WITNESS STATEMENT OF CHRISTINE MORGAN

I, Christine Elizabeth Morgan, Chief Executive Officer of the National Mental Health Commission, of Level 29, 126 Phillip Street, Sydney, in the State of New South Wales, say as follows:

I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

I make this statement in my capacity as Chief Executive Officer of the National Mental Health Commission (the NMHC).

Background and qualifications

1 I hold a Bachelor's Degree in Law and Arts from the University of Sydney and have been admitted as a Solicitor of the Supreme Court of New South Wales. I also hold an Associate's Degree, Graduate Certificate of Management from the University of New South Wales. I am a member of the Australian Institute of Company Directors and the Governance Institute of Australia.

2 I have many years of experience in executive roles in the corporate and not-for-profit sectors. I previously served as Company Secretary & General Counsel of a number of Australian listed companies being Australand Holdings Ltd, Century Drilling Ltd, Australian Consolidated Investments Ltd (formerly Bell Resources) and Tooth & Co Ltd. I was Executive General Manager responsible for managing the strategic direction and business unit effectiveness of the Wholesale, Broadband & Media Business Unit at Telstra; as General Manager at Wesley Mission, over the areas of Corporate Services and Community & Family Development; and as Chief Executive Officer of The Butterfly Foundation for Eating Disorders and Director of the National Eating Disorders Collaboration.

Current roles

3 My role as CEO of NMHC is to govern the agency to achieve its purpose in accordance with legislative obligations, government directions and the policy framework. My role is supported by the NMHC's Advisory Board, chaired by Lucinda Brogden AM.

4 Under the *Public Governance, Performance and Accountability Act 2013* and the *Public Governance, Performance and Accountability Rule 2014*, the CEO is the Accountable Authority of the NMHC. I am responsible for, and have the legislative power to determine, all matters relating to the policies, practices, administration and operations of

the NMHC. This includes ensuring good corporate governance, entering into arrangements and approving commitments of relevant money on behalf of the Commonwealth and giving instructions to the officials of the NMHC. I report to the Federal Minister for Health.

5 I was appointed as the first National Suicide Prevention Adviser to the Prime Minister in July 2019. I serve in this role in my personal capacity, not as a representative of the NMHC. In this role I report to the Prime Minister.

6 Under the terms of my appointment as National Suicide Prevention Adviser to the Prime Minister, I am required to report on the effectiveness of design, coordination and delivery of suicide prevention activities in Australia; and develop options to improve the whole-of-government coordination and delivery of suicide prevention activities. My term as Adviser will continue until 31 December 2020, with an assessment to be undertaken in July 2020 to determine whether an extension is required.

About the National Mental Health Commission

7 The NMHC was established in 2012 and is an independent executive agency in the Australian Government Health Portfolio.

8 The NMHC is a listed entity under the *Public Governance, Performance and Accountability Act 2013* with the NMHC's purpose set out in clause 15 of Schedule 1 of the *Public Governance, Performance and Accountability Rule 2014*.

9 The NMHC's purpose is to monitor and report on investment in mental health and suicide prevention initiatives; provide evidence-based policy advice to Government and disseminate information on ways to continuously improve Australia's mental health and suicide prevention systems; and act as a catalyst for change to achieve those improvements. This includes increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

10 These functions are reflected in the NMHC's 2019–20 key work areas:

- Monitoring and reporting
- Shaping the future
- Consumer and carer engagement and participation
- Workforce growth and development
- Mental health research

11 The NMHC seeks to ensure that investment in mental health is both effective and efficient. It provides independent reports and advice to the Government and community

on issues relevant to mental health and suicide prevention in Australia. The NMHC works across all areas that promote mental health and prevent mental illness and suicide – not just government and not just health, but education, housing, employment, human services and social support, with the aim of ensuring all Australians achieve their best possible mental health and wellbeing.

12 To achieve the NMHC's objectives, expertise in public sector policy, mental health and suicide prevention is needed. The NMHC engages skilled and experienced staff and has Commissioners on the Advisory Board who bring a broad range of expertise from across different sectors.

