Australian Government
National Mental Health Commission

Royal Commission into Victoria's Mental Health System
PO Box 12079
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National Mental Health Commission – Submission to the Royal Commission into Victoria's Mental Health System

To Whom It May Concern

Thank you for you for the opportunity to make a submission to the Royal Commission into Victoria's Mental Health System.

Please find attached the submission from the National Mental Health Commission to the Royal Commission. There is no confidential material presented.

Should you require clarification, or would like to discuss this submission in further detail, please contact the Deputy CEO, Ms Maureen Lewis at [redacted] or on [redacted]

Yours sincerely,

Christine Morgan
Chief Executive Officer
Commissioner

5 July 2019

Submission to the Royal Commission into Victoria's Mental Health Services

National Mental Health Commission
July 2019

The National Mental Health Commission (the Commission), established in 2012, has a national remit to provide insight, advice and evidence in ways to continuously improve Australia's mental health and suicide prevention system and act as a catalyst for change to achieve system improvements. The Commission also has a mandate to work across all areas that impact on mental health, including education, housing, employment, human services and social support. There are three main strands to the Commission's work: monitoring and reporting on Australia's mental health and suicide prevention systems; providing independent advice to government and the community; and acting as a catalyst for change.

The focus of this Royal Commission aligns with the Commission's Contributing Life Framework, which acknowledges the social determinants of good mental health, and the ambition that individuals can lead 'contributing lives'. The framework recognises that a fulfilling life requires more than just access to health care services. It means that people with experience of mental illness can expect the same rights, opportunities, physical and mental health outcomes as the wider community.

In responding to the Royal Commission's Terms of Reference, the Commission will be providing a national perspective on the issues raised for mental health services, not providing a response to each of the terms individually. Key areas are broken down into the broad themes of 'social determinants', 'unmet need for mental health services', and 'measurement and reporting'. The Commission makes the following recommendations to the Royal Commission into Victoria's Mental Health Services:

Recommendation 1:
Mental health must be seen as a whole-of-government priority, with structural barriers around portfolio-based funding reduced. The Commission believes that a more coordinated approach is needed by governments; one that recognises that mental health outcomes are impacted in myriad ways, and that strategic investment across portfolios is required.

Recommendation 2:
The Commission recommends that the Royal Commission draw on the work undertaken by the Commission and AHURI for guidance on improvements to housing and mental health.

Recommendation 3:
Strategic investment is required over the longer term, using evidence-based planning tools, such as the National Mental Health Services Planning Framework, to develop a suite of service offerings that are able to address the needs of all people who require mental health care. Investment in mental health services requires existing data gaps to be addressed to better understand the quantum of unmet need.

Recommendation 4:
The Commission recommends that governments, including the Victorian government, ensure that people with psychosocial disability have access to appropriate and timely psychosocial support services regardless of whether or not they are in the NDIS.

Recommendation 5:
The Commission recommends that the outcomes of the Victorian pilot emergency department crisis hubs be monitored and evaluated, with the findings reported publicly to ensure learnings can be applied more broadly.

Recommendation 6:
The Commission recommends that the evaluation findings from the suicide prevention trial sites are closely considered by the Victorian Government, and that fragmentation in the system is reduced, whether that be through the expansion of the systems approaches trialled, or through alternative approaches.

The Social Determinants of Health Outcomes

Some of the most powerful root causes of inequalities in mental health are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape the conditions of daily life.[1] People living with mental illness are also more likely to experience a range of adverse social, economic and health outcomes, including experiencing homelessness, being unemployed, being incarcerated and dying prematurely. This reciprocal relationship between mental illness and other social, economic and health factors means that many investments and policy reforms that have the potential to improve the mental health of Victorians may come from outside the health sector and vice versa.

In outlining their social determinants approach to improving mental health, the World Health Organisation (WHO) proposes that the reduction of mental health inequalities will be achieved most effectively through the prioritisation of mental health equity in all policies across all sectors, and that policies from non-health portfolios should explicitly state their likely contribution to mental health.[2] This sentiment is echoed by the New Zealand Government Inquiry into Mental Health and Addiction.[3]

Recommendation 1:
Mental health must be seen as a whole-of-government priority, with structural barriers around portfolio-based funding reduced. The Commission believes that a more coordinated approach is needed by governments; one that recognises that mental health outcomes are impacted in myriad ways, and that strategic investment across portfolios is required.

