of a condition such as anxiety, depression, schizophrenia, or other recognised mental health conditions (World Health Organization and Calouste Gulbenkian Foundation, 2014). Wellbeing and mental health are connected but distinct concepts, each with their own continuum (Westerhof & Keyes, 2010). A person may have a mental health diagnosis, but still experience a positive state of wellbeing, and people can also experience poor mental wellbeing, but not necessarily have a mental health condition (World Health Organization and Calouste Gulbenkian Foundation, 2014).

While everyone benefits from health promoting environments that meet their physical, psychological and social needs, a range of different supports may be needed as people experience higher or lower wellbeing, or degrees of mental health symptoms. Figure 2 illustrates some of the broad types of support that people can benefit from as they experience different levels of wellbeing and mental health. This illustration is a simplification of complex experiences and systems, so some detail and nuance are necessarily omitted. We discuss prevention, early help, psychosocial supports and mental healthcare in greater detail in the coming chapters.

Figure 2 – Dual-continuum model of mental health and wellbeing
(adapted from Tudor, 1996 in Jay et al., 2017)
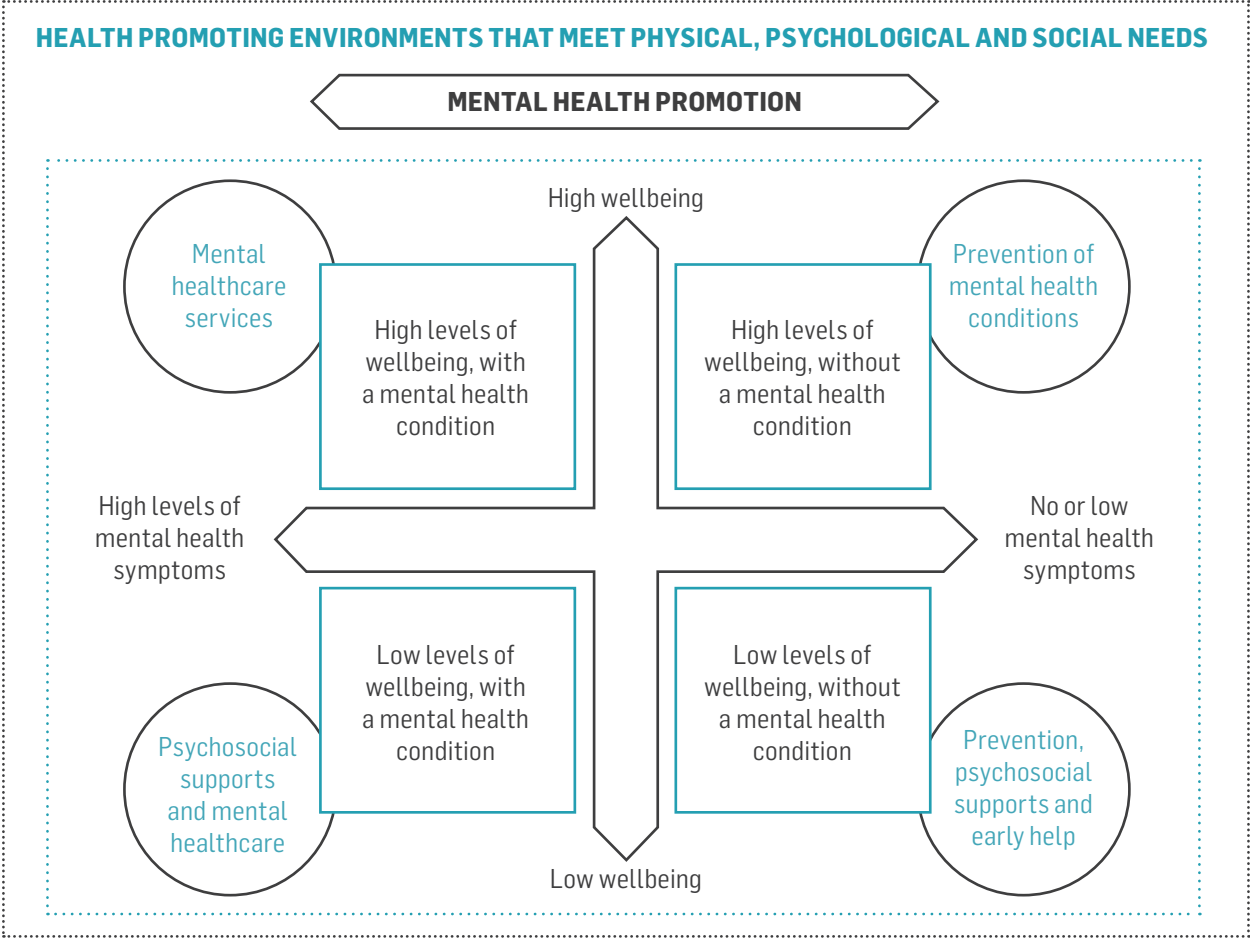
2.2 Terms used in this report

Consumer refers to people with a lived experience of mental health distress, challenges or conditions, or of using mental health services.

Family members and carers refers to people with a lived experience as a carer, family member, friend or other supporter of a consumer. The term acknowledges that not all family members wish to identify as a 'carer', and there may be other important relationships in a consumer's life or recovery process. These terms are used interchangeably in this report.

Psychosocial refers to psychological and social factors that can impact or support a person's mental health and wellbeing. For example, access to meaningful activities, supportive relationships, belonging and safe housing can all be described as psychosocial factors affecting one's wellbeing and mental health.

Social determinants of mental health refers to the recognition that mental health is shaped significantly by the social, economic and physical environments in which people live.

2.3 Review approach and method

Our review approach was based on the aims of this stage of the Mental Health Deep Dive:

- To understand the strategic context, systems and settings influencing mental health in Australia

- To identify the main issues and gaps within existing systems and settings in order to define a series of core 'problem statements'[1] for further exploration in the next stage of this project

Reflecting current guidance on conducting rapid reviews of health systems and policy evidence (Garritty et al., 2021; Tricco, Langlois, & Straus, 2017), this literature review is being conducted through an iterative process informed by design thinking, with the opportunity for stakeholder input to inform the final focus. Design thinking aims to understand a problem broadly, through extracting and integrating various points of view (Hawryszkiewycz, 2014).

Figure 3 – The double diamond design thinking framework, adapted from the UK Design Council's (2004) framework for innovation
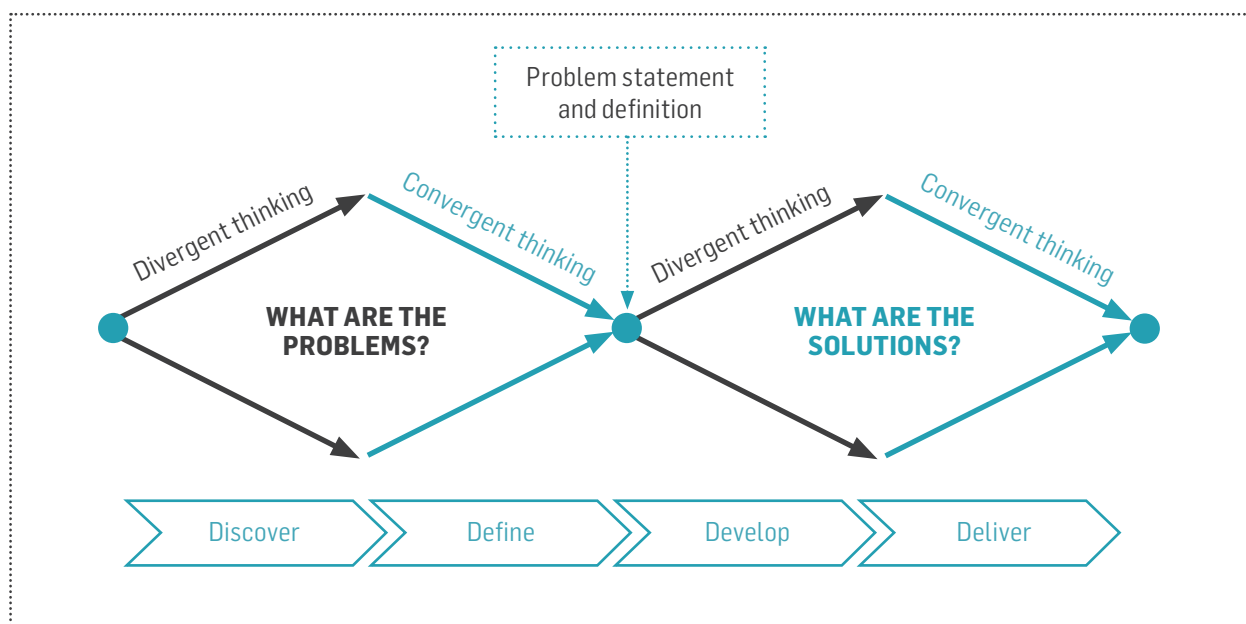
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1 A problem definition process is used in design thinking methods to allow a disciplined focus on an issue, before solutions can be developed.

The double diamond design thinking framework (Design Council, 2004) represents a systematic approach to understanding complex systems, and has been used broadly to help understand complex social problems, both within and external to design thinking. The 'discover' part of the double diamond framework represents a 'divergent' process that is considered valuable for arriving at a holistic overview of the mental health system.

This divergent process, or 'discover phase', allowed the team to effectively cast the net widely, beyond the realm of published academic literature alone. This is important because of very recent major reforms within the mental health sector, recent pressures on the mental health of Australians as a result of COVID-19, bushfires and economic uncertainties, and the increasingly recognised need to capture the perspectives of people living with mental health issues, have not yet made it into the academic literature. However, as information was located and interpreted, the process shifted towards the 'define' phase, or convergence, which involved defining (based on the evidence) what the core problems are. Further details on the review approach and method are provided in an appendix at the end of this report.

2.3.1 Review phase one – Discover

The first phase of the review was guided by the project aims outlined above, and the question asked by the Z Zurich Foundation: "How do we better support mental health and wellbeing frameworks in Australia?" Broad searches were performed to identify the range of content areas relevant to this review.

2.3.2 Review phase two – Define

With the core content areas identified, searches of the grey literature (via Analysis and Policy Observatory) and academic research (via PubMed) were conducted to source further evidence relevant to this review.

This review brings together the findings of the Discover and Define phases. We begin with an overview of policy settings and the mental health system in Australia (chapter 3). Then, the following three chapters (chapters 4-6) each map out a key area of mental health, and chapter 7 presents a conclusion summarising the evidence on the main issues and gaps. The final chapter (chapter 8) then draws on the evidence review to define the current core problems within mental health in Australia.

3. OVERVIEW OF POLICY SETTINGS AND THE MENTAL HEALTH SYSTEM

3.1   *Overview of the Australian mental health system and funding*

Australia's mental health system is complex, with public healthcare funding and service responsibilities split across federal systems such as Medicare, Primary Health Networks and disability services; and state/territory systems that primarily facilitate access to specialist public mental health care in hospitals and in the community (Australian Institute of Health and Welfare, 2021; Cook, 2019).

In addition to the public mental healthcare system, private health insurers fund mental health treatments delivered within a private hospital, or by private healthcare providers (Australian Institute of Health and Welfare, 2021), with individuals paying the costs of private health insurance as well as any additional costs above what is covered by either the public or private system (Cook, 2019). There are also a range of non–government organisations (NGOs) that provide wellbeing, psychosocial and recovery–oriented supports (rather than clinical mental healthcare) to people with a mental health condition (Australian Institute of Health and Welfare, 2021). An overview of these main funding and service areas is provided in Figure 4.

While a much broader range of systems and services intersect with, and influence mental health (for example, Australia's income support system, housing assistance, employment programs, and disability services), this section focuses only on the system and services that deliver mental health care in Australia.

Figure 4 – Summary level diagram of major mental health funding sources

FEDERAL MENTAL HEALTH FUNDING

The Federal government primarily funds a range of mental health-related services through the Medicare Benefits Schedule (MBS), and the Pharmaceutical Benefits Scheme (PBS)/ Repatriation Pharmaceutical Benefits Scheme (RPBS), and a range of broader essential programs and services including income support, disability services (including NDIS which is jointly funded with the states and territories), employment programs, and housing assistance (AIHW 2021). Federal funding also supports telephone and online crisis support services, national digital mental health platforms, and additional programs through Primary Health Networks (PHNs) (AIHW 2021). Federal funding may also contribute to research and health promotion programs, and to funding programs delivered by Non-government organisations.

PRIVATE SECTOR MENTAL HEALTH FUNDING

"Private sector services include admitted patient care in a private psychiatric hospital and private services provided by psychiatrists, psychologists and other allied health professionals. Private health insurers fund treatment costs in private hospitals, public hospitals and out of hospital services provided by health professionals." (AIHW 2021)

NGO AND OTHER MENTAL HEALTH FUNDING

Non-government organisations may be not-for-profit and for-profit, and may receive government and/or private funding. The focus of NGO programs is usually on providing support to people who live with a mental illness to improve wellbeing, rather than on providing clinical mental health care, which is done by other public and private mental health services (AIHW 2021). NGOs may also produce mental health research.

STATE AND TERRITORY MENTAL HEALTH FUNDING

State and territory governments fund public sector specialist mental health services delivered through public acute and psychiatric hospitals, specialised community mental health care services and residential mental health care services, and non-specialised hospital services used by people with a mental health condition (AIHW 2021). State/Territory Mental Health Commissions have a role of driving reform and accountability (all except NT and TAS), commissioning services (WA), and handling complaints (VIC) (Productivity Commission 2020). State and Territory governments fund public education, early childhood services, supported accommodation and housing (AIHW 2021), disability services (including joint funding of the NDIS), drug and alcohol services, police, justice and corrections services - all of which intersect to some degree with mental health (Productivity Commission 2020). States and Territories also fund health promotion and prevention, and efforts to reduce stigma and discrimination (Productivity Commission 2020)

While many large NGO mental health services such as Neami Ltd and Mind Australia receive a high proportion of their funding from government, most of these services focus on providing supports to people with a severe or chronic mental health condition, rather than on prevention and early intervention (headspace and Beyond Blue being exceptions) (Future Generation Investment and EY, 2021). Currently, Private Health Insurers cover approximately 20% of hospital costs related to mental health but are restricted from funding community-based care and support that might promote their customers' mental health (Productivity Commission, 2020).

Several recent reports into the mental health system in Australia suggest that increased funding and wide-scale reform is needed to remediate the existing issues, such as under-investment compared with physical healthcare, complex regulation and governance arrangements, poor service planning and coordination, and inadequate outcome measurement (Productivity Commission, 2020; Victorian Government, 2021). Private funders may have the will and resources to invest in mental health but need clarity from government and NGOs regarding what areas would benefit most from investment (Future Generation Investment and EY, 2021).

3.2   Overview of relevant mental health policy settings and plans

This section provides an overview of the key areas for action identified within Australian policy settings, to provide context relevant to the following chapters of this report. A review of federal, state and territory government mental health strategies and plans revealed a range of common themes and action areas, and a brief summary of these action areas is provided in Table 1. Given the multi-layered and complex nature of Australia's mental health systems and settings, these action areas occur at a range of levels, from the whole system (including prevention initiatives across different settings, psychosocial supports, and mental health services); to how different service systems can better work together to support people's needs; to areas of improvement for mental healthcare services in particular.

Table 1 – Action areas and needs emerging from review of government mental health plans

WHOLE OF SYSTEM ACTION AREAS – PREVENTION, EARLY HELP, MENTAL HEALTH SERVICES AND NON-CLINICAL SUPPORTS

Action area	Example actions	Sources
Increase social equity and inclusion across all life settings *Improve evaluation culture and practice*	• Address mental health risk factors and their social context • Increase cross-sector engagement • Reduce stigma • Provide evidence based suicide prevention • Improve Indigenous mental health and Suicide Prevention outcomes • Improve outcomes measurement, including the measurement of engagement of and responsiveness to target cohorts	• The Fifth National Mental Health and Suicide Prevention Plan 2017 • National Mental Health and Wellbeing Pandemic Response Plan • All current state and territory mental health plans (detailed sources listed in Appendix)

SERVICE SYSTEM ACTION AREAS – EARLY INTERVENTION, MENTAL HEALTH SERVICES AND NON-CLINICAL SUPPORTS

Action area	Example actions	Sources
Create a balanced system that can more effectively support recovery and address the social determinants of mental health, reducing reliance on costly acute services *Systems, policy and services should be informed by people with lived experience, including acknowledgment and support of family members and carers* *Provide equitable and inclusive access to integrated healthcare and psychosocial supports* *Prioritise mental health alongside physical health and access to other supports.*	• Redesign services to address gaps and barriers and facilitate access to supports • Increase collaborative planning, funding, and delivery of services • Provide culturally secure and responsive services • Early intervention - Early in life; early in distress; early in episode • Facilitated access to care and supports • Meet unique needs of marginalised cohorts, including people with complex mental health presentations or needs • Ending homelessness through Housing First approaches • Integrate support for physical, mental, and social health • Evidence based suicide postvention	• Australian Government – Joint Regional Planning for Integrated Regional Mental Health and Suicide Prevention Services (2018) • The Fifth National Mental Health and Suicide Prevention Plan 2017 • National Mental Health and Wellbeing Pandemic Response Plan • All current state and territory mental health plans (detailed sources listed in Appendix)

MENTAL HEALTH SERVICE ACTION AREAS

Action area	Example actions	Sources
Create a better-integrated mental health system through collaboration *Provide equitable and inclusive access to integrated healthcare and psychosocial supports* *Support and resource a diverse, skilled and sustainable mental health workforce*	• Establish partnerships at local, internal, inter-jurisdictional, and national levels to improve the mental health system • Increase public awareness of services in primary health and community settings • Provide flexible access to affordable, quality care • Offer the right level of care at the right time, in the right place • Offer digital and eHealth options in line with people's preferences and needs • Provide clear pathways between levels of care • Integrate mental health and alcohol and other drug responses • Provide career pathways for skilled mental health workers from diverse backgrounds • Data sharing (in alignment with the relevant privacy legislation)	• The Fifth National Mental Health and Suicide Prevention Plan 2017 • National Mental Health and Wellbeing Pandemic Response Plan • All current state and territory mental health plans (detailed sources listed in Appendix)

3.3 Prevalence of mental health conditions, and rationale for reform

The most recent National Health Survey found that an estimated 4.8 million Australians (20.1% of the population) had a mental or behavioural condition in 2017-2018 (Australian Bureau of Statistics, 2018; Cook, 2019), and almost half the population (45%) are estimated to experience a mental health condition in their lifetime (Australian Bureau of Statistics, 2008; Cook, 2019). Despite the high prevalence of mental health conditions, access to appropriate support and care remains an issue in Australia. The recent Productivity Commission report into mental health suggests a series of priority reforms to improve the mental health system, to provide person-centred care and reduce preventable distress (Productivity Commission, 2020). The Commission notes that adopting these priority reforms could generate benefits to people's quality of life and economic participation, with an economic value in the order of $17 billion (Productivity Commission, 2020).

The next section gives an overview of the emergence of lived experience perspectives as vital to informing policy and services across all domains of mental health.