13 The NMHC acknowledges that engaging stakeholders and facilitating meaningful participation is essential to achieving transformational change and ensuring reforms are collectively owned and actioned. It engages with sector stakeholders, consumers, carers, family members and the community to hear their accounts of experiences with the mental health system. It also draws on data, indicators and frameworks to inform an assessment of whether progress is being achieved in the implementation of mental health reforms and the impact of any changes.

14 The NMHC seeks to engage with people with a lived experience of mental health challenges and illness, including carers and other support people, in all areas of its work. It affirms the right of all people to participate in decisions that affect their care and to determine the conditions that enable them to live contributing lives. Diverse and genuine engagement with people with lived experience, their families and other support people adds value to decision-making by providing direct knowledge about the actual needs of the community, which results in better-targeted and more responsive services and initiatives.

15 The NMHC considers the mental health and suicide prevention system through the lens of consumers, carers, families and support people to provide informed evidence-based reports and advice that reflect the experiences of people, and:

- enable a whole-of-life and person-centred view
- provide a focus on groups of people in the community with high levels of need and/or limited access to services
- encompass the continuum of mental health and wellbeing
- draw attention to interface issues between sectors and services
- apply an evidence-based approach.

16 Throughout its existence, the NMHC has applied the *Contributing Life Framework* to its work. The Framework is a whole-of-person, whole-of-system, whole-of-life approach to mental health and wellbeing. This means it considers people across the lifespan, from

pre-birth to old age and across the spectrum of their mental health and wellbeing needs. The *Contributing Life Framework* was developed by the NMHC in the year of its establishment and was first articulated in the NMHC's inaugural National Report Card.[1] It remains the core guiding framework for the NMHC's work.

17 The NMHC is a small organisation with a broad scope. Achieving a substantive cross-sectoral perspective on mental health policy and performance, and a national view beyond the confines of the Commonwealth's jurisdiction, is challenging. While the current work of the NMHC mostly focuses on Commonwealth activity, it seeks engagement and particularly data from jurisdictions where possible. Jurisdictional representation is included on the majority of steering committees and advisory groups established by the Commission for its various projects.

Vision 2030

18 The mental health system in Australia has seen considerable transformation over many decades, from institutionalisation to a community-based approach, focused on recovery-oriented practice. While there has been significant interest and investment in mental health over the past few decades, the experience of many is still of a fractured and inconsistent system. To address this, in 2017 the Commonwealth Minister for Health announced the development of Vision 2030 as part of Australia's Long Term National Health Plan.

19 *Vision 2030: Blueprint for mental health and suicide prevention* seeks to establish a person-centred system of mental wellbeing for Australia which has the capacity to acknowledge, value and respond to the experience of each individual. It will describe the components of an effective mental health and suicide prevention system, the relative balance of those components, and the pathways that link them to enable consumers and professionals to effortlessly navigate the system. It will act as a reference to identify gaps in the current mental health system, and guide investment at the Commonwealth and state and territory levels over time.

20 Vision 2030 anticipates an Australian mental health and suicide prevention system where:

- mental wellbeing across the lifespan is promoted and addressed from pre-pregnancy to old age
- everyone is supported to be mentally well
- mental health is addressed in its full social context

[1] National Mental Health Commission (2012). *A Contributing Life: The 2012 National Report Card on mental health and suicide prevention*. Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/9ab983bc-d825-41cf-ba04-a3d49e8d4257/2012-National-Report-Card-on-Mental-Health-and-Suicide-Prevention.pdf

- mental health is well-understood and acknowledged as part of everyone's experience
- when someone experiences a mental health issue, they are respected and can expect to live a contributing life, without stigma or discrimination
- people with mental ill-health have positive life experiences and reach their potential
- people suffer less avoidable harm as a result of mental health concern
- communities are at the centre of identifying their needs, designing responses, and delivering care
- anyone at risk of or living with a mental health issue has access to affordable, evidence-based care in their community
- anyone at risk of suicide is connected to support care and, if necessary, intervention, as a matter of priority
- services are delivered in a well-functioning, integrated system with consistent, appropriate quality care available across all steps in the spectrum to every individual
- people play a central role in their care, and in the choice, design and delivery of services that support them
- mental health is prioritised by all levels and sectors of government and receives parity and respect within the broader health and welfare systems.
- service and system successes are measured based on outcomes, with a focus on continuous real-time monitoring and quality improvements.