The effects of social determinants on health cannot, and should not, be addressed by mental health interventions alone. Whilst mental health interventions to improve mental health and suicide prevention are critical, they are not sufficient to counter the significant influence of social determinants, including social disadvantage, education and employment, and housing. These issues are explored in more depth below.

Mitigating social disadvantage
Supporting population mental health and wellbeing, and intervening early when individuals are at risk reduces distress, disadvantage and disability over the lifetime. It is also known that policies focussed on early intervention and prevention have positive downstream impacts, particularly for the most disadvantaged in our society. It also reduces the likelihood of contact with more costly supports and services

including the child protection and justice systems, acute hospital based care, and social support payments.

The majority of mental illness has its onset in childhood and adolescence, and the first 1000 days of a person's life have been highlighted as a critical period for neurodevelopment. While social determinants influence the likelihood of mental illness developing across the life course, they are particularly critical during this first 1000 days, where a number of vital skills and abilities develop including social and emotional resilience, and the cognitive capacity needed to engage fully with formal schooling.[4]

Relieving poverty (particularly in the first 1000 days) has been shown to increase birth weight and other outcomes of health, reducing the likelihood of negative outcomes later in life.[5] It is noteworthy that Aboriginal and Torres Strait Islander children experience poverty at significantly higher rates than their non-Indigenous counterparts and have some of the poorest health and developmental outcomes in Australia.[5] Further, the rate of demand for costly downstream services continues to grow, particularly for Indigenous communities.

Education and employment

There are clear links that demonstrate people's experience of mental health will impact on their participation in education and employment. An individual's participation at the various levels of education directly impacts on their employment options. The average level of education and the rate of employment are lower for those with high levels of psychological distress than for the general population.[6] This is of particular significance for young people; of those young people who are not in employment, education or training 31.3% have high or very high levels of psychological distress, compared to 16.5% of other young people.[7] The Commission's 2014 Review noted this link and discussed how a system that responds to whole of life needs can help to increase the participation of all youth in education, employment and training thereby broadening their life choices.

The Commission supports the integration of existing Commonwealth-funded education mental health programs under Mental Health in Education grant for the National Initiative – 'Be You', through to June 2021. This one single, national initiative delivered through early learning services, primary and secondary schools will integrate five existing programs: KidsMatter Early Childhood, KidsMatter Primary, MindMatters, Response Ability and headspace School Support. Beyond Blue is now funded to deliver the 'Be You' initiative building on the success and learnings from the evidence base and ten years of experience of these programs aimed at promoting social and emotional health and wellbeing for children and young people in the education space. It will be important to evaluate this initiative to ensure its effectiveness on better outcomes for children and young people.

Poor mental health also has an effect on employment, both in securing and retaining work. In 2014-15, 60.7% of those who reported having a mental illness were employed, compared with 78.3% of the general population.[8] There is a significant gap in services that bring together mental health and employment support. Those programs that do, for example the Partners in Recovery and Personal Helpers and Mentors programs, tend to be focussed on those with severe mental illnesses.[6] In addition, these services are currently being phased out with clients transitioning into the National Disability Insurance Scheme (NDIS) where eligible. While the NDIS is

currently examining strategies for improving employment rates for participants under the scheme, with outcomes from a NDIS Participant Employment Taskforce due in July 2019, it is unclear what mental health and employment support services will replace these programs.

Further work is required to better integrate support services for people with mental health issues in educational and employment support settings. Better linkages between employment services, community mental health services and education-institute-based mental health services will reduce gaps and aid those with poor mental health during critical transition stages. In addition, school supports need to be strengthened with evidence based promotion and prevention programs made available in all schools.