3.4 The emergence of learning from lived experience to inform policy

3.4.1 Lenses of knowing

The idea of evidence-based policy is well established. However, this initially referred to utilising research findings, and then bringing in practitioner perspectives to inform policy (Shonkoff, 2000). It has only been more recently that service user perspectives have also been highlighted as essential.

Of course, understanding and accommodating the lived experience of service users is not at all new. Expert clinicians, for example, may have great insight and skill in understanding the lived experience of their patients. It is just that little of that "narrative understanding" has been uncovered and codified in academic literature, or formally integrated into policy development. Much of that rich clinical knowledge remains tacit (Greenfield, 2010). Until recently it was not systematically collected or reflected on at a policy or systems level.

There is great need for making the service user experience more explicit, and the lived experiences of people with mental health conditions and their family members and carers more visible to policy makers, researchers and commissioners - and also to enable those with lived experience to play a more active part in owning their expertise and presenting it to others as the owners of this knowledge.

3.4.2 Bringing in the lived experience perspective

- In Australia, the Statement on Consumer and Community Participation in Health and Medical Research outlined the importance of consumers and the community playing an active role in health and medical research (National Health and Medical Research Council and Consumers Health Forum of Australia, 2002). This is also increasingly recognised and codified in policy frameworks and standards, such as the National Safety and Quality Standards for Health Care and Digital Mental Health (Standard 2) (Australian Commission on Safety and Quality in Health Care, 2020) and the National Standards for Mental Health Services (Australian Government Department of Health, 2010a) and Principles of Recovery Orientated Mental Health Practice (Australian Government Department of Health, 2010b).

...to inform policy

- Many have argued that to be relevant and effective, service design and implementation must be informed by end users (Boote, Telford and Cooper, 2002). People who use services are the best placed to identify existing gaps and how their needs may best be met (Davidson, et al., 2009).

...to inform mental health academic research

- Consumer and carer involvement in mental health research is a growing and developing field. Whilst there has been policy and in-principle support for such involvement from governments around

the world, lived experience researchers conducting academic research in partnership with other consumers, family members and carers remains uncommon (Banfield et al, 2018).

...to promote meaningful engagement, healing and recovery

- There is growing acceptance of the mental health recovery movement, and that embedding consumer perspectives at all points of policy development creates a solid foundation for consumers, family members and carers to move beyond tokenistic modes of participation and into meaningful and effective involvement (Hancock et al. 2012) in both mental health research and policy design.

Having provided an overview of Australia's mental health system and funding arrangements, outlined areas for action identified within current federal, state and territory plans, and addressed the importance of lived experience in leading policy and system change, we now briefly discuss the impacts of COVID-19 on mental health.

3.5 Impacts of COVID-19

The COVID-19 pandemic is having significant impacts on mental health and service delivery. Emerging research on the mental health impacts of COVID-19 is finding both high levels of negative emotions among people with existing mental health conditions, and high psychological distress levels in the general population (National Mental Health Commission, 2020; Rossell et al., 2021). Predictors of high negative emotion include being young (18-24), female, single, at higher risk of death from COVID-19, and having experienced a mental health condition; while protective factors included having a large amount of savings, and being a home-owner (Rossell et al., 2021). The widespread impacts of COVID-19 on employment, financial stability, social connections and stress are providing stark examples of how social and economic inequities can influence mental health for different groups of people – such as young people, who are more likely to have insecure employment (Kaleveld, Bock, & Maycock-Sayce, 2020).

Within Australia, rapid policy and practice changes were made to respond to the impacts of COVID-19 on mental health, and implications for access to mental healthcare (National Mental Health Commission, 2020; Victorian Government, 2020). Major developments included increased outreach and support for those at risk of suicide, the expansion of digital and telehealth services, increased coordination between primary and acute care services, and greater focus on responding to other basic needs, such as housing for people experiencing homelessness, and meeting social, emotional and cultural needs at a time when people may have had very restricted access to their usual social activities and supports (National Mental Health Commission, 2020; Victorian Government, 2020). The Better Access initiative, which provides Medicare rebates to people accessing psychological support, was extended to offer telehealth sessions to everyone (regardless of geographical location), and to provide an additional ten sessions of support per calendar year to people experiencing ongoing mental health impacts from the pandemic (Australian Government, 2021). The Federal Government also contributed $26.9 million to fund the Head to Help program, a collaborative initiative with the Victorian Government and coordinated by local Primary Health Networks in partnership with local services, which provides a phone-based point of contact and referral service for people seeking mental health care in Victoria (Head to Help, 2021).

3.6 Chapter summary

The impacts of COVID-19 highlight the ways in which social and economic factors to influence mental health for better or worse. Recognising the impacts of socioeconomic, cultural and political contexts on mental health, and the ways in which broader systems and structures (from policies, to the healthcare system, to workplaces and communities) influence the opportunities for life and health that people can access (United Nations, 2020), this evidence review takes the (widely-accepted) ecological, social determinants of health perspective of mental health (Carey & Crammond, 2015; Patel et al., 2018; Productivity Commission, 2020; World Health Organization and Calouste Gulbenkian Foundation, 2014).

Reviewing the evidence through a narrative lens of equity aligns with two of the Z Zurich Foundation's three

focus areas – improving mental wellbeing, and enabling social equity. It also acknowledges that experiences of mental health or distress are not only located within the formal mental health service system, but occur throughout our lifespan, from infancy and early childhood, to adolescence and adulthood – and within all of the settings we inhabit throughout life, from home, to school, work and our communities (as shown in Figure 5).

Figure 5 – Influences on mental health and illness across life settings and stages
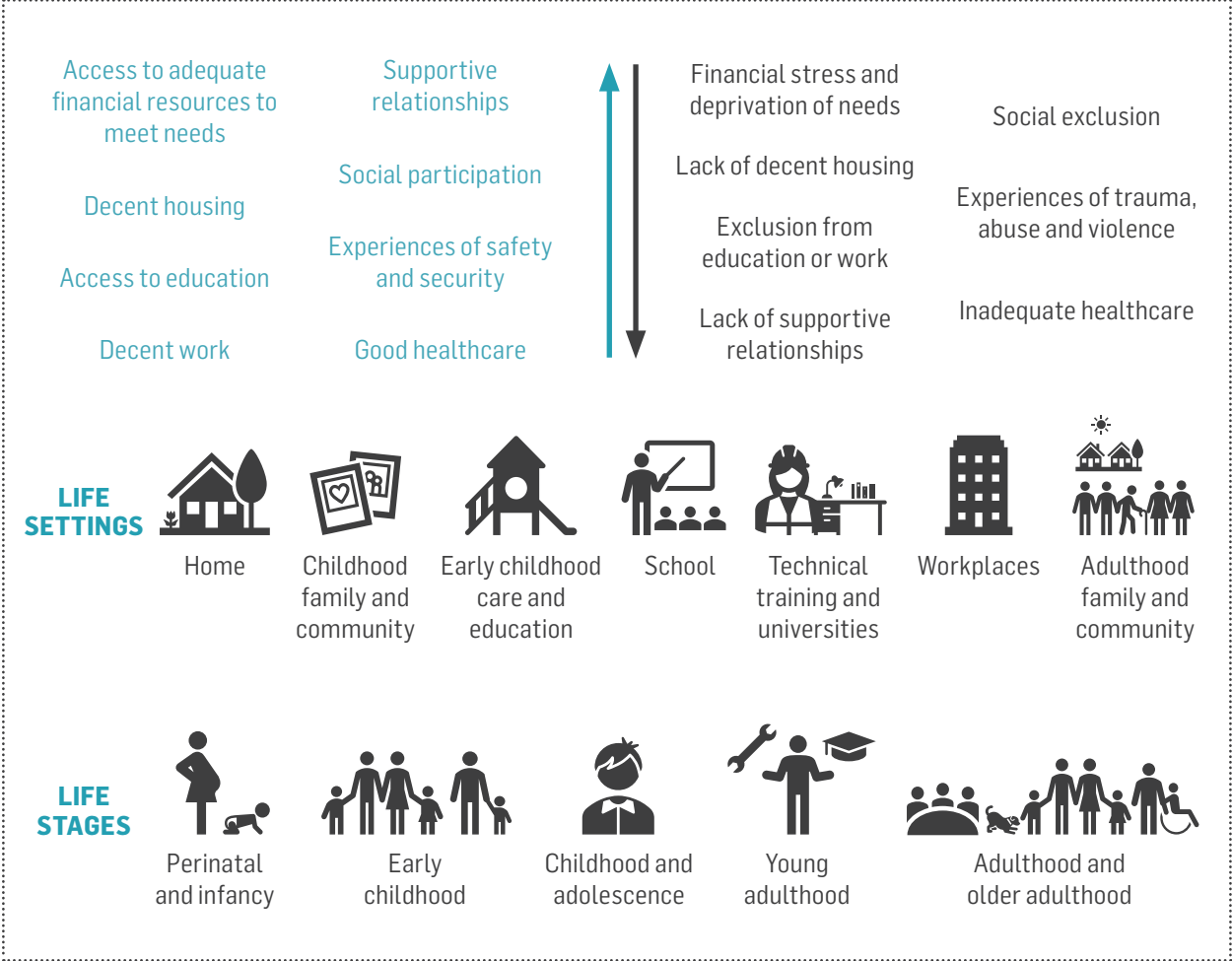
Supporting mental health therefore spans many settings and forms, from prevention of mental health conditions and early help across the lifespan, to improving community-based supports that enable people to live well, to mental healthcare services. These intersecting domains of mental health form the next chapters of this report.

- *Prevention and early help* (Chapter 4) – for children, young people, and adults across settings including school, tertiary education and workplaces

- *Improving psychosocial and community based supports* (Chapter 5)

- *Improving experiences of mental health services* (Chapter 6)

4. PREVENTION AND EARLY HELP

The next sections examine the current main issues specific to life stages or settings in which people face challenges to their mental health and wellbeing, and identify where services and understandings surrounding mental health and wellbeing are lacking within the broader policy context. These stages sit within and are influenced by the Australian policy settings and context of the mental health system as previously outlined in this report.

The reform areas outlined by the Productivity Commission (2020), and those outlined by the Royal Commission into Victoria's mental health system (2021) acknowledge that in addition to individual biological and psychological factors, a broad range of social, political, economic and environmental factors impact mental health for better or worse (Patel et al., 2018; World Health Organization and Calouste Gulbenkian Foundation, 2014), meaning risks to mental health are not equally distributed among the population (Productivity Commission, 2020). Risk factors for mental health conditions are strongly associated with social inequities (Allen, Balfour, Bell, & Marmot, 2014), and these same inequities in access to resources can make mental healthcare inaccessible or unaffordable to those who need it (Victorian Government, 2021). Provision of quality, person-centred mental healthcare is part of the picture, but attention to people's social and economic circumstances, cultural understandings of mental health, and opportunities to prevent mental health conditions are also called-for by Australian and international mental health researchers (Jorm, 2018; Patel et al., 2018), by the recent public inquiry processes into mental health in Australia (Productivity Commission, 2020; Victorian Government, 2021), and by organisations focused on increasing effective investment into mental health (Future Generation Investment and EY, 2021).

The following section discusses prevention and early help, with a focus on children and young people. These are two groups for which there is a strong case for increased investment in prevention of mental health conditions and early help. Mental health is essential to healthy childhood development and enables children and young people to thrive and grow through to their transition into adulthood (Productivity Commission, 2020; Victorian Government, 2021). Giving families and their children or young people the tools to support development provides a means to better cope with challenges arising from their environment, external stressors and the difficulties of growing up. Existing services and support systems around families, children and young people can also play a role in early identification of distress or mental health challenges, and provision of support.

This section is divided to address five key areas of prevention and early help, with a chapter summary at the end:

4.1	Social and emotional wellbeing of children
4.2	Young people, training, education and employment
4.3	Workplaces
4.4	Social inclusion and stigma
4.5	Suicide prevention
4.6	Chapter summary

4.1   Social and emotional wellbeing of children: early childhood and schooling

4.1.1   What are the current main issues in this area of mental health?

Early childhood and schooling spans the developmental period in infancy through to children's engagement with the education system. It is well-established that childhood mental health and wellbeing significantly influences life trajectory, long-term engagement within the community, and experiences of social inclusion. However, there are currently failings within the structure of the education system, and barriers affecting young people's ability to access services to best support mental health and wellbeing.

4.1.1.1 Childhood mental health and wellbeing impacts life trajectory

Mental health challenges often emerge in early childhood and adolescence, and can have substantial and lasting impacts on life trajectory. Wellbeing in childhood, however, is associated with a range of positive outcomes, including improved social relationships, engagement, academic achievement and economic security (VicHealth, 2015). Prevention activities and early intervention to prevent progression from early signs of psychological distress to a diagnosable condition aims at reducing the duration and severity of mental health conditions. Specifically, interventions look to identify and modify factors associated with mental health conditions including perinatal influences, family and other interpersonal relationships, and pre-schools and schools (Mrazek & Haggerty, 1994). Investing in the mental health and wellbeing of children delivers significant returns, and impacts a broad range of outcomes, including students' engagement in learning and their education, and in their longer-term engagement, and contributions to productivity, consumption and innovation (The Centre for Adolescent Health, 2018; Productivity Commission, 2020).

4.1.1.2   Expectations about the role of the education system in mental health and wellbeing are not accompanied by adequate structural and material support

Perinatal mental health services, pre-schools and schools are well-placed to play a significant role in prevention of mental health conditions, and promotion of childhood wellbeing. However, there are significant challenges in the provision of specialist services to specific at-risk families during infancy, and within the schooling system, where educators face challenges in fulfilling the expectations of the evolving role of education facilities (Productivity Commission, 2020). Additionally, there is a consistent picture of concerns about the impact of high-stakes testing practices on physical and mental health of students, which coincides with various developmental changes (physiological, neurological, psychological, social) that students go through during their schooling years (Wyn, Turnbull & Grimshaw, 2014). The emergence of competing priorities within the education system leaves insufficient attention and time dedicated to cultivating and promoting mental health and wellbeing, even with increasing community expectations around their involvement in such aspects of prevention and intervention.

Three key areas are highlighted as particular areas of concern related to structural and material support:

1. At a community level, schools navigate a crowded space of curricula, frameworks, community organisations, specialists and government programs in an attempt to canvas effective support for their students and engage with the intersection of policy, support and education in a holistic and meaningful way (Productivity Commission, 2020).

2. To support prevention and early identification of mental health challenges, several challenging aspects of workforce training are consistently highlighted in relation to early childhood educators, including the time required for and the sheer number of available professional development training courses, inconsistent approaches in pre-service training programs and insufficient quality monitoring of independent training programs. Changes in this area appear to be relatively slow-moving; for example, since publication of the National Mental Health Commission Review (NMHC, 2014), improvements in workforce training (a key recommendation in this report) have seen only minor improvements in care.

3. To support informed policy and targeted service provision, services that can be, and are currently provided in schools face challenges in the lack of a unified approach to program evaluation. While opportunity exists for well-placed prevention interventions in this environment, there is currently tracking of mental health and wellbeing benefits for program evaluation that occur at a state, but not national, level (Gregory et al., 2019; National Mental Health Commission, 2014; Productivity Commission, 2020). For example, for children up to 5 years, the most comprehensive national data source is the Australian Early Development Census that is administered every three years. However, data at a school level largely involves state and territory specific tools, which cannot be compared across jurisdictions and which is collected and used inconsistently (NSW Auditor-General, 2019; Productivity Commission, 2020). This poses difficulties in evaluating interventions and whole-of-school approaches, and in compiling a clear picture of children and young people's mental health and wellbeing in schools and their benefits.

4.1.2 What gaps remain and who is under-served?

Across the early lifespan (pre-natal mental health including for parents and families through to support for children through their school years), there are several outstanding gaps in services and policy coordination that continue to impact the quality of mental healthcare and prevention activities in this area. Specifically, these include the lack of unified national data that facilitates adequate evaluation of prevention initiatives, lack of a clear training pathway for educators to understand and best support early intervention in educational facilities, and barriers including financial cost and accessibility of appropriate assessment and therapeutic services (Productivity Commission, 2020).

4.1.2.1 Greater availability and accessibility of services tailored to specific populations

Programs that support specific aspects of infant, pre-school and school-age social and emotional development do not reach all families who need support, or are not consistently implemented on the ground. For example, families are not always able to access programs designed to share strategies intended to mitigate specific risks, including the development of Fetal Alcohol Spectrum Disorder (New South Wales Parliament, 2018). Families with the greatest needs, including children presenting with conduct disorders, and those with an intellectual disability and a mental health condition, often face difficulties with engagement (Productivity Commission, 2020). Further, families risk receiving less intensive services than needed, or no health services at all when attempting to access programs that support children exposed to factors that increase risk of mental health conditions in adulthood (i.e., poor physical health, personal trauma, socio-economic disadvantage, accessibility issues including those living in remote areas, being in out of home care/child protection system and in particular, Aboriginal and Torres Strait Islander children) (Guy et al., 2016).

4.1.2.2 Children need school-based mental health and wellbeing support but barriers to access remain

There is a growing consensus amongst key stakeholders that a modern education system should develop cognitive, emotional and social skills, however, its role in the mental health and wellbeing of children and young adults is not formalised to see meaningful change and support (The Centre for Adolescent Health, 2018). The National School Reform Agreement (2019-2023) (Council of Australian Governments, 2018) applies to both government and non-government schools, however, does not encompass wellbeing as part of the Agreement's outcomes or reporting requirements, effectively excluding mental health and wellbeing support from a unified curriculum. In addition, the unclear roles and responsibilities across the range of professions involved in care, a lack of defined communication pathways to benefit collaborative care, and a focus on reactive (as opposed to proactive) care limits the ability to provide effective prevention support (Productivity Commission, 2020).

Within the schooling cohort, providing support for children known to be at increased risk of experiencing mental health conditions remains a challenge. Schools are well-placed to identify children at risk and provide early intervention for the benefit of mental health and wellbeing. However, wellbeing programs in schools are more often based on risk of disengagement from education (and managing behavioural and emotional issues

to this end), rather than offering mental health support to these students (i.e., NSW Department of Education and Communities, 2015). There are exceptions, although relatively few, that offer targeted programs. For example, the Foundation House School Support program for migrant and refugee students who are at risk of psychological distress, having experienced traumatic events in their country of origin (Victorian Foundation for Survivors of Torture, 2019). Challenges that accompany intervention focused on mental health support include coordination between parties involved in supporting children with complex needs, especially for those at risk of disengaging from school in light of a mental or physical health condition or caring responsibilities. This is not routinely successful given reliance on coordination between an often large team of professionals, or unclear policies for referral pathways (Productivity Commission, 2020; Schnyder et al., 2020). Additionally, concerns around the low rates of access to mental health support for children in out-of-home care and Aboriginal and Torres Strait Islander children remain (Productivity Commission, 2020).

4.2   Young people, training, education and employment

4.2.1   What are the current main issues in this area of mental health?

Mental health conditions commonly emerge in adolescence and early adulthood (Orygen and the World Economic Forum, 2020), and this is a transitional life stage which can present many new challenges for young people as they move into further study or employment (Maheen & Milner, 2019). During this life-stage, tertiary and vocational education institutions form some of the major life settings young people are engaged with. In Australia, tertiary education comprises higher education providers (University study) and Vocational Education and Training (VET), though there can be some overlap between VET and higher education, with some organisations providing both (Productivity Commission, 2020). Many people participating in tertiary education are within an age group (18-24) that experiences higher rates of mental health conditions and suicide than the rest of the adult population, but support in these settings is variable (Orygen and the World Economic Forum, 2020; Productivity Commission, 2020). In addition to the acute effects on young people's health and quality of life, experiencing mental health challenges at this transitional age can have extended impacts on young people's economic and social participation as they age (Orygen and the World Economic Forum, 2020; Productivity Commission, 2020).