21 Vision 2030 envisages an ecosystem of care that will encourage and support diversity, specialisation and integration, and will create journeys that are personalised and without gaps. This will be a continuously learning system, prioritising outcomes and the cost-benefit impact of allocating available resources.

22 To enable this system and ensure that mental health is consistently and fairly prioritised by all levels of government, a strong, coordinated suite of national governance structures are required:

- *National agreements:* The system should be clearly defined and implementable through formal agreements between the Australian Government and state and territory governments that outline outcomes and performance measurement, roles and responsibilities, joint administrative and funding arrangements, mechanisms for oversight and data collection and sharing.

- *National policy and legislation:* There should be clear consistency and interoperability of mental health policy and legislation across states and

territories and between the Australian Government and state and territory governments.

- *Coordinated leadership*: There should be a dedicated body or agreed approach to coordination and oversight of diverse regional and community responses and enable collective learning.

- *Investment:* The system must have sufficient resources, targeted effectively, to enable sustainability and development to meet future needs, with funding commensurate with prevalence and costs of mental ill-health while valuing prevention, addressing social determinants and prioritising early intervention.

- *Standards and specifications:* The system needs to be underpinned by enforceable standards and specifications that provide clear benchmarks for the delivery of consistent, quality care nationally and identify key elements of best practice, requirements for professionals in the workforce and evidence-informed models for essential components of care, accompanied by tools for implementation.

23 Vision 2030 will be accompanied by a detailed implementation Roadmap that will identify the long-term strategies in investment, coordination, development and performance measurement required to achieve the goals and objectives for the mental health system as outlined in Vision 2030.

24 Collaboration is recognised as a primary driver to enable change in the implementation of Vision 2030. The NMHC is working alongside states and territories through the Mental Health Principal Committee (Council of Australian Governments) to endorse content from the final Vision 2030 products as a national mental health strategy and action plan.

25 In bringing state, territory and federal governments together under an ambitious but implementable, outcome-oriented mental health framework, Vision 2030 aspires to create the collaborative, consistent environment needed to enable sustainable change.

26 Consultation and stakeholder engagement are key to the effective development and implementation of Vision 2030 and its Roadmap. The project seeks to incorporate as wide a range of experience (including lived/living experience) as possible when developing evidence-based responses to mental health and psychosocial wellbeing. Consensus-building activities are a core aspect of the multi-layered and iterative approach to the development of the Vision and Roadmap.

27 From July to September 2019, the NMHC conducted a consultation about the future of mental health care, suicide prevention and wellbeing in Australia. This provided an

opportunity to ground Vision 2030 in the experiences and insights of those with a lived experience, their carers, health and allied health and other professionals and communities. The Commission held 26 Town Hall meetings and 17 service provider stakeholder meetings, connecting with over 1,300 individuals including representatives from approximately 86 organisations. This was accompanied by an online consultation which received 2,090 responses. All information was analysed to identify key themes and consensus about the barriers experienced, community needs and opportunities to improve the experience of mental health care.

28 Whilst the findings from this consultation have provided a meaningful and intricate picture about the current state of the system – what is working and what needs to change – it is important to also note the data limitations when interpreting these findings. All participants were self-selecting from an opportunistic sample. Furthermore, demographic information was not collected and the face-to-face nature of the meetings may have influenced responses (e.g. vocal individual contributors and groupthink phenomena).