Housing and homelessness

In 2017, the Commission funded the Australian Housing and Urban Research Institute (AHURI) to conduct an in-depth piece of research on housing, homelessness and mental health. This work, as well as drawing on insights from previous consultations and investigative panels, involved an extensive review of the published evidence. The resulting report on this research (the AHURI report)[9] sets out 19 policy options to improve support for people with mental illness and their housing needs.

The prevention of homelessness should be a key policy aim. The AHURI report identifies that even a brief period of homelessness may have detrimental effects on a person's mental health, and reduced mental health may persist for some time even after the person finds new housing. Prevention strategies operate at the structural level and include tenancy sustainment programs, building the capacity of the housing sector to recognise and effectively respond to the early warning signs of a mental health crisis, and implementing "no discharge into homelessness" policies in all hospitals.

Integration between housing, homelessness and mental health services is key to achieving better outcomes. The AHURI report identifies that a lack of policy integration, pooled funding, and cross-sector accountability mechanisms between the housing, homelessness and mental health sectors impedes the development of integrated solutions. Changing these factors requires collaborative leadership across all levels of governments and across sectors. The UK's joint commissioning model [10] for housing and healthcare could be considered as a new model for Australia, particularly as a way of harnessing pooled funding.

Social housing stock is another key policy element to improving housing stability for people with mental illness. The AHURI report identifies that there is a lack of affordable, safe and appropriate housing for people with mental illness, and that this is an impediment to scaling up integrated initiatives found to be successful at the local level. The lack of housing stock creates inflexibility in the market, compounded by social housing allocation system requirements restricting choice for those on a waiting list.[11] Having few properties makes it harder for housing providers to offer appropriate housing. This is especially true if the stock does not reflect the needs of the majority of those who need social housing. AHURI recommends coordination with the private rental sector to facilitate access to an immediate and greater supply of established homes.

Recommendation 2:
The Commission recommends that the Royal Commission draw on the work undertaken by the Commission and AHURI for guidance on improvements to housing and mental health.

It is essential that these social inequalities are addressed to reduce the risks associated with mental health issues. This needs to be done using a whole-of-government and holistic approach to mental health reform, with particular focus on the most vulnerable within our community, including Aboriginal and Torres Strait Islander peoples.

Unmet need for mental health services

Mental health services include both clinical treatment services and non-clinical mental health support services. People with a mental illness who use mental health services generally feel like their needs are met, but around 32% of people feel that their need for talking therapy is unmet, 43% of people feel that their information needs are not met, almost 70% of people report an unmet need for social intervention and 66% of people report an unmet need for skills training.[12]

This is unsurprising as general practitioners, who may be able to adequately address mild concerns, and emergency departments, which are equipped to manage acute crises, are readily available, but there are few public community-based treatment options, that are appropriate for moderate concerns, available in between.[13,14] This significant unmet need is often referred to as the "missing middle".

Increasing service use
People with mental illness are increasingly accessing clinical treatment services in a range of settings.

In 2015-16, 12.4% of all GP encounters were due to mental health issues (compared to 10.4% in 2006-07) with 62% of those encounters being managed by prescribing, supplying or recommending medication.[15]

Around 420,000 people received community treatment services in 2016-17, compared with 327,000 in 2007-08. In 2016-17, Victorian community treatment services saw the lowest rate of patients compared to all other jurisdictions.[16]

In 2017-18, 3.6% of all emergency department presentations were mental health-related, up from 2.9% in 2011-12. This equates to over 98,000 more presentations now compared to six years ago.[17]

While the use of clinical mental health services is increasing, it is difficult to measure the amount of unmet need, as the available data does not quantify people who are turned away from services or how long people are waiting to access services. However, increases in the use of emergency departments to manage acute episodes of mental illness suggest that people with a moderate to severe mental illness are not getting the care they need in the community.

There remains limited service options for people with a moderate mental illness who require more support than existing community mental health care services can provide. The alternate service options that are available are either accessed through private health insurance, which many people don't have, or they are expensive and therefore unaffordable for many.