4.2.1.1   Early adulthood can be a stressful time in life

A range of social factors related to this transitional life stage of pursuing further training or education can contribute to young people experiencing mental health challenges. Some of these factors include the stress associated with study, or balancing study and other commitments such as work (Maheen & Milner, 2019); being separated from usual support networks of family/friends (if a student is studying away from their home); and financial stress (Orygen, 2017; Productivity Commission, 2020). However, education also confers benefits for future economic and social participation, and mental health (Productivity Commission, 2020).

4.2.1.2   Prevention and early intervention can help, but support and training are needed

Current youth mental health frameworks call for increased investment in prevention and early intervention (Orygen, 2020; Orygen and the World Economic Forum, 2020). Research from the RAND Corporation in the US has found that investing in prevention and early intervention at tertiary education institutions has net economic benefits, particularly when institutions have a high proportion of students from groups with lower socioeconomic status – but teachers are not always well equipped to respond to students presenting with mental health challenges, and need access to support and training to assist them in responding effectively (Orygen, 2017; Productivity Commission, 2020).

4.2.1.3   Apprentices and trainees experience high rates of bullying

There is evidence that apprentices and trainees experience high rates of bullying, affecting both their mental health, and (dis)continuation of pathways (Productivity Commission, 2020). Bullying has been shown to contribute to the development of mental health conditions (Jadambaa et al., 2019), and is a source of preventable harm that must be addressed to protect mental health.

4.2.1.4   Barriers to help-seeking and access to care

Mental health conditions may be under-reported in education and training settings, but the experience of some institutions is that issues such as anxiety are increasing (Productivity Commission, 2020). Despite this, there are also students who may be experiencing mental health challenges, but do not feel comfortable disclosing this or seeking support (Orygen, 2017). Mental health support varies greatly by educational institution, and demand for support (e.g. counselling) can exceed supply (Orygen, 2017; Productivity Commission, 2020). Some institutions provide onsite support, some provide external referrals to other services, and most require proof of a mental health condition (e.g. diagnosis by a healthcare professional) to access educational accommodations (Productivity Commission, 2020). Like other people seeking mental healthcare, young people need care that is accessible, affordable and responsive to their needs – and currently this is not always the case within a tertiary education system that provides variable access to support (Orygen and the World Economic Forum, 2020).

4.2.2 What gaps remain and who is under-served?

4.2.2.1   Students who may experience increased risk of mental health conditions

Several groups of students may experience increased risk of mental health conditions due to the inequities they experience in our society (Centre for Education Statistics and Evaluation 2020; Department of Developmental Disability Neuropsychiatry UNSW 2016; Orygen, 2020), including:

- Aboriginal and Torres Strait Islander students

- LGBTIQ+ students

- Students from low socioeconomic backgrounds

- Students from regional or rural/remote areas

- Students with disability

- Non-English speaking students from a migrant or refugee background

While evidence is inconclusive, some research suggests that international students may experience higher rates of mental health challenges (Productivity Commission, 2020). Tertiary education institutions need to ensure that international students have health insurance that provides for adequate access to mental health support, including culturally responsive services that cater for diverse language needs (Productivity Commission, 2020).

4.2.2.2   Young people who are disengaged from training/education and work

Young people transitioning into adulthood (16-24) have much higher rates of unemployment than the general population, which can contribute to stress, social and economic exclusion, and worse mental health (Productivity Commission, 2020). Disengagement from training/education or work places young people at higher risk of longer term negative social, economic, and wellbeing outcomes, while engagement in education/training and decent employment can have both short and long-term benefits (Orygen and the World Economic Forum, 2020; Productivity Commission, 2020). Young people not in education, training or work have higher risk of mental health conditions, but are also less likely to seek support – and strategies for re-engaging young people in work or study after they disengage are inconsistent (Productivity Commission, 2020). Gaining work (even with support from programs such as Individual Placement and Support) can be challenging for young people without existing employment experience (Productivity Commission, 2020).

4.2.2.3   Young people in precarious work

Employed young people often work in precarious industries/casual roles, which are more impacted by economic shocks such as the impacts of COVID-19 (Orygen and the World Economic Forum, 2020; Productivity Commission, 2020).

4.2.2.4 Young people exiting care, or caring for someone else

Young people exiting out-of-home-care, and young family members or carers supporting someone else with an illness or disability are also at greater risk for mental health conditions, and impacts to education, future employment and income (Productivity Commission, 2020).

4.3 Workplaces

For many people from early adulthood to older adulthood, workplaces represent a significant life setting which can influence their mental health for better or worse (World Health Organization and Calouste Gulbenkian Foundation, 2014) – and people may experience mental health conditions during the course of their employment. This makes workplaces an important setting for prevention of mental health conditions, through providing environments that are both physically and mentally safe (for example, free from discrimination and bullying) and support good mental health. Mentally healthy workplaces can benefit both employees (through supporting health), and employers (through decreased work absences, improved productivity, and reduced worker's compensation claims) (Productivity Commission, 2020).

Recent reports into mental health call for more attention to the settings outside of the mental health system that can impact mental health and wellbeing (Victorian Government, 2021). For example, it's known that participation in activities such as education and work can have protective or positive effects on mental health, social and economic inclusion (Elmes, 2019; Hergenrather, Zeglin, McGuire-Kuletz, & Rhodes, 2015; Productivity Commission, 2020). However, the quality of jobs and workplace environments matter, as these factors can influence mental health for better or worse. The recent impacts of COVID-19 have illustrated that employment security is not equally distributed, with young people and those in casual or precarious work more at risk of lost work and financial hardship (Kaleveld, Bock, & Maycock-Sayce, 2020). Finally, in the context of a culture that positions people with a mental health condition as less capable, people with a mental health condition can be discouraged or excluded from participating in meaningful parts of life such as (among others) education (Orygen, 2014; Reavley, Jorm, & Morgan, 2017) and work (Gladman & Waghorn, 2016; Morgan et al., 2017; Productivity Commission, 2020).

4.3.1 What are the current main issues in this area of mental health?

Some of the current issues in workplace mental health include the need for workplace environments to have a stronger focus on protecting and promoting mental health alongside physical health and safety; supporting employees experiencing mental health challenges; and addressing inequities in work opportunities for people who have a mental health condition.

4.3.1.1 Jobs and workplace environments need to protect and promote mental health

While employment can contribute to improved mental health (Modini et al., 2016), job quality and the work environment are important factors. Insecure work, unsafe work environments, and jobs that involve high levels of demands combined with low levels of resources, support or rewards can have negative effects on mental health (Butterworth et al., 2011; Hergenrather et al., 2015; Productivity Commission, 2020). Different jobs (such as teaching, emergency services, construction, and defence force work) also have different intrinsic demands and risks for exposure to psychological or physical injury. Current recommendations include (Productivity Commission, 2020):

- Updating workplace health and safety guidelines to focus equally on creating mentally and physically healthy workplace environments

- Enabling workers compensation schemes to fund mental health care and rehabilitation for up to six months, regardless of liability

4.3.2 What gaps remain and who is under-served?

4.3.2.1 Inequities in access to employment for people with a mental health condition

Australian and international research on stigma illustrates the ways in which stigmatising cultural attitudes can play out in the context of a workplace to limit people's employment opportunities – for example, through misconceptions about people's capabilities meaning that people with a mental health condition are passed over in recruitment (Gladman & Waghorn, 2016), and less likely to be employed (Productivity Commission, 2020) or promoted into roles with high levels of responsibility (Holley, Stromwall, & Bashor, 2012; Reavley et al., 2017). Unemployment is a known risk factor for mental health conditions, as is poor quality work (World Health Organization and Calouste Gulbenkian Foundation, 2014). The recent Productivity Commission report (2020) identifies some promising strategies for increasing equity of access to employment for people with mental health conditions, including Individual Placement and Support programs designed to facilitate competitive employment. There is also evidence that social enterprises (businesses that trade to fulfil a social mission) can provide meaningful work opportunities for people with a mental health condition who may otherwise be excluded from employment (Evans & Wilton, 2019; Williams, Fossey, & Harvey, 2012).

4.3.2.2 Barriers to protecting and supporting mental health in the workplace

Currently, stigma remains a barrier to discussions of mental health at work (Rafferty, Troth, & Jordan, 2020). In addition, evidence regarding effective workplace mental health promotion interventions is limited, with many of the available guidelines being focused on how to detect and manage mental health symptoms when they occur, rather than being focused on how to prevent mental health challenges in the workplace (Memish, Martin, Bartlett, Dawkins, & Sanderson, 2017). These gaps in evidence can leave workplaces without clear guidelines for investment in structured health promotion programs, and limited confidence to act on mental health (Memish et al., 2017; Productivity Commission, 2020). However, some new online resources have recently been created to support mentally healthy workplaces in Australia, including the Heads Up initiative by Beyond Blue (2021) supported by the Mentally Healthy Workplace Alliance, and the Thrive at Work initiative (2021), by the Future of Work Institute at Curtin University in partnership with the Government of Western Australia Mental Health Commission. These frameworks provide guidance that focuses on prevention of harm and promotion of wellbeing at work, alongside supporting employees who are experiencing mental health challenges (Thrive at Work, 2021).

4.4 Social inclusion and stigma reduction

Social inclusion refers to the opportunity to participate in activities in society, while social exclusion refers to the inability and denial of resources to participate in the normal relationships and activities available to the majority of people in society (Levitas et al., 2007; Davey & Gordon, 2017). Stigma is an inherently social experience, stemming from the negative judgement based on devalued group identity (Allport, 1954; Scheyett, 2005). While separate in intent, these concepts have been applied to a long history of discrimination often faced by people with a mental health condition, and can influence our experiences of social inclusion and the accessibility of appropriate mental health services (Productivity Commission, 2020; Wahl, 1999).

4.4.1 What are the current main issues in this area of mental health?

4.4.1.1 Negative impact of social isolation and inclusion on mental health and wellbeing

Social isolation itself has been linked to increased mental health challenges and emotional distress, suicide, poor health behaviours and sleep, and sustained reductions in wellbeing (Holt-Lunstad et al., 2015; Shankar et al., 2015). Not unique to Australia, but also across Europe, North America and Asia, the risk of premature death associated with social isolation and loneliness is substantial, and comparable to the risk of other well-known risk factors including poor quality diet and lack of physical activity (Holt-Lunstad et al., 2015). On the contrary, social inclusion and participation are protective factors in the reduction of risk in developing a mental health condition, and also play a role in aspects of recovery, reconnection and minimising the likelihood of relapse for people with a mental health condition (Productivity Commission, 2020).

4.4.1.2 Stigma towards people with a mental health condition impacts help-seeking

The impact of stigma and social isolation cannot be underestimated within the context of mental health help-seeking. Stigma can be experienced in multiple forms, including negative attitudes related to help-seeking within the health sector, or around clinical presentations of mental health conditions and their impact on people's ability to access support services in community (Productivity Commission, 2020). People with a mental health condition report experiencing stigma and discrimination in their interactions with the health sector, which can reduce adherence to treatment requirements and motivation to seek support, and increase psychological distress (COAG Health Council, 2017).

4.4.1.3 Stigma intersects with people's experience of multiple sectors within the community

The multi-dimensional nature of social exclusion means that policies and interventions to reduce experienced disadvantage associated with stigmatising attitudes need to address multiple aspects of existing health and social structures. Intersections between mental health conditions and disability, housing, employment and income support, youth economic participation, interactions with the justice system, access to primary, specialist and emergency healthcare services, and psychosocial supports should be considered for their impact, and present challenges in navigating across sectors without the experience resulting in greater distress or limiting access to appropriate services (Productivity Commission, 2020). For example, income support is strongly associated with mental health conditions, not simply because people with mental health conditions are disproportionately excluded from employment, but social stigma towards income support recipients can be demoralising (Kiely & Butterworth, 2013). Additionally, misattribution of mental health symptoms, underdiagnosis (as in the case of diagnostic overshadowing), lack of understanding, and policy that does not reflect current understandings of mental health can occur within other sectors such as the insurance industry, and this can pose difficulties for consumers in receiving appropriate mental healthcare and accessing support that can protect against delays in treatment, financial hardship and emotional distress (Jamieson & Mason, 2019; Productivity Commission, 2020).

Stigma is one factor amongst others such as racism, persistent socioeconomic disadvantage, loneliness and trauma, that form major barriers to social participation and connection, and are consequently strongly associated with distress and mental health challenges. Specifically, structures in play within society have an intersecting influential role on the health outcomes of Aboriginal and Torres Strait Islander people, where socioeconomic disadvantage that might be associated with racism (i.e., housing stress, insufficient education and employment opportunities, and incarceration), social isolation and increased psychological distress are strongly interlinked (Australian Government, 2017; Productivity Commission, 2020).

4.4.2 What gaps remain and who is under-served?

Significantly, there is no current national Stigma Reduction Strategy designed to reduce stigma towards people with mental health conditions; though this forms a primary recommendation from the Productivity Commission report (2020) and is in progress at the time of this report's release.

4.4.2.1 Specific experiences of stigma and social exclusion

Social exclusion is created by inequities in our society that are unevenly distributed across the population, with all of the following groups being impacted by these inequities also having disproportionately high rates of mental health conditions: women, people who did not complete year 12 (or equivalent), those with a long-term chronic health condition, Aboriginal and Torres Strait Islander people, people living in public/community housing, single parents (Scutella, Wilkins & Kostenko, 2009) and people with disability (Australian Institute of Health and Welfare, 2020; Department of Developmental Disability Neuropsychiatry UNSW, 2016).

Social stigma towards people with a mental health condition changes over time, and compared to previous levels, mental health literacy has improved (Reavley & Jorm, 2011). However, the same survey reports that perceptions that people living with a mental health condition are dangerous and unpredictable (specifically for people living with depression, depression with suicidal thoughts, or schizophrenia) have increased since

2003. Additionally, people may be influenced by social and cultural beliefs that are associated with delayed help-seeking and shame towards mental conditions at a young age, or within family.

There are continuing opportunities to benefit from cultural knowledge and understandings of mental health challenges to facilitate recovery and reduce stigma and social exclusion. Experiences of racism, ongoing grief, loss and intergenerational trauma contribute to the psychological distress of many Aboriginal and Torres Strait Islander people, and their cumulative and sustained effects can have a substantial negative effect on social and emotional wellbeing (Australian Government, 2017; Productivity Commission, 2020). A considered and culturally responsive exploration of the intersection between traditional healers and mainstream mental health services to generate evidence about how cultural practices work best in partnership with mainstream mental health services is essential in further working to reduce disengagement due to stigma and exclusion, and recognise and work against structures that can increase psychological distress.

4.4.2.2 Addressing barriers to social inclusion

There are many material resources and structures that play a significant role in social exclusion, including:

- Geographical or systematic isolation (i.e., people living in rural or remote areas, elderly people, refugees, and people with intellectual disabilities), increasing loneliness and risk of mental health challenges

- Physical distancing measures implemented in response to the COVID-19 pandemic, limiting access to community resources (including public libraries, museums, religious institutions, neighbourhood houses and community centres sporting clubs, parks and community gardens) and increasing loneliness and negative impacts on health and wellbeing

- The role of young and informal carers and family, preventing full participation in education and employment

Such factors mean that people who experience material disadvantage are often limited in their ability to meet their basic needs, while concurrently experiencing fewer opportunities for social interaction (Productivity Commission, 2020). This section has described the intersecting social inequities that contribute to social exclusion and stigma, and the impacts of these on distress and mental health challenges. The next section discusses the important topic of suicide prevention.

4.5 Suicide prevention

4.5.1 What are the current main issues in this area of mental health?

Suicide and suicide attempts are stark indicators of population mental health challenges. Despite substantial community interventions, the suicide rate in Australia has not declined noticeably since the introduction of suicide prevention frameworks and intervention with the introduction of the 1995 National Youth Suicide Prevention Strategy and extension of this prevention work into the National Suicide Prevention Strategy in 2000 (Australian Healthcare Associates, 2014). The effects, including hopelessness, pain, loss and grief, are felt on many levels, including individually, within families, and the community; the quantifiable costs of suicides and non-fatal suicide attempts are estimated to be about $30 billion each year, while the social and emotional costs are beyond measure (Productivity Commission, 2020). Suicide remains difficult to predict, in spite of known static and dynamic risk factors across a range of people within the Australian community (i.e., unemployment, trauma, abuse, harmful use of alcohol, discrimination experienced by people within the LGBTIQ+ community, Aboriginal and Torres Strait Islander people and others) (Dudgeon et al., 2018; COAG Health Council, 2017).

4.5.1.1 Current approaches to suicide prevention

Approaches to suicide prevention activities are currently focused on crisis care. However, within the context of the Fifth National Mental Health Plan (COAG Health Council, 2017), the Australian Government has committed to working with state and territory governments to also ensure adequate aftercare follow-up for

people who have self-harmed or attempted suicide. With Australia's post-2015 strategy for suicide prevention moving towards a systems approach (i.e., servicing the needs of local communities), there is increasing focus on a flexible funding pool to Primary Health Networks in developing and implementing suicide prevention activities. This structure allows adoption of specific focus on communities that are placed at greater risk, including for Aboriginal and Torres Strait Islander people, and people within the LGBTIQ+ community (Productivity Commission, 2020). Further federal funding has also been directed towards services designed to improve aftercare and postvention services following a suicide attempt (Hunt, 2020). To date, however, evaluations have not been completed to assess the effectiveness within community, and there are issues in duplication or gaps in local services (Productivity Commission, 2020). Well-designed interventions and evaluations are essential for generating an evidence base to determine their effectiveness with regards to what works, for whom, and in what circumstances.

4.5.1.2 Lack of targeted, appropriate funding for Aboriginal and Torres Strait Islander people

At present, the negative health impacts of racism and other intersecting inequities discussed in the previous sections contribute to suicide rates among Aboriginal and Torres Strait Islander people that are double those of other Australians, with an increase now predicted within the context of the COVID-19 pandemic; the ongoing health response is critical to managing mental health. However, recent Government investment has focused largely on mainstream services that will not meet the specific needs of Aboriginal and Torres Strait Islander peoples and communities alone, given the pronounced levels of health and socio-economic disadvantage in Australia (Dudgeon et al., 2020). The lack of outcomes-based evaluations, particularly relevant for Indigenous suicide prevention, was a clear failing of Australia's previous approach to suicide prevention (Aboriginal and Torres Strait Islander Suicide Evaluation Project 2016; Clifford, Doran & Tsey 2013).

4.5.2 What gaps remain and who is under-served?

Services that do exist for crisis support do not necessarily provide adequate therapeutic care for patients (i.e., some hospital emergency services), or are unable to provide essential services including aftercare, that offer longer-term support for people experiencing suicidal ideation and recovering from a suicide attempt. While there are some promising examples of such prevention and aftercare services (i.e., Victoria's HOPE program (Victorian Government, 2019), Beyond Blue's The Way Back Support Service), people who present to services other than hospital following a suicide attempt (i.e., GPs and other government services), or express suicidal ideation in the absence of an attempt still do not necessarily receive aftercare (Productivity Commission, 2020).