29 The following themes were consistently raised across the consultations. While the following themes were raised consistently across the Town Hall meetings, the importance or frequency varied between communities.

(a) Barriers to accessing care

(1) A range of barriers were identified, from practical considerations such as the absence of affordable services or health professionals in the area and service gaps to issues with attitudes towards mental health, social determinants of wellbeing and trust in the services available.

(2) Mental health is not well understood and this results in shame (self-stigma), social and structural stigma and discrimination. Such experiences occur in both informal and formal settings such as service providers and workplaces and may be perceived or feared due to past experiences. In the online survey: 63% identified fear of what may happen after seeking help as a barrier to accessing care; 59% identified fear of being judged or worried about what people may think as a barrier to accessing care; and 55% identified feeling shame and embarrassment as a barrier to accessing care.

(3) There is significant variability in services' capacity to deliver appropriate, quality care across the country. Participants reported that services are not providing consistent, quality care. This may relate broadly to the quality of interventions, but also often means that services are not culturally appropriate or offered in a safe way for a

person's circumstances. In the online survey: 34% indicated that they don't trust services or providers of help; 45% indicated previous help had not had any impact or created improvement; and 61% indicated that negative experiences of seeking help in the past were a barrier to accessing care.

(4) The system creates barriers to identifying needs and providing quality care that is accessible to all. Care is not financially, geographically or practically accessible for many Australians and individuals are often not able to access the services that are available. Services being unaffordable was raised by 20% of all Town Hall attendees and was considered an important barrier to care by 70% of survey respondents. The expense of treatment more broadly was also raised, with individuals noting that even if they were able to access psychological interventions, the costs of medications, travel, loss of work hours and so on, were also detrimental to their wellbeing. Services had limited availability to meet the needs of their community. This included long waitlists, not being available after hours, or not practically accessible with the means of transport available.

(5) The accessibility of the system was also raised, with consultation participants noting that services are not easily navigable or coordinated, making it difficult to enter care at the level required. There is no consistency to the services available across the spectrum of care with different gaps experienced in different locations (including the gap in service provision between primary and acute services, commonly referred to as the 'missing middle'). Workforce challenges (training, staffing levels, retention and support) mean that the workforce cannot deliver suitable quality services and does not offer the breadth of services needed.

(b) Needs and opportunities for change

(1) Town Hall data showed the uniqueness of community experiences and needs outside of geographic commonalities (for example, 'rural' or 'metro'). Communities are best placed to understand their needs. A 'whole-of-community' approach ensures that communities are viewed collectively and are placed at the centre of wellbeing.

(2) A considerable proportion of all responses were either unique or generically described (43% of all responses sub-classified as 'other') and did not neatly fall into more specific categories. The breadth of particular ideas for improvement may reflect the diversity of needs across individuals and communities and points to a need for service

and policy responses to be locally and individually tailored. The largest single category of ideas comprised systemic solutions, that is, how services are designed and delivered. The remaining ideas related to particular services or initiatives – the majority of which would be provided in the community.

(3) The idea of a hub or centre was often identified (by 9% of attendees) as a possible development. However, there was much diversity in what this kind of service response looked like in individual communities. There were similar levels of support for initiatives focussing on the workforce (11%) and raising general levels of education and awareness around mental health (10%).

30 In January 2020, development of the Roadmap commenced. The Roadmap project seeks to bring the sector, governments and the community together through the use of three iterative methods of consultation:

- an Advisory Group to represent stakeholder groups and provide guidance, input and feedback to the Roadmap development process. This group consists of significant stakeholder representatives and representative bodies including NMHC Commissioners, lived experience representatives, Aboriginal and Torres Strait Islander representatives, government, non-profit, service providers, research and workforce
- targeted consensus and feedback consultations via an online survey distributed to representatives from all areas of lived experience, government, service providers, insurers, research and workforce
- ongoing flexible individual consultations with key stakeholders within the mental health system.