Data gaps

Evidence-based tools such as the National Mental Health Services Planning Framework – Planning Support Tool can assist governments, Primary Health Networks and local health authorities to respond to the emerging and future needs of their populations by using evidence, epidemiological data and expert opinion to estimate the need and expected demand for mental health care and the level and mix of mental health services that may be required. However, due to gaps in the available national mental health service data collections, it is not currently possible in all jurisdictions to routinely compare the existing level and mix of mental health services with the optimal levels estimated by the Planning Support Tool. These comparisons would provide invaluable knowledge to better inform effective mental health service planning, as well as enabling regular monitoring of progress towards eliminating unmet need.

Data on the use of non-clinical mental health services delivered by non-government organisations (NGOs) is not currently systematically collected or reported at the national level, however the sector is commonly described as under-resourced.[18] Community support services can be accessed directly, without the need for referral or prior hospitalisation (unlike community treatment services) and support people within their communities, reducing the need for hospital admissions. For these reasons, and when they work in partnership with public mental health services, community support services are an essential part of the mental health system.

Data is routinely collected and reported about the specialist disability support services provided under the National Disability Agreement (NDA) to service users with a psychiatric disability.[19] However, most existing NDA service users are expected to transition to the NDIS over time and data about support services provided to people with psychosocial disability through the NDIS is not currently publicly available.

Further data is needed on the utilisation of the full range of community support services in order to better understand the service gaps and the quantum of unmet need.

Recommendation 3:
Strategic investment is required over the longer term, using evidence-based planning tools, such as the National Mental Health Services Planning Framework, to develop a suite of service offerings that are able to address the needs of all people who require mental health care. Investment in mental health services requires existing data gaps to be addressed to better understand the quantum of unmet need.

Impact of the NDIS on availability of psychosocial supports

A range of psychosocial support options are available under the NDIS for those deemed eligible. However, the Commission is concerned about the psychosocial

support options for those who are found ineligible to access the scheme, or who choose not to test their eligibility or drop out of the process. It is currently unclear what support services will be available for this group, particularly when both Commonwealth and state/territory funding for mental health services is being redirected to the NDIS.[20]

The Commission supports the COAG commitment to ensuring that all existing clients of Commonwealth funded mental health services who do not meet the NDIS eligibility, will be provided continuity of support, consistent with their current arrangements. It is understood that the Commonwealth Government is now working to ensure that continuity of service arrangements are in place by 1 July 2019. The Commission also supports the announcement of the National Psychosocial Support measure to assist people with psychosocial disability who are not eligible for the NDIS, and not currently in any existing Commonwealth Government program.

The Commission also welcomes the recent announcement[21] to provide funding to the Primary Health Networks to provide an additional 12 months support for clients transitioning from Commonwealth funded mental health programs to the NDIS.

While these announcements recognise the need for psychosocial support options for those who are found ineligible to access the scheme, there is uncertainty about how these services will be accessed and what the nature of these services will be. There is a risk that if people don't have access to appropriate psychosocial supports this could lead to an increased need to access acute services which have wider implications for the broader health system.

Similar concerns have been echoed in multiple other reports and forums, with some stakeholders highlighting the potential impact on more costly downstream services. In a hearing held on 15 February 2018, the Joint Standing Committee on the NDIS heard that the sector is concerned about the transition of services to the NDIS, with one stakeholder stating that "*the rolling over of Commonwealth funding to the NDIS and the resulting decrease in community-based services will lead to more episodes of crisis for individuals with a mental health condition and an increase in complex presentations to emergency departments and hospitals*".[22] Further commentary confirmed that inadequate supports in plans and poor coordination between the health system and disability supports have led to increased hospitalisation of people with mental illness.[22]

Recommendation 4:
The Commission recommends that governments, including the Victorian government, ensure that people with psychosocial disability have access to appropriate and timely psychosocial support services regardless of whether or not they are in the NDIS.