Compounding this issue is that many people in distress do not use mental health services, with possible reasons for reduced engagement including a lack of appropriate services, stigma and community attitudes towards help-seeking and a lack of community-based mental health and suicide prevention services (Productivity Commission, 2020). Training people in community to support destigmatisation and postvention support is recommended to challenge stigma towards suicide and mental health conditions, supported by greater coordination between federal, state and territory governments to prevent inconsistency, gaps and duplication of services (Productivity Commission, 2020).

4.5.2.1 Supporting people before they are in need of crisis care

Data suggests that we underestimate the scale of the problem of self-harm, suicidal ideation and attempts in community. While not all people who intentionally self-harm are attempting suicide, such rates indicate that the rate of suicide attempts is likely to be significantly higher than that of suicide deaths, which is not captured by ambulance data (Turning Point, 2019). Slade et al. (2009) show that many more people had attempted suicide (3%) or had made a suicide plan (4%), and even more (13%) had 'serious thoughts' about suicide at some time. Specifically, groups that fall within this category are likely to be women, who are less likely to die by suicide, however, tend to have far higher rates of hospitalisation due to intentional self-harm then men, and Aboriginal and Torres Strait Islander women, who have particularly high rates of intentional self-harm (Productivity Commission, 2020).

4.5.2.2 Supporting Aboriginal and Torres Strait Islander people's needs in suicide prevention

Implementation of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) (2016), appears slow or non-existent, with ample opportunity to support recommendations including:

- Community-led suicide prevention activity

- Development and funding for the incoming National Aboriginal and Torres Strait Islander Suicide Prevention Strategy Implementation Plan, and

- Designation of Aboriginal Community Controlled Health Organisations (ACCHOs) as preferred providers of suicide prevention programs for Aboriginal and Torres Strait Islander people

4.6 Chapter Summary

Prevention and early intervention are instrumental in early childhood and young adult development and play significant roles in long term outcomes including engagement and productivity within the community. Outstanding issues highlighted throughout this section include the need to continue early detection activities, to support services that are able to provide responsive prevention, early help and care for specific populations that experience higher risk of mental health conditions (influenced by current social inequities), and the need to collect and use national data to support evaluation of intervention programs and individual outcomes. Such forms of mental health and wellbeing care are not only limited to activities within the mental health system. The intersection between sectors, including education and employment, reveals opportunity to highlight the need to support people seeking to access services, and provide adequate training within overlapping industries. Furthermore, it provides opportunity to reduce the burden of severe mental health conditions, and reduce reliance on crisis care services, instead focusing greater resources towards prevention, early help, psychosocial and community-based supports.

5. IMPROVING PSYCHOSOCIAL AND COMMUNITY-BASED SUPPORTS

While clinical interventions will always be an essential component of the mental health system, the dominance of these interventions has been critiqued in recent years by experts, policy makers and the growing voice of people with lived experience of mental health conditions. Understandings of mental health have broadened significantly beyond the bio-medical frame, to include the impacts of the social determinants of mental health, and the importance of prevention and early intervention, as well as what it takes to support recovery and rebuilding one's life following experience of a mental health condition, as well as being supported to stay well and out of hospital. It is in these areas that psychosocial and community-based supports make a significant contribution to the mental health sector.

5.1   What are the current main issues in this area of mental health?

5.1.1   Defining community mental health support

Community mental health support refers to a range of non-clinical options and services (both formal and informal) which respond to mental distress in a non-institutional setting. This may include grassroots, peer-led and family inclusive options. Some examples include safe spaces, peer-support groups, open dialogue groups, Hearing Voices groups, and community run supports. Community supports do not include clinical mental health services delivered through community clinics and teams (adapted from a definition developed by Martin, Mahoney & Pracilio, 2020).

5.1.2   Inadequacy of psychosocial supports

We know there are inadequate non-clinical psychosocial/community supports available in the community. This is understood in terms of what we know about needs as what is critical for a more financially sustainable mental health system. We are understanding more and more that hospital stays, highly qualified clinicians, and medication is not always the answer. As Australian psychiatrist Patrick McGorry has pointed out, prevention over intervention works best as a guiding principle in health care systems. Not only do prevention, early intervention and community support contribute significantly to people's emotional and social wellbeing, they also need to be recognised as integral to a financially sustainable health system (Worthington, 2015).

The Productivity Commission (2020, p. 42) estimates that approximately 690 000 people with a mental health condition would be likely to benefit from access to psychosocial support services, were they available (about 290 000 of these people have a severe and persistent mental health condition). However, only about 34 000 people with a primary psychosocial disability receive psychosocial supports under the NDIS, and 75 000 people receive psychosocial support directly from other federal, state and territory government-funded programs.

5.1.3   Why are psychosocial supports critical?

Non-clinical psychosocial supports are an important part of the mental health system, as well as for providing people across a diverse range of cohorts with the options and choice with which they can determine their own needs and how to support their mental health, social and emotional wellbeing. Non-clinical supports are needed to:

- *Support people to be able to live well in their communities and stay out of hospital*
  The National Mental Health Commission has acknowledged that high rates of emergency department admissions and readmissions to acute psychiatric services is evidence of a *"failure to provide timely and adequate community based mental health supports"* (National Mental Health Commission, 2014).

- *Support people's functional recovery from experiences of mental health conditions, as well as social and emotional recovery and rebuilding of lives, so they can live a connected, contributing life that involves connection with others, participation in social life and work*
  The Productivity Commission (2020, p.41) states that *"Recovery from mental illness necessarily involves recovery not just of the individual alone, but recovery within their family and community context. For all people with mental illness, social inclusion – the capacity to live contributing lives and participate as fully as possible in the community – is a necessary, but too often neglected, part of a recovery plan."*

- *Provide alternative supports to people who would not otherwise access clinical supports, and complementary supports while people wait for or are discharged from clinical interventions*
  Clinical interventions may not be an option for people due to rigid criteria, long wait lists, costs, difficulties accessing care for particular mental health conditions or co-occurring conditions. In addition, clinical options may not be preferred due to people's cultural background, fear of stigma and not wanting a diagnosis, traumatic past experiences with mental health services or general distrust of mainstream services and/or clinical care (Kaleveld, Bock & Seivwright, 2020).

- *Provide ways to more effectively intervene where people experience the social determinants of mental health*
  The Productivity Commission recommends that community mental health supports be more actively and deliberately brought into services that address housing and homelessness, interactions with the justice system and education and employment as people facing these points of transition or crisis and most likely to be experiencing mental health challenges or distress (Productivity Commission, 2020).

5.1.4 What are the reasons for the lack of psychosocial supports in our mental health system?

Given the recognition of the critical role played by non-clinical psychosocial supports, why is there an enormous gap between demand and supports available? The Productivity Commission (2020, p. 42) has outlined some reasons as being:

- The community mental health sector is made up of a large but unknown number of small-scale, poorly defined and measured services

- There is currently little transparency around who is delivering what supports to which people and what outcomes they achieve

- Confusing and inconsistent eligibility criteria for some supports with delays in application approval

- Very short funding cycles

- Lack of job security and difficulties retaining high quality staff

- Loss of funding and staff to NDIS funded services

It could also be that cohorts that are not accessing services (for example young people, people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander people) are not consulted nor visible to policy makers due to a lack of data about their needs and unmet needs. As a case in point, the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Western Australia Mental Health Commission, 2019) is a planning and policy framework that is built on data collected on people with a severe mental health condition only who are accessing clinical supports.

The dominance of the bio-medical model, and the privileging of the expert lens in planning and developing mental health supports could also explain why community mental health supports are lacking. However this is changing, and lived experience voices are being captured more systematically and are calling for system reform.

For example, the recent Royal Commission into the mental health system in Victoria included and responded to the views of consumers, family members and carers, some of which are outlined here in relation to the expressed need for more community mental health supports:

- *"Create alternatives to the current system. There should be places for people to go when they are having breakdowns. Mental healthcare should be taken out of hospitals so that these can be places of care and healing"* (Victorian Government, 2021, p. 230)

- *"I want the Royal Commission to remake the system into healing and respite centres: mental health services should be taken out of the hospital and put onto natural grounds, where you can have natural healing and therapies"* (Victorian Government, 2021, p. 230)

- *"Focus on community based support for those who can manage in the community, rather than institutionalisation. Holistic care programs such as art therapy, group programs, involving nature and bush work in a mental health setting"* (Victorian Government, 2021, p. 230)

The Royal Commission into Victoria's Mental Health System Final Report (Victorian Government, 2021) identifies an expanded role for community mental health and wellbeing services, which will help address inequities in services available. They propose:

- An expanded range of treatments and therapies and wellbeing supports (currently known as 'psychosocial supports'), improved care planning and coordination, day-to-day practical assistance and connections to other community services including housing

- Services to help people find and access treatment, care and support and a new comprehensive response to emergencies and crises that is available 24 hours a day, seven days a week

- Supports for primary and secondary care providers (such as GPs and community health services) from mental health specialists, or shared care arrangements between specialists and GPs and community health services to better support consumers (Victorian Government, 2021 p. 20)

The Commission proposes that community mental health and wellbeing services should encompass a broad range of local informal supports and providers including public health services, public hospitals, non-government organisations, community health services, private providers, new consumer-led providers and a range of primary and secondary services. People will access services by attending site-based services, through digital platforms and via home and community visits (Victorian Government, 2021).

5.2   What gaps remain and who is under-served?

5.2.1 More options supporting the wellbeing of children and young people

The options available to support young people and especially children are severely lacking. This is particularly true for children who have not interacted with clinical pathways or received a formal diagnosis and yet still urgently require support for their emotional health and wellbeing.

The Australian Child and Adolescent Survey of Mental Health and Wellbeing 2015 (Australian Government, 2015) findings show that one fifth of adolescents (19.9%) have very high or high levels of mental health distress. Four fifths (82.4%) reported needing some type of help for emotional or behavioural problems in the previous 12 months. Of these, three quarters (76.8%) had their needs fully or partially met. Barriers to seeking help included stigma and poor mental health literacy.

The Young People Priority Framework (Government of Western Australia, 2020) makes recommendations for how young people, aged 12 to 24, can be better supported across both the public health system and non-government services. Vulnerabilities and mental health risks are heightened as young people transition to adulthood, and in these critical years there are a lack of community supports that effectively engage young people. This is especially true for young people who may need support or help with distress, but do not have a formal diagnosis, connection to a clinician nor the ability to access support (Kaleveld, Bock & Seivwright, 2020).

5.2.2 Family members and carers

As mentioned in the previous section, young family members whose parents have a mental health condition or who are caring for a family member with an illness or disability are at greater risk for mental health challenges (Productivity Commission, 2020). While we know that carers have unmet needs for support themselves, a Tuna Blue Report (2019) describes the current way that our service system engages family members and carers as 'light touch', noting that 'intensive support models involving families and carers are missing'. Policy makers are starting to look more closely at the family unit that wraps around an individual, and how best to support the whole family. This report also notes that a new model of support that focuses just on family members' and carers' own distress, and their own needs would be greatly beneficial to this group "whom we know need more than information provision and self-care opportunities" (Tuna Blue, 2019).

5.2.3 Priority needs to be given to providing psychosocial supports in regional areas

People living in regional, rural and remote Australia have very little options or choices when it comes to how to address their need for mental health supports and social and emotional wellbeing.

Modelling undertaken for planning in Western Australia, for example, showed a need to invest significantly in community supports in regional, rural and remote WA (Western Australia Mental Health Commission, 2019). It is estimated that 1.2 million hours of community support are needed for regional, rural and remote areas by 2025 (Western Australia Mental Health Commission, 2019). That is more than what is in place in 2020 for the entire state. The Productivity Commission (2020) recommends that regional demand for psychosocial supports for people with mental health conditions be estimated, and that this is a priority area.

5.2.4 Increasing support options for people with acute mental health issues and multiple unmet needs including co-occurring alcohol and other drug issues

State and federal frameworks and plans frequently recognise the need to improve access to services that have the capacity to address co-occurring mental health and alcohol and other drug needs. Some people who experience acute mental health issues feel their needs are not adequately met in clinical settings, or they have past negative experiences of services which has left them with a sense of distrust and alienation. For some people, community mental health supports provide a much-needed alternative or complement to clinical options, that they experience as more suitable and empowering.

However, the current lack of community support options leads to problems with supports that are available – i.e., long waitlists, accessibility barriers such as location and rigid eligibility criteria, which further frustrates attempts to get the support needed. Consumers and family members describe the challenges of accessing services not equipped to respond to their multiple unmet needs, and being referred on to other services that also do not have the capacity to engage them or respond to their needs.

5.3 Chapter summary

Currently, a significant portion of the mental health system is designed around clinical interventions that focus on symptom reduction, whereas our understandings of what people may need to stay mentally healthy is much broader than this. Psychosocial supports delivered in non-clinical community settings offer holistic, person-centred approaches that can support connection and recovery. These approaches are especially important for cohorts such as people from culturally and linguistically diverse backgrounds or young people, who may be reluctant to seek clinical care, may not want a diagnosis, but may be willing to engage initially in a supportive service that helps them maintain wellbeing.

6. IMPROVING EXPERIENCES OF MENTAL HEALTH SERVICES

Alongside efforts to promote mental health and prevent mental health distress across the lifespan, and to provide community-based psychosocial supports that support people's wellbeing, access to safe, responsive mental healthcare is vital too. People with lived experience of mental health conditions have long advocated for improvements to the current fragmented, under-resourced mental health system (Kaine & Lawn, 2021), and these voices carry through the recent federal and state commission processes (Productivity Commission, 2020; Victorian Government, 2021). The emerging evidence on COVID-19's impact on mental health has also led to strong calls for a focus on rapid provision of appropriately targeted services to meet the growing need for mental health support (Kaleveld, Bock, & Maycock-Sayce, 2020; National Mental Health Commission, 2020; Rossell et al., 2021). The need for reform of mental health services is longstanding, and only more pressing in the context of COVID-19. This section explores the main issues and gaps within the current system – including difficulties in accessing the right level of care at the right time contributing to a crisis-driven system, a fragmented approach to healthcare that doesn't respond to the needs of the whole person, and mental health services that leave many people out. Some of the current proposed reforms are noted against these issues below.

6.1   What are the current main issues in this area of mental health?

6.1.1   Access to person-centred, evidence-informed care, and better coordination of services

Despite successive national strategies identifying the goal of ensuring access to effective mental health treatment and support (COAG Health Council, 2017), up to a million people in Australia with a mental health condition are not accessing any mental health care (Productivity Commission, 2020). Within the current Australian mental healthcare system, there are significant issues regarding access to care that is safe, affordable, culturally inclusive, guided by informed choice, and aligned with people's individual needs and values (Productivity Commission, 2020; Victorian Government, 2021). The Productivity Commission (2020) and the recent Royal Commission into Victoria's mental health system (Victorian Government, 2021) both found that people seeking mental health care can experience barriers in:

- Navigating the mental health system and accessing the support they need, due to:

  - Issues with availability of appropriate services (for example, in their location, with the required cultural capability, and without significant wait-times)

  - Issues with affordability of services

  - Complexity of support needs, which may encompass needs for mental healthcare services, as well as other supports.

- Access to clear information about:

  - Their right to choose their provider of mental health care

  - The different evidence based treatment options available to them (including alternatives to medication)

  - The expected risks, benefits, waiting times and costs of different treatment options.

There are currently multiple telephone and online based services designed to support people seeking help - either through providing a point of contact for people in crisis, directing people to other supports, or through provision of self-guided or human/therapist supported online therapy. However, these services do not use standardised assessment and referral pathways, which can result in overlap, confusion and difficulty among people seeking support (COAG Health Council, 2017; Productivity Commission, 2020; Victorian Government,

2021). Sometimes there are mental healthcare options available, but these may not be culturally appropriate, or wait times for appointments may be very long, meaning that people can become more distressed while waiting to access mental healthcare (Productivity Commission, 2020; Victorian Government, 2021). While some healthcare providers waive co-payments if needed, cost can still be a barrier for people to be able to access rebated mental healthcare, meaning that people with fewer financial resources have less access to services (Productivity Commission, 2020). At the same time, there are many people who might benefit from low-intensity services (such as supported online treatment), but these services are currently underutilized (Productivity Commission, 2020).

While digital mental healthcare has sometimes been presented as an alternative to in-person care, there is great interest in blended care – better utilisation of technology with and within in-person settings (see Australia's Digital Health Strategy, Australian Government 2021). One major limitation to this is building a digitally-capable workforce (there are currently no digital competencies embedded in training or via professional bodies). Another limitation is consistent and realistic funding for the ongoing provision of evidence-based, secure digital mental health tools and services. Current evidence suggests that digital screening and treatment effects can vary, but online therapy can improve people's mental health in the short-term (Titov et al., 2015), and longer-term (Andersson et al., 2018). However, further evidence of the long-term effects of Australian programs is needed (Andersson et al., 2018; Sin et al., 2020).

Some examples of specific practical reforms suggested by the recent Productivity Commission report (2020) include:

- Improvements in the Head to Health platform, to assist people in seeking appropriate support

- Federal government fund a publicly-controlled national digital mental health platform that:

  - Provides a free, nationally consistent assessment and referral process that replaces the existing requirement for a GP-provided mental health treatment plan

  - Provides guidance on recommended evidence-based service options

  - Provides access to low-intensity digital mental health support, and pathways to other mental healthcare options and services if needed.

- Increased funding for supported online treatment, and increased communication of its effectiveness as a treatment option (while noting that these services are not a replacement for face-to-face services, which continue to be important for many people). One noted possibility for supporting access to online treatment is through Private Health Insurers, for example a recent partnership between Bupa and the Clinical Research Unit for Anxiety and Depression (St Vincent's Hospital and the University of New South Wales)

- Better information provision regarding medication side-effects and alternative options

- Clear information about people's right to choose their provider, and online tools to support this process

- Tools, training, and consultation options to support GPs in their provision of mental health-related services, and provision of best-practice resources to paramedics to support their delivery of care for people experiencing a mental health-related emergency

- Permanent access to telehealth consultations with psychologists and psychiatrists, and improved access to group psychological therapy

6.1.2 'The vast wasteland', or 'missing middle' of mental health services

Access to specialist mental healthcare through hospital and community-based services is often crisis-driven, meaning that people must often reach the point of being at extreme risk (for example, of death by suicide)

before receiving specialist mental healthcare – and even then, the services provided are often time-limited (Productivity Commission, 2020; Victorian Government, 2021). Mental health advocate, writer and podcaster Honor Eastly describes this gap in services as 'the vast wasteland' (Eastly, 2018). Under-provision at this level of care means that hundreds of thousands of people are turned away from the public mental healthcare system, or do not receive enough care at this level to meet their needs (Kaine & Lawn, 2021; Productivity Commission, 2020; Victorian Government, 2021).

A contributing factor is that (while figures vary across jurisdictions), the average proportion of clinician time spent directly with people seeking clinical care is around 20%, while the optimal proportion of time spent on direct care provision is proposed as between 67-85% of clinician time, and service planning in the National Mental Health Service Planning Framework is designed based on around 67% of clinician time going to direct healthcare provision (Productivity Commission, 2020). This means that service provision at the ambulatory care level may only be providing a third of the level of care that is required (Productivity Commission, 2020). Recent research suggests that people accessing private mental healthcare experience many of the same issues of difficulty accessing appropriate care when they need it (Kaine & Lawn, 2021). Moving towards staged care (offering different levels of care matched to people's needs) is one proposed solution to these issues (Sawrikar et al., 2021; Victorian Government, 2021). Community-based mental healthcare that provides both therapeutic and psychosocial support has been found to improve outcomes for people (O'Donnell et al., 2020). Recommendations from the Productivity Commission report include (Productivity Commission, 2020):

- Evaluation of the Medicare Benefits Schedule Better Access Initiative and whether additional psychological therapy sessions would be beneficial (for example, increasing these from 10 to 20 rebated sessions)

- A review of current service provision against what is considered to be best practice

- Increased funding for ambulatory (specialist outpatient mental healthcare) services, and more clinical time spent directly with mental healthcare consumers

- Review of the current restrictions preventing private health insurers from funding community-based care

6.1.3   Crisis care

Service gaps at the ambulatory care level are one driver of increased presentations to emergency departments, as people are often unable to get the specialist mental healthcare they need until they reach crisis point (Productivity Commission, 2020; Victorian Government, 2021). High demands on emergency departments means that people can have long waiting times to receive mental health crisis care, and the emergency department can be a stressful environment for people who are already in distress (Productivity Commission, 2020). If crisis care services were available outside a hospital environment (such as peer and clinician-led after-hours services, or mobile crisis teams that could go to the person in distress) this may be more suitable, but there are currently minimal alternatives such as this available in Australia (Productivity Commission, 2020).

Availability of non-acute and acute bed-based care is limited, which means that many people presenting in crisis and at risk of suicide are still turned away and referred back to their GP or other community-based service options, wait times for inpatient services can be long, and patients may sometimes be discharged early due to high demand for available beds (Productivity Commission, 2020). At the same time, some people in acute bed-based services could potentially be discharged from hospital earlier if appropriate or supported accommodation was available (Productivity Commission, 2020). While there is a need to ensure adequate supply of acute care beds for people requiring acute hospital-based mental healthcare, the increase in required acute beds might be relatively small if more services were available at ambulatory and non-acute care levels, and people could access the care they needed before ending up in an emergency department (Productivity Commission, 2020; Victorian Government, 2021). There are also potential alternatives to acute care beds where appropriate for the person – such as hospital in the home for people who have safe

accommodation and a carer available (Productivity Commission, 2020). Recommendations for reform include (Productivity Commission, 2020):

- Provision of alternatives to emergency departments for people experiencing acute mental health crisis (e.g. community based after-hours/mobile services)

- Creating specific spaces within emergency departments for people with a mental health condition, and within acute mental health wards for young people and women to ensure their safety

- Review of acute bed-based mental healthcare, and increased funding to address shortfalls

6.1.4 Integrated care to support physical and mental health

There is currently a 10-15 year gap in life-expectancy between people with, and without a mental health condition, and people with co-existing physical health or additional mental health conditions do not always receive care that responds to all of their health needs (National Mental Health Commission, 2016; Productivity Commission, 2020; Victorian Government, 2021). Despite the high prevalence of mental health conditions in people with substance use issues (Kingston, Marel, & Mills, 2017), people with coexisting substance use issues (dual diagnosis) are sometimes turned away from mental healthcare services, and need better access to holistic care (Productivity Commission, 2020; Victorian Government, 2021).

Compared with the general population, a higher proportion of people with a mental health condition have physical health conditions, with higher rates of respiratory disease, cancer, diabetes, osteoporosis and chronic pain, and higher rates of death from cardiovascular disease (National Mental Health Commission, 2016; Productivity Commission, 2020). Contributing factors include the two-way relationship between mental and physical health, lifestyle factors such as rates of smoking, access to nutritious food and capacity to participate in physical activity, impacts of some mental health medications, and gaps in provision or quality of physical healthcare for people with a mental health condition (National Mental Health Commission, 2016; Productivity Commission, 2020). Improving physical health for people living with a mental health condition is a priority of the Fifth National Mental Health and Suicide Prevention Plan (COAG Health Council, 2017). Current recommendations include (Productivity Commission, 2020):

- Explicit targets and plans from the federal, state and territory governments to reduce the life-expectancy gap for people with a mental health condition compared to the general population, and implementation of recommendations in the Equally Well Consensus Statement

- Better coordination of healthcare between primary and hospital based services, and across physical and mental healthcare services

- Integrated regional commissioning of mental health and substance use services

- Specialised comprehensive services for people with dual diagnosis (a co-existing mental health condition and substance use issue) to access holistic support

6.1.5 Lived experience perspectives are not adequately valued or empowered to drive change

Many recent reports on Australia's mental health system call for greater involvement and empowerment of people with lived experience of a mental health condition to be involved in decision making, and lead system change (Kaine & Lawn, 2021; Productivity Commission, 2020; Victorian Government, 2021). This extends from the individual level of people participating in informed decision-making about their own mental healthcare (Kaine & Lawn, 2021), to family members and carers being heard and engaged appropriately where they are an integral part of a person's support system (Victorian Government, 2021), to system reform being informed and led by people with lived experience (Productivity Commission, 2020). Current barriers to realising the potential of lived experience perspectives and workers include stigma and discrimination impacting on perceived legitimacy, and lack of infrastructure and support to enable lived experience work (Victorian Government, 2021).

6.1.6 *Resourcing of the mental health workforce*

Provision of quality mental healthcare is dependent on the availability of skilled mental health workers who are sufficiently resourced to provide good care (Productivity Commission, 2020; Victorian Government, 2021). Recent reports into mental health services suggest that quality mental healthcare needs to (Kaine & Lawn, 2021; Victorian Government, 2021):

- Be trauma-informed (understanding the relationship between trauma and mental health conditions)

- Be recovery-oriented - focused on recovery of a life that is meaningful to the person and enables them to participate and contribute in their community (not just focused on recovery from symptoms)

- Build consistent and continuous relationships of trust, listening and empathy, that are non-judgmental and non-stigmatising

- Respect people's rights and dignity and involve them in decisions about their care as much as possible

Currently, there are some existing and projected skill gaps within the system, including the utilisation of peer workers, and the availability of:

- Psychiatrists treating children, young people, and older adults

- Mental health nurses

- Mental health workers outside major cities

- Mental health workers who are culturally capable in providing person-centred mental healthcare to Aboriginal and Torres Strait Islander people, and culturally and linguistically diverse people

There are also workplace culture issues within some mental health services, which contribute to stress and burnout for workers, and negative outcomes for people receiving mental healthcare (Productivity Commission, 2020).

These issues have prompted the recent recommendations by the Productivity Commission (2020) and the Royal Commission into Victoria's mental health system for:

- Reforms in mental health workforce planning to ensure that the right mix of supports and skilled workers is in place to deliver needed services effectively

- Additional training for mental health workers on medical and non-pharmacological treatments

- Additional funding for, and promotion of the peer workforce as a contributor to positive outcomes

- Reduction of stigma in mental health services

- Promotion of mental healthcare work as a career option to build a highly skilled professional workforce

6.2 *What gaps remain and who is under-served?*

6.2.1 *Matching services with demand*

Public mental health services require more funding and optimization of services to effectively meet demands for mental healthcare (Productivity Commission, 2020; Victorian Government, 2021). Current demand on crisis care is high but could potentially be reduced by more adequate resourcing at the non-acute/middle level of mental healthcare, where there is currently a large gap in service provision (Productivity Commission, 2020). Increased resourcing at this service level would support people whose mental healthcare needs cannot be met by primary healthcare services alone, but who miss out on more intensive clinical, community and hospital based mental healthcare services because demand for these services outstrips their availability (Productivity Commission, 2020). Currently, this 'middle' section of mental healthcare faces the greatest

under-provision of services, meaning that people with higher support needs are missing out on appropriate healthcare or not receiving enough mental healthcare (Kaine & Lawn, 2021), and more demand pressure is transferring to acute services because of the lack of care options at this middle level (Productivity Commission, 2020).

The Productivity Commission report (2020) also recommends a digital platform and increased access to supported online therapies for people requiring low-intensity supports, and the National Mental Health and Wellbeing Pandemic Response Plan identifies the importance of expanding access to these supports beyond COVID-19 (National Mental Health Commission, 2020). Despite these recommendations, it is acknowledged that low-intensity digital therapies are currently underutilised. This requires consideration of the degree to which provision of more digital mental healthcare services will be matched with additional demand from those seeking mental healthcare – and a national consultation is currently underway to support further planning (PricewaterhouseCoopers, 2020).

People in certain populations, such as those from rural and remote areas, and people who identify as LGBTIQ+, may be more likely to use online services in response to in-person service inaccessibility, or previous negative experiences with face-to-face mental healthcare (Productivity Commission, 2020). Free and low-cost digital mental health services may also be more affordable for people experiencing unemployment or other financial constraints (Productivity Commission, 2020). However, most supported online treatment services remain available only in English, which means that they are not necessarily accessible for culturally and linguistically diverse people (Productivity Commission, 2020). In addition, access to digital technology is not evenly distributed in Australia, with 2.5 million Australians not online, and those in rural areas, or those with lower levels of education, employment, and income being less likely to have high rates of digital technology access, affordability, and ability (Thomas et al., 2020).

In addition to the need to better match services to demand, several specific population groups that are currently under-served by the mental health system could benefit from increased equity in mental healthcare. It is important to note that people have multi-faceted, intersecting identities, and may belong to more than one of the under-served groups discussed below.

6.2.2 The need for increased equity in mental healthcare

As outlined in the previous sections, intersecting inequities within our society contribute to some communities of people experiencing greater socioeconomic disadvantage, and increased risk of harm (for example, through experiences of racism, homophobia, transphobia and ableism). These social inequities contribute to both a greater risk of experiencing mental health challenges, and to greater barriers in accessing safe and responsive care.

6.2.3 Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander perspectives on health vary across different cultural groups, but commonly health is viewed holistically, meaning that mental health is connected to physical, cultural and spiritual health, and influenced by connection to community and Country (Australian Government, 2017). The intergenerational trauma, racism and disadvantage inflicted on Aboriginal and Torres Strait Islander people since invasion are direct contributors to increased cumulative stress, and decreased wellbeing and mental health (Australian Government, 2017; Victorian Government, 2021). Mental healthcare professionals do not always understand the extent and impacts of ongoing trauma on Aboriginal and Torres Strait Islander people, which can contribute to unhelpful or potentially re-traumatising experiences of seeking mental healthcare (The Lowitja Institute, 2018).

Self-determined and culturally valid approaches to care are vital, including recognition of the strengths of Aboriginal and Torres Strait Islander people, and the importance of kinship. Access to culturally capable mental healthcare can be an issue both at the level of primary and community-based care, and in hospital-based services (Productivity Commission, 2020). Options should be available across the spectrum of services

for Aboriginal and Torres Strait Islander people to access clinical and culturally informed care that supports social and emotional wellbeing (Productivity Commission, 2020). Pathways to better care include cultural competency training for all staff, employing Aboriginal and Torres Strait Islander mental healthcare workers, and funding services led by Aboriginal and Torres Strait Islander people (Productivity Commission, 2020; Victorian Government, 2021).

6.2.4 Culturally and Linguistically Diverse people

Within Australia, the majority of mental health services are informed by western cultural understandings of mental health, and supports are largely offered in English language (Productivity Commission, 2020). Research suggests that refugees and people seeking asylum have high rates of post-traumatic stress disorder and depression (Blackmore et al., 2020), and people from culturally and linguistically diverse backgrounds can face additional barriers in access to mental healthcare including inaccessible information, cultural barriers around mental health stigma, and distrust in services (Byrow et al. 2020; Victorian Government, 2021; Wohler & Dantas, 2017). The Framework for Mental Health in Multicultural Australia identifies the need for service planning that accounts for the needs of culturally and linguistically diverse people and provides training to ensure culturally safe and responsive services (Embrace Multicultural Mental Health, 2016; Victorian Government, 2021). Increased diversity and inclusion within the mental health workforce is also identified as an area for improvement (Embrace Multicultural Mental Health, 2016; Productivity Commission, 2020).

6.2.5 People experiencing greater socioeconomic disadvantage

People with a mental health condition are more likely to have low incomes and no private health insurance, and for some people, experiences of mental health challenges can increase the risk of housing instability (Victorian Government, 2021). People living in areas with greater socioeconomic disadvantage are less likely to access mental health services through the Medicare Benefits Schedule (MBS) (Productivity Commission, 2020). Public mental health services are catchment-based, meaning that people are required to access services in their local area where possible, and service access can vary greatly by location, often proving challenging for people in rural areas (Victorian Government, 2021).

6.2.6 People who are Lesbian, Gay, Bisexual, Transgender, Intersex or Queer + (LGBTIQ+)

Though mental health challenges are not experienced by all LGBTIQ+ people, as a population LGBTIQ+ people can experience stigma, discrimination, abuse and exclusion (Jacobs & Morris, 2016), and these factors contribute to higher rates of psychological distress and suicide attempts than found in the general population (Hill, Bourne, McNair, Carman, & Lyons, 2020). While LGBTIQ+ people more commonly access mainstream health services than services that are specifically designed for the LGBTIQ+ community, people may not always feel that their sexuality or gender identity are respected in mainstream services (Hill et al., 2020), or that the care they receive is responsive and inclusive (Victorian Government, 2021). A survey of LGBTIQ+ Australians has found that the majority (75%) would be more likely to use a healthcare service if it is accredited as LGBTIQ+ inclusive – for example, via the Rainbow Tick accreditation (Hill et al., 2020). Inclusion of sexual orientation, gender diversity and intersex within mental health and wellbeing frameworks is recommended, as well as initiatives that reduce stigma against the LGBTIQ+ community, provision of wrap-around support, and funding for community-controlled and inclusive services (Fairchild et al., 2019; Hill et al., 2020).

6.2.7 People in rural or remote areas

The proportion of people in remote or very remote areas accessing any MBS-rebated psychological sessions is just 2%, compared to 5% in cities – one factor contributing to this is the distribution of the mental health workforce, and (limited) availability of local services (Farmer et al., 2020; Productivity Commission, 2020). Stigma is another factor contributing to barriers to care (State of Victoria, 2021). Socioeconomic disadvantage can occur more frequently in rural areas, and this may intersect with limited service accessibility to create

additional cost barriers to service access (Farmer et al., 2020; Victorian Government, 2021). Suicide rates remain higher in rural areas than the city (Victorian Government, 2021). The availability of telehealth services to people in rural or remote areas provides a necessary pathway of access for those without in-person service options, and there is evidence that telehealth services have improved mental healthcare access for regional and remote areas (Productivity Commission, 2020).

6.2.8 People with disability

People with disability are more likely to experience higher levels of psychological distress, anxiety and depression than people without disability (Australian Institute of Health and Welfare 2020); and people with intellectual disability are two to three times more likely to experience common mental health conditions than the general population (Department of Developmental Disability Neuropsychiatry UNSW, 2016). Social factors such as exclusion, lack of access to work, adequate housing and financial resources contribute to these higher levels of distress and poor mental health (Australian Institute of Health and Welfare, 2011; Kavanagh, Krnjacki & Kelly, 2012). In general, people with disability use health services more than those without disability – but can still experience barriers to care such as inaccessible information or physical spaces, and discrimination from health professionals (Australian Institute of Health and Welfare, 2020).

People with disability (particularly those with intellectual disability) can experience 'diagnostic overshadowing', where health professionals attribute a person's mental state to their disability rather than exploring and treating presenting mental health concerns as their own issue (Department of Developmental Disability Neuropsychiatry UNSW, 2016; Jamieson & Mason, 2019). The Intellectual Disability Mental Health Core Competency Framework (Department of Developmental Disability Neuropsychiatry UNSW, 2016) represents one specific framework designed to improve mental health professionals' core competencies in working with people with intellectual disability and a mental health condition, and contribute to better mental health service experiences for this cohort. However, few other examples of mental health frameworks focused on people with disability were found.

6.2.9 Older adults

Despite our ageing population, investment in mental healthcare services for older adults has not kept pace with demand, meaning that not everyone who seeks help receives it (Victorian Government, 2021).

6.3 Chapter summary

This section has summarised the current main issues with Australia's mental health service system – including barriers to accessing person-centred, evidence-informed care, the need for better coordination of services, the 'missing middle' of mental health services driving people towards crisis care, and the need for better integrated care that supports the mental and physical health of the whole person. Lived experience perspectives, and increased equity within the mental health system and workforce are vital to designing a system that provides safe, inclusive and responsive care for everyone who needs it. The following section concludes the evidence review – bringing together the key findings across the domains of prevention and early help, psychosocial and community-based supports, and mental health services.

7. CONCLUSION OF EVIDENCE REVIEW

A summary of the key reform directions and themes arising from this evidence review are provided in the dot points below and illustrated in Figure 6. The reviewed evidence suggests that many of the main issues (equity, learning from lived experience, attention to the social factors that influence mental health, access to the right care at the right time, and supports to enable a meaningful, connected life) are quite consistent across the areas of prevention, early intervention, non-clinical supports and mental health services. Some areas for action apply across all systems and settings that impact mental health, while others apply to the broad range of mental health services and non-clinical supports people access, or to mental health services specifically. Further detail on these key reform directions is provided in the Appendix in Table 2.

7.1 Areas for action

Based on our review of the evidence, the key areas for action emerging from our understanding of the strategic context are:

7.1.1 Across all mental health systems and settings

- Systems, policy and services that impact the lives of people with mental health conditions need to be informed by people with lived experience - including acknowledgment and support of family members and carers. While the importance of lived experience perspectives is becoming more recognised, further work is needed to empower lived experience leadership of change.

- We need to improve evaluation culture and practice in mental health. Better measurement of outcomes can contribute to knowledge for a more effective mental health system, and influence future funding decisions. Sharing knowledge across sectors also has the potential to address persisting mental health knowledge gaps for educators, employers, and communities.

7.1.2 Prevention and early help

- We need to recognise and reduce current social inequities that affect mental health. Currently, the people our society places most at risk of mental health conditions are also the least likely to receive access to safe and responsive healthcare, and mental health stigma is still contributing to health inequities and barriers to support.

- We need an increased focus and resources towards prevention of mental-ill health across the lifespan, from early childhood through to education and workplace settings and beyond, including intervention aimed at infants and children, as well as their parents and families.

- The broad range of stakeholders within the workforce likely to play a role in supporting people experiencing mental health challenges (i.e., educators, insurance companies, employers) often lack access to appropriate training that can foster greater understanding of mental health conditions and develop capacity to support people within the community.

- Suicide prevention remains a vital focus area, alongside appropriate postvention for people affected by suicide attempts. We need to support the implementation of recommendations to improve suicide prevention and postvention services.