Suicide Prevention

Suicide is a significant public health problem in Australia and internationally. In 2017, 3,128 people died by suicide in Australia, making suicide the 13th leading cause of death.[23] The number of people who are hospitalised due to intentional self-harm is more than 20 times the number of people who die by suicide and a previous attempt is the most reliable predictor of a subsequent death by suicide.[24-26] Aboriginal and Torres Strait Islander rates of suicide are also higher than the rest of the population,

with Indigenous Australians 2.1 times more likely than non-Indigenous Australians to have died as a result of suicide in 2016.[23]

Not everyone who attempts suicide seeks healthcare, but a significant minority do and this provides a significant opportunity for intervention.[27] Furthermore, whether a person's experience of accessing a health service following a suicide attempt was positive or negative can influence future help-seeking behaviour.[27] Therefore, it is important to ensure that people who are at risk of suicide are getting a consistent, evidence-based minimum standard of care when they present to health services.

While work is occurring at the national level to provide this consistent minimum standard, there are many opportunities for states to implement improvements to their health systems to better support people who are at risk of suicide or who are experiencing a suicidal crisis.

Each year, more than a quarter of a million Australians present to emergency departments seeking help for acute mental and behavioural conditions, including people experiencing a suicidal crisis. Yet, for many of these people, the evidence suggests that emergency departments are not adequately resourced or positioned to be a timely and accessible entry point to the mental health system. In some cases, people leave the emergency department before receiving the care they need. For others long stays in emergency departments are associated with suboptimal treatment like restraint, seclusion and lengthy periods of sedation.[28]

A range of options require exploration in order to ensure that people experiencing mental health or suicidal crisis get the high quality care and support they need, including the provision of alternatives to emergency departments for those who do not require medical intervention, and the implementation of strategies to improve the management of mental health and suicidal crisis within emergency departments.

A number of alternative models have been proposed or trialled, including 'walk-in' crisis services such as The Living Room in the USA[29], and short-term residential respite services such as Maytree in the UK.[30]

A range of initiatives to improve emergency department care for people experiencing mental health and suicidal crisis have also been trialled. This reflects increasing acknowledgement among mental healthcare professionals that improvements need to be made to range of available crisis intervention services.[29]

The Commission notes that the Victorian government is currently establishing six new emergency department crisis hubs – specially designed 24-hour short-stay units in emergency departments, to treat people during times of mental health and drug and alcohol crisis.[31]

Recommendation 5:
The Commission recommends that the outcomes of the Victorian pilot emergency department crisis hubs be monitored and evaluated, with the findings reported publicly to ensure learnings can be applied more broadly.

Suicide rates in Australia have not declined over the past decade, however the suicide prevention sector has grown rapidly. Historically, suicide prevention efforts have been fragmented in terms of geography, scope and funding. There are multiple funders, with the Commonwealth, State and Territory Governments, private sector, research centres and philanthropic organisations all investing in new infrastructure, programs and initiatives.[32] This results in a lack of coordination in suicide prevention programs and duplication of effort.[14] The significance and complexity of the problem demands an integrated, whole of systems approach, with new structures put in place to enable meaningful collaboration.

A systems approach to suicide prevention recognises that successful suicide prevention requires a multilevel, multifactorial approach, involving both healthcare and community professionals and organisations, along with government and non-government agencies. Such an approach reflects the evidence that suicide is the result of an accumulation of risk factors and has multiple points for intervention.[33]

Typical interventions in a systems approach include aftercare following a suicide attempt or for those at risk, increasing the availability of psychological or psychiatric services in the community, training of frontline staff, and restricting access to means.

There are currently four sets of systems-approach trials to suicide prevention occurring in 29 sites across the country, including 13 in Victoria. These trials are important in order to better understand how a systems approach works, including what combination of interventions best works for the local area. This will help build the evidence base in relation to suicide prevention, and help guide future local communities to comprehensively implement their own suicide prevention activities.

An evaluation of these trial activities is currently underway, looking at both implementation and outcomes within the local community. Until the evaluation outcomes are known, it will not be clear whether these systems approaches are having a positive impact. It will be vitally important for all governments to consider the findings from the evaluation and determine whether expansion or revision of the approach is required.

Recommendation 6:
The Commission recommends that the evaluation findings from the suicide prevention trial sites are closely considered by the Victorian Government, and that fragmentation in the system is reduced, whether that be through the expansion of the systems approaches trialled, or through alternative approaches.