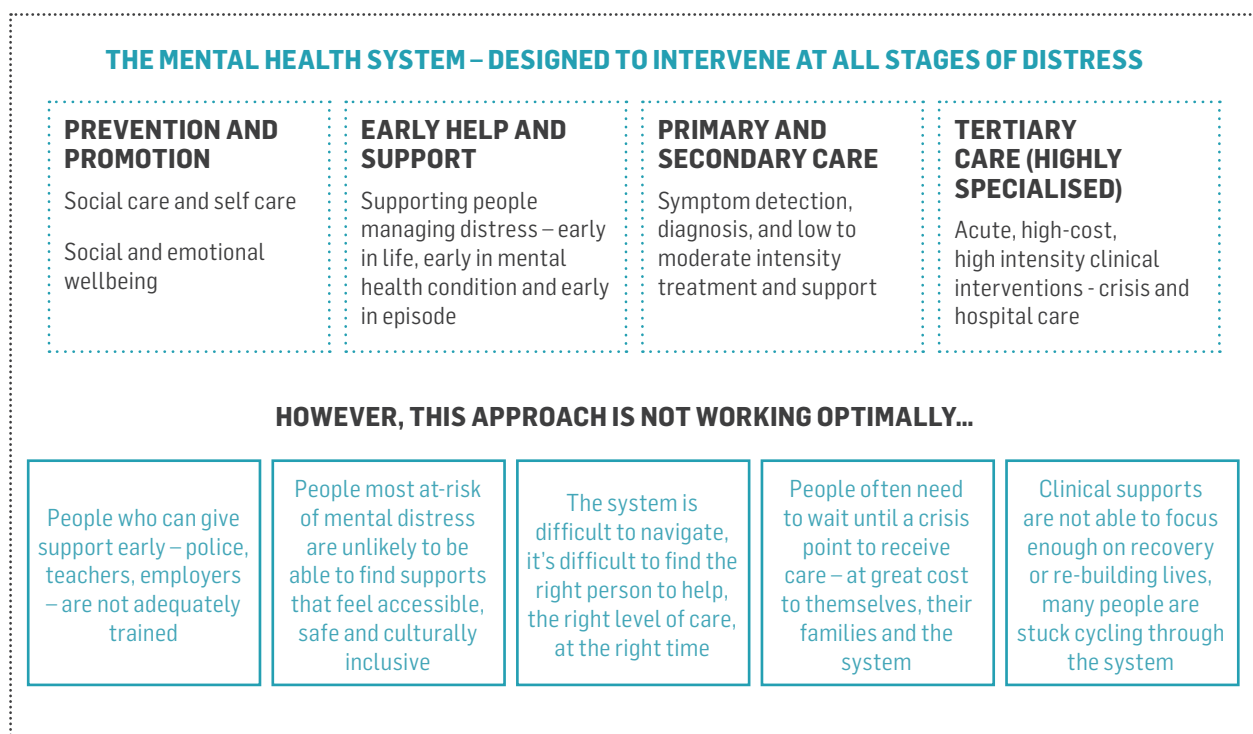### 7.1.3 Improving psychosocial and community-based supports

- Social factors such as safe, affordable housing, access to employment and connection to community can all contribute to good mental health, as does physical health. There is a need for greater integration of services beyond mental healthcare to support people who experience mental health conditions to meet these needs.

- Supporting recovery is critical if we are to prevent people cycling continuously through the mental health system. Recovery is best supported outside of clinical care, where psychosocial supports delivered in community settings can help people establish connection to others, strengthen skills and find secure housing and employment. There is evidence that these supports are greatly lacking and underfunded.

7.1.4 *Improving experiences of mental health services*

- Australia's mental health system is challenging to navigate, and the levels of care provided across the spectrum from early help-seeking to crisis care are mismatched with demand, meaning many people are missing out on the support they need. We need to provide equitable, flexible and inclusive access to prevention and early-help programs, healthcare and psychosocial supports.

- The mental health system is currently fragmented, with unclear pathways between different services or levels of care. There remains a need for increased collaboration between mental health services, to contribute to a better-integrated mental health system that can more effectively support people experiencing a mental health condition.

- The mental health workforce is currently under-resourced and at risk of staffing short-falls. There are also gaps in provision of culturally safe and responsive care for Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, and other marginalised groups. More can be done to support and resource a diverse, skilled and sustainable mental health workforce.

Figure 6 – Summary of current issues in mental health

THE MENTAL HEALTH SYSTEM – DESIGNED TO INTERVENE AT ALL STAGES OF DISTRESS

PREVENTION AND PROMOTION	EARLY HELP AND SUPPORT	PRIMARY AND SECONDARY CARE	TERTIARY CARE (HIGHLY SPECIALISED)
Social care and self care Social and emotional wellbeing	Supporting people managing distress – early in life, early in mental health condition and early in episode	Symptom detection, diagnosis, and low to moderate intensity treatment and support	Acute, high-cost, high intensity clinical interventions - crisis and hospital care

HOWEVER, THIS APPROACH IS NOT WORKING OPTIMALLY...

| People who can give support early – police, teachers, employers – are not adequately trained | People most at-risk of mental distress are unlikely to be able to find supports that feel accessible, safe and culturally inclusive | The system is difficult to navigate, it's difficult to find the right person to help, the right level of care, at the right time | People often need to wait until a crisis point to receive care – at great cost to themselves, their families and the system | Clinical supports are not able to focus enough on recovery or re-building lives, many people are stuck cycling through the system |

8. PROBLEM STATEMENTS BASED ON EVIDENCE REVIEW FINDINGS

8.1 Introduction to problem statements

This section draws on the evidence review presented in the previous chapters, to arrive at problem statements for the next phases of the research. In design thinking frameworks, problem statements are used to focus on one problem only (at a time), and thus the statements are short, and they do not suggest solutions.

These problem statements are intended to clarify what the key problems are, before exploring potential solutions. As part of our iterative approach to this project, these problem definitions will inform our discussion and focus for the next stage of the project – examples of promising practice that might address the selected problem statement/s.

8.2 Problem statements

Waiting for people to be in crisis and access acute care is not working

- Stigma and discrimination about mental health conditions prevents people seeking help early, and can exacerbate people's experience of mental health challenges and distress.

- People who can give support early – police, teachers, employers – are not adequately trained to understand mental health conditions, or connect people to mental health supports.

- People often choose to wait (or are forced to wait) until a crisis point to receive care – at great cost to themselves, their families and the system.

Social inequalities are exacerbated by access barriers and system design

- People most at-risk of a mental health condition are least likely to want to, or to be able to find supports that feel safe or are accessible.

- There is a lack of visibility, data about, or deep understanding of the needs of those cohorts who are least likely to seek and receive support - including children and young people, people living in rural and remote areas, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, people with disability (particularly intellectual disability), LGBTIQ+ people, and men).

Care is fragmented/not coordinated well, it is difficult to support people where they are at, and to help them move through their experience to a holistic recovery

- Even when a person has a strong sense of their own needs and seeks help, the system is difficult to navigate – many are unable to find the right person to help, the right level of care, at the right time, and to sustain that support.

- Clinical supports are not able to focus enough on recovery or re-building lives, leaving many people stuck cycling through the system, going from crisis to crisis.

- The mental health crisis in Australia is not improving despite investments.

- Heavy investment in acute, tertiary care is expensive and not cost-effective, contributing to the inadequate spread of resources and supports across other areas.

- Despite a long history of community interventions, Australia's suicide rate has not declined noticeably; suicide remains difficult to predict.

- Social isolation has been exacerbated during the COVID-19 pandemic with physical places to meet and connect with people becoming inaccessible.

9. REFERENCES

Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project. (2016). *Solutions That Work: What the Evidence and Our People Tell Us*. University of Western Australia. https://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, 26(4), 392–407. https://doi.org/10.3109/09540261.2014.928270

Allport, G. W. (1954). *The nature of prejudice*. Addison Wesley.

Andersson, G., Rozental, A., Shafran, R. and Carlbring, P. (2018). Long-term effects of internet-supported cognitive behaviour therapy. Expert Review of Neurotherapeutics 18(1): 21–28. 10.1080/14737175.2018.1400381

Australian Bureau of Statistics. (2008, October). *National Survey of Mental Health and Wellbeing: Summary of Results*. https://www.abs.gov.au/statistics/health/mental-health/national-survey-mental-health-and-wellbeing-summary-results/latest-release

Australian Bureau of Statistics. (2018, December). *National Health Survey: First Results, 2017-18*. Canberra, Australia. https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001

Australian Government. (2020). *National Safety and Quality Digital Mental Health (NSQDMH)* Standards. Australian Commission on Safety and Quality in Health Care.

Australian Government. (2015). The Mental Health of Children and Adolescents: Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health.

Australian Government. (2017). *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*. Department of the Prime Minister and Cabinet. https://apo.org.au/node/273566

Australian Government Department of Health. (2010a). National standards for mental health services 2010. https://www1.health. gov.au/internet/publications/publishing.nsf/Content/mental-pubs-nservst10-toc

Australian Government Department of Health. (2010b). Principles of recovery oriented mental health practice. https://www1.health. gov.au/internet/publications/publishing.nsf/Content/mental-pubs-inongov-toc~mental-pubs-i-nongov-pri

Australian Government. (2018). *Joint Regional Planning for Integrated Regional Mental Health and Suicide Prevention Services. Department of Health*. https://www.health.gov.au/sites/default/files/documents/2020/11/joint-regional-planning-for-integrated-mental-health-and-suicide-prevention-services-compendium-of-resources.pdf

Australian Government. (2021). *Better Access initiative*. Department of Health. https://www.health.gov.au/initiatives-and-programs/better-access-initiative

Australian Government. (2021). *Digital mental health services*. Department of Health. https://www.health.gov.au/initiatives-and-programs/digital-mental-health-services

Australian Government. (2021). *National Digital Health Strategy and Framework for Action*. Australian Digital Health Agency. https://www.digitalhealth.gov.au/about-us/national-digital-health-strategy-and-framework-for-action

Australian Healthcare Associates. (2014). Evaluation of Suicide Prevention Activities, Final Report. Department of Health and Ageing. Woden, Australian Capital Territory. http://nla.gov.au/nla.arc-147902

Australian Institute of Health and Welfare. (2021). Mental Health Services in Australia. https://www.aihw. gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/summary-of-mental-health-services-in-australia/australias-mental-health-system

Australian Institute of Health and Welfare (2020). Health of people with disability. https://www.aihw.gov.au/reports/australias-health/health-of-people-with-disability

Australian Institute of Health and Welfare (2011). The use of health services among Australians with disability. https://www.aihw.gov.au/reports/disability-services/the-use-of-health-services-among-australians-with/contents/summary

Banfield, M., Randall, R., O'Brien, M., Hope, S., Gulliver, A., Forbes, O., Morse, A. & Griffiths, K. (2018). Lived experience researchers partnering with consumers and carers to improve mental health research: Reflections from an Australian initiative. *International Journal of Mental Health Nursing*, 27(4), 1219–1229. https://doi.org/10.1111/inm.12482

Beyond Blue. (2021). *Heads Up*. https://www.headsup.org.au

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLoS Medicine*, 17(9), e1003337. https://doi.org/10.1371/journal.pmed.1003337

Boote J., Telford R., & Cooper, C. (2002). Consumer involvement in health research: a review and research agenda. *Health Policy*, 6(2), 213-36. https://doi.org/10.1016/s0168-8510(01)00214-7

Butterworth, P., Leach, L. S., Strazdins, L., Olesen, S. C., Rodgers, B., & Broom, D. H. (2011). The psychosocial quality of work determines whether employment has benefits for mental health: results from a longitudinal national household panel survey. *Occupational and Environmental Medicine,* 68(11), 806-812. https://doi.org/10.1136/oem.2010.059030

Byrow, Y., Pajak, R., Specker, P., Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review* 75: 101812. https://doi.org/10.1016/j.cpr.2019.101812

Capital Health Network. (2019). *Australian Capital Territory Mental Health and Suicide Prevention Plan 2019-2024. Part A: The Framework*. https://www.chnact.org.au/wp-content/uploads/2020/02/CHN-Mental-Health-and-Suicide-Prevention-Plan.pdf

Carey, G., & Crammond, B. (2015). Systems change for the social determinants of health. *BMC Public Health*, 15, 662. https://doi.org/10.1186/s12889-015-1979-8

Centre for Education Statistics and Evaluation. (2020). *What works best: 2020 update*. NSW Department of Education. https://www.cese.nsw.gov.au//images/stories/PDF/What-works-best-2020-update.pdf

Clifford, A.C., Doran, C.M., & Tsey, K. (2013). A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand. *BMC Public Health*, 13, 463. https://doi.org/10.1186/1471-2458-13-463

Cook, L. (2019). *Mental health in Australia: a quick guide*. Parliament of Australia. https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1819/Quick_Guides/MentalHealth

COAG Health Council. (2017). *The fifth national mental health and suicide prevention plan*. Council of Australian Governments. https://www.mentalhealthcommission.gov.au/getmedia/0209d27b-1873-4245-b6e5-49e770084b81/Monitoring/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan.pdf

Council of Australian Governments. (2018). *National School Reform Agreement*. Department of Education and Training, Australian Government. https://www.dese.gov.au/quality-schools-package/resources/national-school-reform-agreement

Davey, S., & Gordon, S. (2017). Definitions of social inclusion and social exclusion: the invisibility of mental illness and the social conditions of participation. *International Journal of Culture and Mental Health*, 10(3), 229–237. https://doi.org/10.1080/17542863.2017.1295091

Davidson, L., Ridgway, P., Schmutte, T., & O'Connell, M. (2009). Purposes and goals of service user involvement in mental health research. In: J. Wallcraft, B. Schrank & M. Amering (Eds.), *Handbook of service user involvement in mental health research*. Wiley-Blackwell. https://doi.org/10.1002/9780470743157.ch7

Department of Developmental Disability Neuropsychiatry UNSW. (2016). *The Intellectual Disability Mental Health Core Competency Framework: A Manual for Mental Health Professionals* Sydney, Australia. https://www.3dn.unsw.edu.au/sites/default/files/IDMH_Core_Competency_Framework.pdf

Design Council. (2004). What is the framework for innovation? Design Council's evolved Double Diamond. https://www.designcouncil.org.uk/news-opinion/what-framework-innovation-design-councils-evolved-double-diamond

Dudgeon, P., Derry, K. L., & Wright, M. (2020). *A National COVID-19 Pandemic Issues Paper on Mental Health and Wellbeing for Aboriginal and Torres Strait Islander Peoples*. The University of Western Australia, Poche Centre for Indigenous Health. https://apo.org.au/node/306661

Eastly, H. (2018, October). 02 *The Vast Wasteland*. https://www.abc.net.au/radio/programs/no-feeling-is-final/02-the-vast-wasteland/10315902

Elmes, A. I. (2019). Health impacts of a WISE: a longitudinal study. *Social Enterprise Journal*, 15(4), 457-474. https://doi.org/10.1108/SEJ-12-2018-0082

Embrace Multicultural Mental Health. (2016). *What is the Framework and how was it developed?* [Fact sheet] https://embracementalhealth.org.au/sites/default/files/framework/overview_fact_sheet.pdf

Evans, J., & Wilton, R. (2019). Well Enough to Work? Social Enterprise Employment and the Geographies of Mental Health Recovery. *Annals of the American Association of Geographers*, 109(1), 87-103. https://doi.org/10.1080/24694452.2018.1473753

Farmer, J., White, C., McCosker, A., Perkins, D., Dalton, H., Powell, N., Salvador-Carulla, L., Bagheri, N., Salinas, J.A. & Tabatabaei, H. (2020). *Improving the mental health of rural Australians: a review*. Social Innovation Research Institute, Swinburne University of Technology. https://apo.org.au/node/303323

Fairchild J, Carman M, Bourne A, Power J, Jones J, Parsons M, Meddings J, Herd J, Moussa B, Gillespie C, Ruth S, Ball J, & Bernasochi A (2019). *Royal Commission into Victoria's Mental Health System: Toward a mental health system that works for LGBTIQ people*. Rainbow Health Victoria, Thorne Harbour Health, Switchboard Victoria. https://cdn.thorneharbour.org/media/documents/RHV_THH_SV_RCMH_July_2019.pdf

Future Generation Investment and EY. (2021). *Australia's mental health crisis: why private funders are not answering the call*. https://futuregeninvest.com.au/wp-content/uploads/2019/10/Australias_Mental_Health_Crisis.pdf

Garritty, C., Gartlehner, G., Nussbaumer-Streit, B., King, V. J., Hamel, C., Kamel, C., . . . Stevens, A. (2021). Cochrane Rapid Reviews Methods Group offers evidence-informed guidance to conduct rapid reviews. *Journal of Clinical Epidemiology*, 130, 13-22. https://doi.org/10.1016/j.jclinepi.2020.10.007

Gladman, B., & Waghorn, G. (2016). Personal experiences of people with serious mental illness when seeking, obtaining and maintaining competitive employment in Queensland, Australia. *Work*, 53(4), 835-843. https://doi.org/10.3233/WOR-162252

Government of Western Australia. (2020). Young People Priority Framework. Mental Health Commission.

Greenfield, B. & Jensen, G. (2010). Understanding the Lived Experiences of Patients: Application of a Phenomenological Approach to Ethics. *Physical Therapy*, 90(8), 1185-1197. https://doi.org/10.2522/ptj.20090348

Gregory, T., Engelhardt, D., Lewkowicz, A., Luddy, S., Guhn, M., Gadermann, A., Schonert-Reichl, K., & Brinkman, S. (2019). Validity of the Middle Years Development Instrument for population monitoring of student wellbeing in Australian school children. *Child Indicators Research*, 12(3), 873–899. https://doi.org/10.1007/s12187-018-9562-3

Guy, S., Furber, G., Leach, M. & Segal, L. (2016). How many children in Australia are at risk of adult mental illness? *Australian and New Zealand Journal of Psychiatry*, 50(12), 1146–1160. https://doi.org/10.1177/0004867416640098

Hancock, N., Bundy, A., Tamsett, S. & McMahon, M. (2012). Participation of mental health consumers in research: Training addressed and reliability assessed. *Australian Occupational Therapy Journal*, 59(3), 218–224. https://doi.org/10.1111/j.1440-1630.2012.01011.x

Hawryszkiewycz, I. (2014), "Design thinking to focus in achieving value in complex environments", Proceedings of the AMCIS2014 Conference, Savannah, Georgia.