Evidence supports that providing immediate post-crisis aftercare and a period of psychosocial support on discharge from an emergency department or hospital admission can reduce the reoccurrence of suicidal behaviours and enable a person to continue steps towards sustained mental health wellbeing.[34] Aftercare services in Australia typically include some psychosocial support and non-clinical assertive outreach focusing on connecting the person with immediate treatment and support, but also helping to identify and resolve the factors that contributed to the suicide attempt or crisis. However, there is no universal access to these services in Australia, with many areas having no services available, and those that are available vary in their quality, length and scope.

Workforce

There is a diversity of professions which contribute to the overall mental health workforce in Australia, and workforce trends are changing over time. In some cases, trends such as the ageing workforce have serious implications for the sustainability of the workforce. In 2016, about 3 in 5 mental health nurses (58.8%) were aged 45 and above, and a third (32.7%) were aged 55 and older.[35] Other clinical specialities including psychiatry and psychology show similar patterns, with over half of psychologists aged 45 and over, and more than one quarter aged 55 and over in 2016. This increased to more than 70% for psychiatrists aged 45 and over, and more than 40% aged 55 and over.[35] Another trend is the movement of mental health professionals from public to private settings. Mental health professionals in the public sector are under increased pressure. A lack of resources and an over-stretched public system are some of the factors contributing to the shift from public to the private work setting,[36] particularly amongst psychiatrists.[37,38] There is also a perception that since the introduction of the Better Access initiative there has been a migration of psychologists, social workers and occupational therapists to the private sector, however it is difficult to conclude whether this occurrence is a direct result of Better Access or for other reasons.[39]

As the workforce evolves, and new requirements including skill mix and varied scope of practice are placed upon mental health practitioners, there is a need to ensure that high quality training and education is available. This includes knowledge of and capacity to deliver trauma-informed care. Trauma-informed care requires consideration of a person's environment beyond the immediate service being provided, and that their symptoms or presentation may reflect an adaptation to trauma, rather than a specific pathology.[40] Trauma-informed care also reflects an understanding of the widespread impact of trauma, potential paths for recovery, and actively seeks to prevent re-traumatisation. Trauma-informed approaches to care have also been described as a strength-based framework, which contrasts with traditional settings and systems[40] including the move towards employment of staff with lived experiences such as peer workers in acute and community health services.

One of the biggest issues in relation to the mental health workforce across professional streams and geographical areas is high staff turnover. There is a well-known range of contributing factors including stress and burnout, an ageing workforce, excessive workloads, insecure tenure, limited career paths, and reduced time for training, mentoring and supervision.[41] Mental health professionals operating in rural and remote areas, and those operating in private practice, may also experience isolation.

These issues can be mitigated through a range of workplace initiatives, including innovative supervision and support opportunities, particularly for workforces who are isolated; increased opportunities for training and professional development; addressing staff shortages to alleviate excessive workloads wherever possible; and implementation of mentally healthy workplace initiatives.

The Commission supports the Government's announcement of $1 million to develop a National Mental Health Workforce Strategy,[42] and is working with the Department of Health to ensure the strategy addresses the concerns raised above. The Commission also acknowledges the work that has been done by states and territories on workforce planning issues. The National Mental Health Workforce

Strategy will need to ensure the workforce planning occurring in states and territories is taken into account.

Funding, commissioning and service planning

The fundamental approach to funding mental health services from State agencies requires considerable review. The Commission's 2014 review articulated the fact that the mental health system in Australia has fundamental structural shortcomings. In effect, the way the mental health and suicide prevention system is designed and funded means that meaningful help is often not available until a person has deteriorated to crisis point.

The current system gives primacy to the traditional model of health care which promotes ever subspecialised clinical treatment modalities that neglect to acknowledge the broader social, human and economic factors at play.

There are also structural barriers around portfolio-based funding and decision making by governments, which dis-incentivise spending in one portfolio when the economic return over time will accrue in a different portfolio area (and budget), or indeed a different jurisdiction altogether.