Head to Help. (2021). *About Head to Help.* https://headtohelp.org.au/about

Hergenrather, K. C., Zeglin, R. J., McGuire-Kuletz, M., & Rhodes, S. D. (2015). Employment as a Social Determinant of Health: A Review of Longitudinal Studies Exploring the Relationship Between Employment Status and Mental Health. *Rehabilitation Research, Policy, and Education*, 29(3), 261-290. https://connect.springerpub.com/content/sgrrrpe/29/1/2

Hill, A. O., Bourne, A., McNair, R., Carman, M., & Lyons, A. (2020). *Private lives 3: the health and wellbeing of LGBTIQ people in Australia.* Australian Research Centre in Sex, Health and Society, La Trobe University. https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf

Holley, L. C., Stromwall, L. K., & Bashor, K. E. (2012). Reconceptualizing Stigma: Toward a Critical Anti-Oppression Paradigm. *Stigma Research and Action*, 2(2), 51-61. https://doi.org/10.5463/SRA.V1I3.46

Holt-Lunstad J., Smith, T., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. *Perspectives on Psychological Science*, 10(2), 227–37. https://doi.org/10.1177/1745691614568352

Hunt, G. (2020). *Immediate response plan to focus on people with disability during coronavirus: media release.* https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/immediate-response-plan-to-focus-on-people-with-disability-during-coronavirus

Jacobs, R., & Morris, S. (2016). *National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health and Suicide Prevention Strategy: A New Strategy for Inclusion and Action.* National LGBTI Health Alliance. https://d3n8a8pro7vhmx.cloudfront.net/lgbtihealth/pages/409/attachments/original/1585378577/LGBTI_Report_MentalHealthandSuicidePrevention_Final_Low-Res-WEB-1.pdf?1585378577

Jadambaa, A., Thomas, H. J., Scott, J. G., Graves, N., Brain, D., & Pacella, R. (2019). The contribution of bullying victimisation to the burden of anxiety and depressive disorders in Australia. *Epidemiology and Psychiatric Sciences*, 29, e54. https://doi.org/10.1017/s2045796019000489

Jamieson, D., & Mason, J. (2019). Investigating the Existence of the Diagnostic Overshadowing Bias in Australia. *Journal of Mental Health Research in Intellectual Disabilities*, 12(1-2), 58–70. https://doi.org/10.1080/19315864.2019.1595231

Jay, L., Macadam, B., Gardner, P., Mahboub, L. (2017). Hope headquarters: recovery college. *Health Promotion Journal of Australia* 28(2): 170–173. https://doi.org/10.1071/HE17034

Jorm, A. F. (2018). Australia's 'Better Access' scheme: Has it had an impact on population mental health? *Australian & New Zealand Journal of Psychiatry*, 52(11), 1057–1062. https://doi.org/10.1177/0004867418804066

Kaine, C., & Lawn, S. (2021). *The 'Missing Middle' Lived Experience Perspectives: Identifying why people slip through the gaps or do not receive the mental health care they need.* Lived Experience Australia. https://6f044093-f272-427f-b749-e2aef1d4ae8d.filesusr.com/ugd/907260_8b2ad57fd3e8494080e609c7f82281d4.pdf

Kaleveld, L., Bock, C., & Maycock-Sayce, R. (2020). *COVID-19 and mental health: CSI response.* Centre for Social Impact. https://www.csi.edu.au/media/uploads/csi_fact_sheet_covid_and_mental_health.pdf

Kaleveld, L., Bock, C., & Seivwright, A. (2020). *Increasing and improving community mental health supports in Western Australia.* Centre for Social Impact. https://doi.org/10.26182/5f5719f478a17

Kavanagh, A. and L. K. Krnjacki, Monica (2012). *Disability and health inequalities in Australia.* Victoria, Australia, VicHealth. https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/Health-Inequalities/VH_Disability-Summary_web.pdf?la=en&hash=3347870D3B7ADF0227C5B7B831E02A2ED27AE31E

Kiely, K.M. and Butterworth, P. (2013). Social disadvantage and individual vulnerability: A longitudinal investigation of welfare receipt and mental health in Australia. *Australian and New Zealand Journal of Psychiatry*, 47(7), 654–666. https://doi.org/10.1177/0004867413484094

Kingston, R. E. F., Marel, C., & Mills, K. L. (2017). A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. *Drug Alcohol Review*, 36(4), 527–539. https://doi.org/10.1111/dar.12448

Levitas, R., Pantazis, C., Fahmy, E., Gordon, D., Lloyd, E., & Patsios, D. (2007). *The multi-dimensional analysis of social exclusion.* University of Bristol. https://dera.ioe.ac.uk/6853/1/multidimensional.pdf

Maheen, H., & Milner, A. (2019). *Young people, transition into work and mental wellbeing.* Victorian Health Promotion Foundation. https://apo.org.au/sites/default/files/resource-files/2019-09/apo-nid272731.pdf

Manderscheid, R. W., Ryff, C. D., Freeman, E. J., McKnight-Eily, L. R., Dhingra, S., & Strine, T. W. (2009). Evolving definitions of mental illness and wellness. *Preventing Chronic Disease*, 7(1), 1–6. https://www.ncbi.nlm.nih.gov/pmc/PMC2811514

Martin, R., Mahoney, N., & Pracilio, A. (2020). Community Mental Health Support Review for Western Australian Association for Mental Health. Curtin University.

Memish, K., Martin, A., Bartlett, L., Dawkins, S., & Sanderson, K. (2017). Workplace mental health: An international review of guidelines. *Preventive Medicine*, 101, 213–222. https://doi.org/10.1016/j.ypmed.2017.03.017

Modini, M., Joyce, S., Mykletun, A., Christensen, H., Bryant, R. A., Mitchell, P. B., & Harvey, S. B. (2016). The mental health benefits of employment: Results of a systematic meta-review. *Australasian Psychiatry*, 24(4), 331–336. https://doi.org/10.1177/1039856215618523

Morgan, V. A., Waterreus, A., Carr, V., Castle, D., Cohen, M., Harvey, C., Galletly, C., Mackinnon, A., McGorry, P., McGrath, J. J., Neil, A. L., Saw, S. Badcock, J. C., Foley, D. L., Waghorn, G., Coker, S., & Jablensky, A. (2017). Responding to challenges for people with psychotic illness: Updated evidence from the Survey of High Impact Psychosis. *Australian & New Zealand Journal of Psychiatry*, 51(2), 124–140. https://doi.org/10.1177/0004867416679738

Mrazek, P.J. & Haggerty, R.J. (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. National Academy Press.

National Health and Medical Research Council and Consumers Health Forum of Australia. (2002). *Statement on Consumer and Community Participation in Health and Medical Research*. Australian Government.

National Health and Medical Research Council and Consumers Health Forum of Australia. (2016). *Statement on Consumer and Community Involvement in Health and Medical Research*. Australian Government. https://www.nhmrc.gov.au/about-us/publications/statement-consumer-and-community-involvement-health-and-medical-research

National Mental Health Commission. (2014). *Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services: Summary Report*. Australian Government. http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2014-contributinglives-review.aspx

National Mental Health Commission. (2016). *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*. Australian Government. https://www.equallywell.org.au/wp-content/uploads/2018/12/Equally-Well-National-Consensus-Booklet-47537.pdf

National Mental Health Commission. (2020). *National mental health and wellbeing pandemic response plan*. Australian Government. https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce-5d1a-44fc-b1e9-c002046l4cb5/National-Mental-Health-and-Wellbeing-Pandemic-Response-Plan

New South Wales Parliament. (2018). *Support for New Parents and Babies in New South Wales* (No. 2/56). Legislative Assembly of New South Wales, Committee on Community Services. https://www.parliament.nsw.gov.au/ladocs/inquiries/2461/Final%20report%20-%20Support%20for%20new%20parents%20and%20babies%20-%20November%202018.pdf

Northern Territory Government. (2019). *Northern Territory Mental Health Strategic Plan 2019-2025*. https://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/7737/3/NT%20Mental%20health%20strategic%20Plan%202019_2025.pdf

NSW Auditor-General. (2019). *Wellbeing of Secondary School Students*. Audit Office of New South Wales. https://www.audit.nsw.gov.au/sites/default/files/pdf-downloads/Wellbeing%20of%20secondary%20school%20students_PDF%20report_0.pdf

NSW Department of Education and Communities. (2015). *The Wellbeing Framework for Schools*. New South Wales Government. https://education.nsw.gov.au/content/dam/main-education/student-wellbeing/whole-school-approach/Wellbeing_Framework_for_Schools.pdf

NSW Mental Health Commission. (2014). *Living Well: A Strategic Plan for Mental Health in NSW*. New South Wales Government. https://nswmentalhealthcommission.com.au/sites/default/files/141002%20Living%20Well%20-%20A%20Strategic%20Plan%20(1).pdf

O'Donnell, R., Savaglio, M., Vicary, D., & Skouteris, H. (2020). Effect of community mental health care programs in Australia: a systematic review. *Australian Journal of Primary Health*, 26(6), 443-451. https://doi.org/10.1071/py20147

Office of the Auditor General. (2019). *Access to State-Managed Adult Mental Health Services Report 4: 2019-20*. Western Australian Government. https://audit.wa.gov.au/reports-and-publications/reports/access-to-state-managed-adultmental-health-services

Orygen. (2014). *Tell them they're dreaming: Work, education and young people with mental illness in Australia*. Orygen: The National Centre of Excellence in Youth Mental Health. https://www.orygen.org.au/Policy-Advocacy/Policy-Reports/Work-Education-Young-People

Orygen. (2017). *Under the radar: the mental health of Australian university students.* Orygen: The National Centre of Excellence in Youth Mental Health. https://www.orygen.org.au/Policy/Policy-Reports/Under-the-radar/Orygen-Under_the_radar_report?ext=.

Orygen. (2020). *Australian University Mental Health Framework.* Orygen: The National Centre of Excellence in Youth Mental Health. https://www.orygen.org.au/Policy/University-Mental-Health-Framework/Framework/University-Mental-Health-Framework.aspx

Orygen and the World Economic Forum. (2020). *A Global Framework for Youth Mental Health: Investing in Future Mental Capital for Individuals, Communities and Economies.* https://www.orygen.org.au/About/Orygen-Global/Files/Orygen-WEF-global-framework-for-youth-mental-healt.aspx

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., UnÜtzer, J. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392(10157), 1553-1598. https://doi.org/10.1016/S0140-6736(18)31612-X

PricewaterhouseCoopers. (2020). *Scoping and development of a National Digital Mental Health Framework: Consultation Paper.* Department of Health, Australian Government. https://www.pwc.com.au/health/National-Digital-Mental-Health-Framework_Consultation-Paper.pdf

Productivity Commission. (2020). *Mental health: Productivity Commission inquiry report.* Australian Government. https://www.pc.gov.au/inquiries/completed/mental-health/report

Productivity Commission. (2020), *Report on Government Services 2020 - Part E Health.* https://www.pc.gov.au/research/ongoing/report-on-government-services/2020

Queensland Mental Health Commission. (2018). *Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023.* Queensland Government. https://www.qmhc.qld.gov.au/sites/default/files/files/qmhc_2018_strategic_plan.pdf

Rafferty, A., Troth, A., & Jordan, P. (2020). *Implementing mental health initiatives in Australian business – triggers, facilitators and barriers.* Australian Industry Group. https://cdn.aigroup.com.au/Reports/2020/Report_Mental_Health_in_Australian_Business_Jan2020.pdf

Reavley, N.J. & Jorm, A.F. (2011). Stigmatizing attitudes towards people with mental disorders: findings from an Australian National Survey of Mental Health Literacy and Stigma. *Australian and New Zealand Journal of Psychiatry*, 45(12), 1086–1093. https://doi.org/10.3109/00048674.2011.621061

Reavley, N. J., Jorm, A. F., & Morgan, A. J. (2017). Discrimination and positive treatment toward people with mental health problems in workplace and education settings: Findings from an Australian National Survey. *Stigma and Health*, 2(4), 254-265. https://doi.org/10.1037/sah0000059

Rossell, S. L., Neill, E., Phillipou, A., Tan, E. J., Toh, W. L., Van Rheenen, T. E., & Meyer, D. (2021). An overview of current mental health in the general population of Australia during the COVID-19 pandemic: Results from the COLLATE project. *Psychiatry Research, 296*, 113660. https://doi.org/10.1016/j.psychres.2020.113660

Sawrikar, V., Stewart, E., LaMonica, H. M., Iorfino, F., Davenport, T. A., Cross, S., Naismith, S. L., Mowszowski, L., Guastella, A., & Hickie, I. B. (2021). Using Staged Care to Provide "Right Care First Time" to People With Common Affective Disorders. *Psychiatric Services*, appi.ps.202000145. https://doi.org/10.1176/appi.ps.202000145

Scheyett, A. (2005). The mark of madness: Stigma, serious mental illnesses, and social work. *Social Work in Mental Health*, 3(4), 79–97. https://doi.org/10.1300/J200v03n04_05

Schnyder, N., Sawyer, M.G, Lawrence, D., Panczak, R., Burgess, R., & Harris, M. G. (2020). Barriers to mental health care for Australian children and adolescents in 1998 and 2013–2014. *Australian and New Zealand Journal of Psychiatry*, 54(10), 1007–1019. https://doi.org/10.1177/0004867420919158

Scutella, R., Wilkins, R., & Horn, M. (2009). *Measuring Poverty and Social Exclusion in Australia: A Proposed Multidimensional Framework for Identifying Socio-Economic Disadvantage* (Working Paper, No. 4/09). Melbourne Institute of Applied Economic and Social Research. https://melbourneinstitute.unimelb.edu.au/downloads/working_paper_series/wp2009n04.pdf

Shankar A, Rafnsson S & Steptoe A. (2015). Longitudinal associations between social connections and subjective wellbeing in the English Longitudinal Study of Ageing. *Psychology & Health*, 30(6), 686–698. https://doi.org/10.1080/08870446.2014.979823

Shonkoff, J.P. (2000). Science, Policy and Practice: Three Cultures in Search of a Shared Mission. *Child Development*, 71(1), 181–187. https://doi.org/10.1111/1467-8624.00132

Sin, J., Galeazzi, G., McGregor, E., Collom, J., Taylor, A., Barrett, B., Lawrence, V., & Henderson, C. (2020). Digital Interventions for Screening and Treating Common Mental Disorders or Symptoms of Common Mental Illness in Adults: Systematic Review and Meta-analysis. *Journal of Medical Internet Research*, 22(9), e20581. https://doi.org/10.2196/20581

Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J. & Saw, S. (2009). *The Mental Health of Australians 2: Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Australian Government. https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-m-mhaust2-toc

South Australian Government. (2019). *Mental Health Services Plan 2020-2025*. SA Health. https://www.sahealth.sa.gov.au/wps/wcm/connect/8520124e-0250-4393-819e-71bca0db4ad9/19032.2+MHSP-report-web-no+watermark.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-8520124e-0250-4393-819e-71bca0db4ad9-nwLp6cp

Tasmanian Government. (2020). *Rethink 2020: A state plan for mental health in Tasmania 2020-2025*. Regional Mental Health and Suicide Prevention Plan Steering Group Tasmania https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/419549/Rethink_2020_A_state_plan_for_mental_health_in_Tasmania_20202025.pdf

The Centre for Adolescent Health, Murdoch Children's Research Institute (2018). *Student Wellbeing, Engagement and Learning across the Middle Years*, Canberra: Australian Government Department of Education and Training.

The Lowitja Institute. (2018). *Journeys to healing and strong wellbeing*. https://www.lowitja.org.au/content/Document/Lowitja-Publishing/lowitja_consulting_journeys_to_healing_report.pdf

Thomas, J., Barraket, J., Wilson, C., Holcombe-James, I., Kennedy, J., Rennie, E., Ewing, S., & MacDonald, T. (2020). *Measuring Australia's digital divide: the Australian digital inclusion index 2020*. Roy Morgan. https://digitalinclusionindex.org.au/wp-content/uploads/2020/10/TLS_ADII_Report-2020_WebU.pdf

Titov, N., Dear, B.F., Staples, L.G., Bennett-Levy, J., Klein, B., Rapee, R.M., Shann, C., Richards, D., Andersson, G., Ritterband, L., Purtell, C., Bezuidenhout, G., Johnston, L. and Nielssen, O.B. (2015). MindSpot Clinic: An Accessible, Efficient, and Effective Online Treatment Service for Anxiety and Depression. *Psychiatric Services* 66:10, 1043-1050. 10.1176/appi.ps.201400477

Tuna Blue. (2019). *Consumer & Carer Co-review of the Community Support Program Area*. Western Australia Mental Health Commission. https://www.mhc.wa.gov.au/about-us/news-and-media/news-updates/consumer-andcarer-co-review-of-the-community-support-program-area-final-report

Tudor, K. (1996). Mental Health Promotion: Paradigms and Practice. Routledge: London.

Turning Point. (2019). *Beyond the Emergency: A National Study of Ambulance Responses to Men's Mental Health.* Beyond Blue. https://www.beyondblue.org.au/docs/default-source/default-document-library/beyond-the-emergency-report.pdf

Thrive at work. (2021). The Thrive at Work Framework. https://www.thriveatwork.org.au/framework

Tricco, A., Langlois, E., & Straus, S. (Eds.). (2017). *Rapid reviews to strengthen health policy and systems: a practical guide.* World Health Organization. https://www.who.int/alliance-hpsr/resources/publications/rapid-review-guide/en

United Nations. (2020). *World Social Report 2020: Inequality in a rapidly changing world.* Department of Economic and Social Affairs of the United Nations Secretariat. https://www.un.org/development/desa/dspd/wp-content/uploads/sites/22/2020/01/World-Social-Report-2020-FullReport.pdf

Victorian Foundation for Survivors of Torture. (2019). '*School is where you need to be equal and learn': insights from students of refugee backgrounds on learning and engagement in Victorian secondary schools.* Foundation House. https://www.foundationhouse.org.au/wp-conten/uploads/2019/12/STUDENT-PERSPECTIVE-RESEARCH-PROJECT-REPORT_A4_WEB.pdf

Victorian Government. (2015). *Victoria's 10-year mental health plan.* Department of Health & Human Services. https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorias-10-year-mental-health-plan

Victorian Government. (2019). *Royal Commission into Victoria's Mental Health System: Interim Report.* https://finalreport.rcvmhs.vic.gov.au/download-the-interim-report

Victorian Government. (2020). *Framework and guidance for mental health care during COVID-19.* Department of Health & Human Services. https://www.dhhs.vic.gov.au/sites/default/files/documents/202005/COVID-19%20Mental%20Health%20Framework-20200505.pdf

Victorian Government. (2021). *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations.* https://finalreport.rcvmhs.vic.gov.au/download-report

VicHealth. (2015). *Epidemiological evidence relating to resilience and young people: a literature review.* Victorian Health Promotion Foundation. https://www.vichealth.vic.gov.au/~/media/ResourceCentre/PublicationsandResources/Mental%20health/Epidemiological%20evidence%20relating%20to%20resilience%20and%20young%20people.pdf?la=en

Wahl, O. F. (1999). *Telling is risky business.* Rutgers University Press.

Western Australia Mental Health Commission. (2019). *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan) Update 2018.* Western Australian Government. https://www.mhc.wa.gov.au/media/3516/plan-update-2018-corrections-29-july-2020.pdf

Williams, A., Fossey, E., & Harvey, C. (2012). Social firms: Sustainable employment for people with mental illness. *Work-a Journal of Prevention Assessment & Rehabilitation, 43*(1), 53-62. https://doi.org/10.3233/wor-2012-1447

Wohler, Y., & Dantas, J. A. (2017). Barriers Accessing Mental Health Services Among Culturally and Linguistically Diverse (CALD) Immigrant Women in Australia: Policy Implications. *Journal of Immigrant and Minority Health*, 19(3), 697-701. https://doi.org/10.1007/s10903-016-0402-6

World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health.* https://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en

Worthington, E. (2015). *Mental health as significant as tax reform, says economist.* Australian Broadcasting Corporation. https://www.abc.net.au/pm/content/2015/s4287653.htm

Wyn, J., & Grimshaw, L. (2014). *The Experience of Education: The impacts of high stakes testing on school students and their families. A Qualitative Study.* The Whitlam Institute.