The recent New Zealand Report of the Government Inquiry into Mental Health and Addiction[3] acknowledges that they 'have the system they designed', and the findings are in many ways applicable to the Australian/Victorian context. Some key learnings include:

- The issues being tackled cannot be addressed by the health system alone. Tackling the social and economic determinants of mental health and wellbeing starts with a co-ordinated integrated approach across both health and social services.
- A focus on population wellbeing is essential while also delivering practical help in the community when people need it. This cannot be achieved while funding continues to be primarily short term, ad-hoc and fragmented.
- A complete dismantling or restructuring of the health system is neither feasible nor desirable and would inevitably lead to widespread disruption of service delivery and delay progress in making genuine reform. The objective must be greater integration of services with mental health and addiction services retaining strong links to the wider health and disability system.
- Removing roadblocks to accessing good care means addressing issues of affordability of GP led care, and ensuring that foundations are in place for the 'missing middle' - those who are a step up from management in primary care but not acute enough for inpatient admission.

Addressing these key points requires realigned (and increased) funding, an 'invest to save' approach to system funding, more effective commissioning arrangements, and service planning that more closely matches needs in the community. As the UK's New Economics Foundation sees it, "*providing services in the same way, while demand increases and resources dwindle, is not a sustainable option*".[43]

The invest to save model[44] supports this approach and recognises the need to intervene early, investing upfront to avoid significantly higher costs in the future, but not at the cost of existing acute services. Without upfront investments, which have

known positive economic returns, downstream mental health costs will continue to grow, including avoidable emergency department presentations and demand for hospital beds, homelessness support, drug and alcohol treatment and income support. Some of the upfront investments recommended by Mental Health Australia and KPMG in the 2018 Investing to Save report include: adopting a Housing First model, assertive outreach post suicide attempt, and workplace mental health interventions. The report suggests that uptake of these recommendations would generate between $8.2 billion and $12.7 billion from an investment of under $4.4 billion.

Economic modelling work, funded by the Commission, examined ten interventions focussed on prevention of mental illness, including:

- Two interventions delivered via the workplace to promote good mental health and prevent depression.
- Two interventions (one physical, one psychological) for prevention of post-natal depression.
- Two psychological interventions in school settings for the prevention of bullying and depression in children.
- One parenting intervention for the prevention of depression and one e-health program for prevention of anxiety in young people.
- One e-health and one educational intervention to reduce older person's loneliness.

The modelling included an assessment of cost-effectiveness using a return on investment (ROI) ratio and costs saved based on cases of mental illness prevented. Overall the results show that there is good evidence for investing in a range of preventative interventions, both on the grounds of cost-effectiveness and cost-savings. These include less demand on the health budget through use of mental health services (such as less hospitalisation and community based services), as well as increased productivity (via less absenteeism and presenteeism in the workplace). The final results of the modelling are due to be published soon on the Commission's website: http://mentalhealthcommission.gov.au/our-work/update-economics-of-mental-health-in-australia.aspx

The Australian Medical Association (AMA) believes that mental health and psychiatric care is "grossly underfunded" compared to physical health, particularly in light of the burden of disease associated with poor mental health.[18] The AMA has also called for Commonwealth and state/territory governments to work cooperatively to change the current patchwork of overlapping services, recommending that a balance between funding acute public hospital care, primary care, and community-managed mental health is required, and weighted on the basis of need, demand and disease burden.[18] Effective upstream interventions that prevent or ameliorate mental illness and support recovery would realise later savings to a range of other areas of expenditure, and also increase tax revenues.

Concluding remarks

There can be no health without mental health, and good mental health and wellbeing depend on the design, financing and implementation of high quality, evidence based programs and policies across all portfolios. Beyond health and social services, the downstream impacts of poor investment or no investment can be felt in the domains

of housing, employment, education and the justice system. Just as, when early intervention and prevention is delivered in the right place at the right time, the benefits may be returned both within the sector and later in time, in reduced spending on health and social services. Inadequate investment in prevention and community-based services puts pressure on other, more expensive, parts of the system. If we continue to fund and manage services as we have traditionally, the expenditure on mental health will continue to grow, and people with mental health problems will continue to experience poor outcomes. Reform requires all governments and all sectors to work together to implement an evidence-based approach to supporting people's mental health and wellbeing, and to the provision of services.

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