10. APPENDIX

10.1   Detailed review approach and method

The Design Council's (2004) Double Diamond provides a framework for design innovation, to help designers and non-designers to solve complex social, economic and environmental problems. The two diamonds represent a process of exploring an issue more widely or deeply (divergent thinking) and then taking focused action (convergent thinking).

- *Discover*. The first diamond helps people understand, rather than simply assume, what the problem is. It involves speaking to and spending time with people who are affected by the issues.

- *Define*. The insight gathered from the discovery phase can help you to define the challenge in a different way.

- *Develop*. The second diamond encourages people to give different answers to the clearly defined problem, seeking inspiration from elsewhere and co-designing with a range of different people.

- *Deliver*. Delivery involves testing out different solutions at small-scale, rejecting those that will not work and improving the ones that will (Design Council, 2004).

10.1.1 Review phase one - Discover

The first phase of the review was guided by the project aims outlined above, and the question asked by the Z Zurich Foundation: "How do we better support mental health and wellbeing frameworks in Australia?" Broad searches were performed to identify the range of content areas relevant to this review.

Search strategy

An initial Google search for Australian mental health frameworks was conducted by the research team in Feb 2021 (updated in March 2021) using the broad key phrase: "mental health framework" AND "Australia" to scope the range and number of mental health frameworks that might be relevant to this review. This search returned 86,400 results, and the results were screened for relevant material, until no relevant results were found for two consecutive pages at page 10 after screening 100 results.

The inclusion criteria were:

- The framework is primarily focused on mental health/social and emotional wellbeing

- The geographical context of the framework is Australia (national, state/territory, or specific areas e.g. rural and remote)

- The framework was published within the last ten years (2011–2021)

Specific Google searches were also conducted for mental health frameworks focused on particular locations (e.g. states and territories) and populations, including Aboriginal and Torres Strait Islander people, LGBTIQ+ people, people from culturally and linguistically diverse backgrounds, and people with disability. This initial search identified a wide range of mental health frameworks, from national, to state/territory, to collective and individual organisation level.

The research team (comprised of staff with expertise in clinical and community mental health research, psychology, social work, and lived experience knowledge) scanned a sample of the collated mental health frameworks to understand the content areas and populations they covered. From this initial scan of 23 frameworks (published from 2011–2021 and selected for breadth and population diversity), the main content areas covered were:

1. Prevention and mental health promotion

2. Mental health services

3. Broad frameworks encompassing prevention, early intervention, mental health services, and non-clinical supports

This initial scan of Australian mental health frameworks and review of the Productivity Commission (2020) report have informed the way we have framed the current context and evidence on how intersecting systems, settings and issues affect mental health, and people with mental health challenges in Australia, and the focus areas covered in our initial evidence review.

10.1.2 Review phase two – Define

With the core content areas identified, searches of the grey literature (via Analysis and Policy Observatory) and academic research (via PubMed) were conducted to source further evidence relevant to this review.

Search results were screened by the project lead, with a second reviewer confirming inclusion decisions where there was uncertainty. The team also performed manual searches relevant to the content area they were working on – for example, reviewing relevant materials referenced within an included report, or identifying other sources they knew to be relevant. The criteria for inclusion in the review are shown below.

Inclusion criteria:

- Informed by empirical (quantitative or qualitative) evidence on mental health – including lived experience voices

  - Systematic reviews targeted within academic literature to expedite the review process

- Published between 2011–2021

- Based in, or focused on the geographical context of Australia

- Focused on mental health/illness at policy/population level and aligning with one or more the mental health content areas identified by the initial framework scan, including:

  - prevention and early intervention for mental health

  - relevant life course settings and institutions, from school to post-secondary education/training and work

  - the clinical mental health service system and mental health workforce, including funding, commissioning and governance

  - non-clinical services and supports for people with a mental health condition, including family members and carers

- Identifies evidence-based recommendations/approaches to support population mental health in Australia (goes beyond reporting findings only)

- Is peer-reviewed (for academic literature) or endorsed/produced by relevant bodies (for grey literature and frameworks) - for example, a framework for family members and carers endorsed by Mental Health Carers Australia

Due to the need for this first report to provide an overview of a wide range of content areas, and the volume of content located at these early review stages, the research team adopted a purposeful sampling technique. Documents meeting the inclusion criteria above were prioritised for review based on relevance to the stated project objectives and plan, currency, inclusion of lived experience and diversity, and strength of evidence. In total, over 120 works were reviewed, and form the evidence base of this report.

10.2 Detailed policy settings table

Table 2 – detailed actions and needs outlined across policy settings

WHOLE OF SYSTEM ACTION AREAS – PREVENTION, EARLY HELP, MENTAL HEALTH SERVICES AND NON-CLINICAL SUPPORTS

Action area	Need	Sources
Increase social equity and inclusion across all life settings **Improve evaluation culture and practice** Example actions: • Address mental health risk factors and their social context • Increase cross-sector engagement • Reduce stigma • Provide evidence-based suicide prevention • Improve Indigenous Mental health and Suicide Prevention outcomes • Improve outcomes measurement, including the measurement of engagement of and responsiveness to target cohorts	• Actions should improve the social and economic conditions of people's lives • Stigma reduction should include a focus on both mental health conditions, and suicide and recognise the roles of different settings including education settings, workplaces and communities • Although all plans call for increased suicide prevention, few seek for evidence-based approaches • Outcomes measurement should include mental health consumers, family members and carers • Indigenous Australians, culturally and linguistically diverse Australians, and other groups who may experience inequities in access to support	• ACT - Australian Capital Territory Mental Health and Suicide Prevention Plan 2019-2024 • The Fifth National Mental Health and Suicide Prevention Plan 2017 • National Mental Health and Wellbeing Pandemic Response Plan • NSW - Living Well strategic plan for mental health in New South Wales 2014-2024 • NT - Northern Territory Mental Health Strategic Plan 2019-2025 • QLD - Shifting Minds, Queensland Mental Health Alcohol and Other Drugs Plan 2018-2023 • SA - Mental Health Services Plan for South Australia 2020-2025 • TAS - Rethink 2020, a state plan for mental health in Tasmania 2020-2025 • VIC – Victoria's 10 Year Mental Health Plan (2015-2025) • WA – Western Australian Mental Health Alcohol and Other Drug Services Plan 2020-2025 (Plan update 2018)

SERVICE SYSTEM ACTION AREAS – EARLY INTERVENTION, MENTAL HEALTH SERVICES AND NON-CLINICAL SUPPORTS

Action area	Need	Sources
Create a balanced system that can more effectively support recovery and address the social determinants of mental health, reducing reliance on costly and acute services *Systems, policy and services should be informed by people with lived experience, including acknowledgment and support of family members and carers* *Provide equitable, flexible and inclusive access to person-centred, integrated healthcare and non-clinical support* *Prioritise mental health alongside physical health and access to other supports.* Example actions: • Redesign services to address gaps and barriers • Increase collaborative planning, funding, & delivery of services • Provide culturally secure & responsive services • Early intervention – Early in life; early in distress; early in episode • Facilitated access to healthcare and support • Meet the unique needs of various marginalised cohorts, including people with complex mental health presentations or complex needs • Ending homelessness through Housing First approaches • Improve service delivery in rural or remote areas • Integrate support for physical, mental, and social health • Evidence based suicide postvention	• Although most or all documents talked about barriers or gaps faced by consumers in accessing services, only four mentioned both the need to design better systems, policy, and services, and to include those with Lived Experience in the design, development, and implementation thereof. Effective care and support should be holistic and respond to mental health and other social needs (ACT Plan). Currently, the fragmented nature of the service system does not support this (Council of Australian Governments (COAG) Health Council, 2017) • Most strategies and plans focus on interventions early in life and early in distress. Those documents which better capture the link between social and mental wellbeing tend to also mention interventions early in episode. The ACT CHN MHSPP is emblematic of this • Sometimes called coordinated care or system navigation, facilitated access allows consumers, family members and carers to have all of their needs met by assisting them to navigate the various services they may access. Currently, lack of facilitation can result in people not receiving the support they need, contributing to negative health and life outcomes (COAG Health Council, 2017) • Housing First is the best-practice model for ending homelessness. It seeks to give stable, affordable housing to those experiencing – or at risk of experiencing – homelessness while ensuring they are supported to maintain that housing and to meet their other needs. Despite this, only the ACT Plan explicitly supported this model • Postvention is an intervention in the lives of those impacted by suicidal actions, both survivors and loved ones, in recognition that those impacted by suicidal actions are at increased risk of dying by suicide or of undertaking self-harming behaviours	• ACT – Australian Capital Territory Mental Health and Suicide Prevention Plan 2019–2024 • Australian Government – Joint Regional Planning for Integrated Regional Mental Health and Suicide Prevention Services (2018) • The Fifth National Mental Health and Suicide Prevention Plan 2017 • National Mental Health and Wellbeing Pandemic Response Plan • NSW – Living Well strategic plan for mental health in New South Wales 2014–2024 • NT – Northern Territory Mental Health Strategic Plan 2019–2025 • QLD – Shifting Minds, Queensland Mental Health Alcohol and Other Drugs Plan 2018–2023 • SA – Mental Health Services Plan for South Australia 2020–2025 • TAS – Rethink 2020, a state plan for mental health in Tasmania 2020–2025 • VIC – Victoria's 10 Year Mental Health Plan (2015) • WA – Western Australian Mental Health Alcohol and Other Drug Services Plan 2020–2025 (Plan update 2018)

MENTAL HEALTH SERVICE ACTION AREAS

Action area	Need	Sources
Create a better-integrated mental health system through collaboration *Provide equitable, flexible and inclusive access to person-centred, integrated healthcare and non-clinical support* *Support and resource a diverse, skilled and sustainable mental health workforce* Example actions: • Establish partnerships at local, internal, inter-jurisdictional, & national levels to improve the mental health system • Increase public awareness of services in primary health & community settings • Provide flexible access to affordable, quality care • Offer the right level of care at the right time, in the right place • Offer digital & eHealth options in line with people's preferences and needs • Provide clear pathways between levels of care • Integrate mental health and alcohol and other drug responses • Provide career pathways for skilled mental health workers from diverse backgrounds • Data sharing (in alignment with the relevant privacy legislation)	• Almost all of the surveyed documents acknowledge the difficulty faced by people trying to access help for the first time, or to access a new level or type of help. To varying degrees, the listed plans aim to allow consumers (i.e., people seeking assistance for their mental health) to do so such that they can be guided to the appropriate service or program from any access point in the system • Increased awareness of services in primary care and community settings is important and distinct from general awareness of mental health and wellbeing, or mental health conditions. It is also distinct from knowledge of crisis lines or services • There are different models for offering the right level of care, including the older Stepped Care model and the emerging Staged Care approach. Both Stepped- and Staged Care aim to address the presenting need, but Staged Care has the added benefit of being a model explicitly aimed at reducing the likelihood of increasing need or severity. See, for example, the work done by headspace and Prof Ian Hickie & Dr Shane Cross (Sawrikar et al., 2021) • Digital mental healthcare options align with some people's needs and preferences and can provide a bridge or adjunct to in-person care, or meet people's needs where in-person care is not accessible (Australian Government, 2021; Productivity Commission, 2020). However, it's important not to assume these approaches will work for everyone (Kaleveld, Bock, & Seivwright, 2020) • Policies and services must be born of an understanding of the complex interrelation of addictions, substance misuse, and mental health difficulties • Currently, the sustainability of the mental health workforce is at risk due to under-resourcing and high demand (Productivity Commission, 2020). An effective mental health system requires adequate resourcing and support for a diverse, skilled workforce, including career paths for peer workers, Indigenous workers, and culturally and linguistically diverse workers (Productivity Commission, 2020; Victorian Government, 2021) • Increased sharing of data from different sections of the mental health service system to the Australian Institute of Health and Welfare's (AIHW) National Suicide and Self Harm Monitoring System would provide a clearer and more comprehensive view of mental wellbeing, and demand on mental health services (including changes since COVID-19) (National Mental Health Commission, 2020)	• ACT – Australian Capital Territory Mental Health and Suicide Prevention Plan 2019–2024 • The Fifth National Mental Health and Suicide Prevention Plan 2017 • National Mental Health and Wellbeing Pandemic Response Plan • NSW – Living Well strategic plan for mental health in New South Wales 2014–2024 • NT – Northern Territory Mental Health Strategic Plan 2019–2025 • QLD – Shifting Minds, Queensland Mental Health Alcohol and Other Drugs Plan 2018–2023 • SA – Mental Health Services Plan for South Australia 2020–2025 • TAS – Rethink 2020, a state plan for mental health in Tasmania 2020–2025 • VIC – Victoria's 10 Year Mental Health Plan (2015) • WA – Western Australian Mental Health Alcohol and Other Drug Services Plan 2020–2025 (Plan update 2018)

10.3   Detailed key areas for action table

Table 3 – Key areas for action, rationale and supporting evidence arising from the evidence review

ACROSS ALL SYSTEMS AND SETTINGS

Key areas for action	*Rationale and supporting evidence*
Increase social equity and inclusion, and reduce mental health stigma	Recognising that mental health is shaped by "social, cultural, economic and physical environments" (State of Victoria, 2021), supports should be informed by a social equity and "life-course" model across different settings. A life course model helps us understand and respond to the social determinants of health and different risks and settings people experience throughout life – from the prenatal period and early childhood, to childhood, adolescence, adulthood and older adulthood (Patel et al., 2018; Productivity Commission, 2020; State of Victoria, 2021). The National Mental Health and Wellbeing Pandemic Response plan puts forward a rights-based approach to health equity (National Mental Health Commission, 2020, p.4). In recognition of the impacts of different social factors, life-stages and environments, both prevention and early intervention approaches, non-clinical supports, and the mental health system should focus on reducing inequities, and providing safe, inclusive, responsive care and support to everyone (Productivity Commission, 2020; State of Victoria, 2021).
Provide mental health training and support across major life settings such as education, workplaces, and other services	People working across major life settings such as early childhood, secondary and tertiary education, workplaces and other services have the potential to contribute to mentally healthy environments that prevent mental health conditions; and to support people to access early help when they need it. However, education providers, employers, and services beyond the mental health system (such as the justice system, or housing services) do not always have the knowledge, resources or supports required to do this effectively (Productivity Commission, 2020).
Support the implementation of recommendations to improve suicide prevention and postvention	Suicide prevention remains a vital focus area, alongside appropriate postvention for people affected by suicide attempts (Productivity Commission, 2020). Implementation of the Aboriginal and Torres Strait Islander Suicide Evaluation Project (ATSISPEP, 2016), appears slow or non-existent, with ample opportunity to support recommendations including community-led suicide prevention activity; development and funding for the incoming National Aboriginal and Torres Strait Islander Suicide Prevention Strategy Implementation Plan; and designation of Aboriginal Community Controlled Health Organisations (ACCHOs) as preferred providers of suicide prevention programs for Aboriginal and Torres Strait Islander people.
Systems, policy and services should be informed by people with lived experience, including acknowledgment and support of family members and carers	Currently, there are some gaps in evidence about the effectiveness of services (Productivity Commission, 2020), and the lag-time for evidence translating into practice can be long (State of Victoria, 2021). At the same time, evidence from lived experiences and service providers is not always linked into existing data collection and reporting. Better measurement of outcomes can contribute to knowledge for a more effective mental health system, and influence future funding decisions. Sharing knowledge across sectors also has the potential to address mental health knowledge gaps for educators, employers, and communities (Future Generation Investment and Social Returns and EY, 2021; National Mental Health Commission, 2020; Productivity Commission, 2020; State of Victoria, 2021).

ACROSS ALL SERVICES AND SUPPORTS

Key areas for action	Rationale and supporting evidence
Prioritise mental health alongside physical health, and holistic healthcare with access to other supports.	Despite the significant impacts of mental health conditions in Australia, funding for mental healthcare has historically lagged behind funding for physical healthcare (Future Generation Investment and Social Returns and EY, 2021). However, people who experience a mental health condition still have worse physical health than the general population (COAG Health Council, 2017). In addition to improved mental healthcare, improvements are needed in the range of other supports and services that people with a mental health condition may need, including access to resources that promote physical health, holistic healthcare, and access to other services to meet other needs such as housing support (National Mental Health Commission, 2020; Productivity Commission, 2020; State of Victoria, 2021).
Create a balanced system that can more effectively support recovery and address the social determinants of mental health, reducing reliance on costly and acute services	Prevention, early intervention and community support contribute significantly to people's emotional and social wellbeing, and they also need to be recognised as integral to a financially sustainable health system (McGorry, 2015). Currently there is a disproportionate focus on clinical services – overlooking other determinants of mental health including family and kinship groups, providers of social support services and facilitating a person's functional recovery within their community (Productivity Commission, 2020, p.8) High rates of emergency department admissions and readmissions to acute psychiatric services is evidence of "failure to provide timely and adequate community-based mental health supports" (National Mental Health Commission, 2014). The current service mix results in people being cared for in the most intensive and higher cost care settings, which is inefficient and often less effective (National Mental Health Commission, 2014; Office of the Auditor General, 2019; Productivity Commission, 2020, p.8).
Provide equitable, flexible and inclusive access to person/ family/community-centred prevention and early-help programs, mental health information, healthcare, and non-clinical support	Access to appropriate supports and services is an issue across the whole mental health system, from prevention and early help programs through to healthcare and non-clinical supports (Productivity Commission, 2020). The system needs to provide accessible, community based, evidence-informed and responsive care appropriate to the level of support people need, and currently there are service gaps for particular groups, including: • Children and families requiring support, and children in out-of-home-care • Aboriginal and Torres Strait Islander people • People experiencing greater socioeconomic disadvantage • Culturally and linguistically diverse people • People with disability • LGBTIQ+ people • People in regional, rural and remote areas • People with complex presentations or needs, including people with a mental health condition and substance use problems. • Older adults • Women and young people in acute care settings, who can experience services as unsafe (COAG Health Council, 2017; National Mental Health Commission, 2020, Productivity Commission, 2020; State of Victoria, 2021). Currently, barriers and gaps in care mean that people are missing out on the support or care they need at the time they need it, and this is contributing to increased demand for high-intensity mental health services (Jacobs & Morris, 2016; Kaine & Lawn, 2021; Productivity Commission, 2020).

ACROSS MENTAL HEALTH SERVICES

Key areas for action	Rationale and supporting evidence
Create a better-integrated mental health system through collaboration	The mental health system is currently fragmented, with unclear pathways between different services or levels of care creating difficulties in navigating the system, and often requiring people seeking help to repeat their story multiple times (Kaine & Lawn, 2021; Productivity Commission, 2020). Improved integration, communication and collaboration between services would help address this (COAG Health Council, 2017; National Mental Health Commission, 2020; Productivity Commission, 2020; State of Victoria, 2021).
Support and resource a diverse, skilled and sustainable mental health workforce	The mental health workforce is currently under-resourced and at risk of staffing short-falls. There are also gaps in provision of culturally safe and responsive care for Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, and other marginalised groups. Under-provisioning and gaps in care contribute to negative outcomes for people experiencing a mental health condition, and to stress and burnout for mental health professionals (National Mental Health Commission, 2020; Productivity Commission, 2020; State of Victoria, 2021).