31 Governments continue to undertake reviews into the mental health system and develop plans for continued reform. However, most are service-, sector- or jurisdiction-specific and do not address the structure of the system at a national (federated) level, or the perspective of a consumer attempting to navigate that system.

32 An integrated policy and planning approach is required across sectors and levels of government to address the gaps in the system. Better outcomes for people cannot be achieved through any one agency, sector or tier of government working alone. To achieve this, a unified vision for the future mental health system that all jurisdictions can work toward in a focused and systematic way is needed. Vision 2030 is an opportunity to drive this cross-sector leadership, governance and accountability, and to provide the authorising environment required to lever sustainable long-term change.

33 The current platform of significant mental health reform, through the Royal Commission and the Productivity Commission inquiry into mental health, informs Vision 2030 and provides a unique opportunity to prioritise and align mental health reform across jurisdictions and the Commonwealth to achieve national reform and to generate improved mental health outcomes for Australians.

Suicide prevention – State and Commonwealth relations and national reform

34 Australia has had a national approach to suicide prevention for almost 25 years, although the approach has changed over time:

- 1995 National Youth Suicide Prevention Strategy
- 2000 National Suicide Prevention Strategy
- 2009–2014 Fourth National Mental Health Plan (with suicide prevention a priority)
- 2011 Life Framework adopted by all jurisdictions
- 2014 NMHC recommended suicide prevention be included in a national mental health and suicide prevention plan
- 2017–2022 Fifth National Mental Health and Suicide Prevention Plan

35 Under the Fifth National Mental Health and Suicide Prevention Plan, responsibility for suicide prevention is shared by all jurisdictions. The plan is underpinned by an implementation plan and performance indicators, both of which are still in the process of being fully operationalised.

36 In addition to the above national plan, all states and territories have their own suicide prevention plan, strategy or framework. While they have different approaches, there are some commonalities including building resilience, empowering communities, focusing efforts on vulnerable groups, and delivery of suicide prevention, intervention and postvention programs and services.

37 A number of the states and territories (New South Wales, the Northern Territory and Queensland) have a whole-of-government focus, although there is some diversity of suicide prevention leadership, governance and funding structures across jurisdictions. States and territories have generally applied the LIFE Framework contextualised to local needs.

38 The primary success of these efforts is the use of existing multi-jurisdictional cooperative efforts for suicide prevention in Australia. The challenges include the complexity of the policy landscape and the coordination of programs and services across jurisdictions. A priority should be to improve the coordination, monitoring and evaluation of suicide prevention programs and services across Australia. This can be

done by building a national suicide prevention model upon the existing foundation through national leadership, governance and funding structures.

39 While Australia has seen significant funding and activity in suicide prevention, there persists some lack of clarity about what types of suicide prevention activities should be the responsibility of the various levels of government and the sector more broadly. As a result, all levels of government, and indeed the private sector, fund a wide range of suicide prevention activities, raising the potential for duplicative efforts.

40 Suicide prevention place-based trials are one example of this, with trial programs currently funded separately by the Australian Government, state governments and philanthropic organisations. Similarly, post-discharge aftercare, suicide awareness, gatekeeper training and the set-up and management of community suicide prevention networks are funded across jurisdictions, with local government also playing an increasing role in suicide prevention.

41 There is a need to shift the focus in all areas of suicide prevention to take a broader more proactive and balanced approach. As the Productivity Commission identified in the draft report of its inquiry into mental health: "While inevitably there will be 'grey areas', to minimise both service duplication and service gaps, pragmatic governance arrangements to enable the various parts of the mental health system to come together as envisaged under the Fifth National Mental Health and Suicide Prevention Plan are needed."[2]

42 Suicide is not only a mental health issue; there are periods in life that may be inherently stressful due to the disruption they create to a person's identity or support networks. These transitions may include: progressing from primary to secondary to post-school education or the workforce; changing employment or employment status (including retirement); becoming a parent; and experiencing a family breakdown, loss and grief. Government and non-government services often engage with people at these life-cycle transition points and research has indicated that applying a 'transitions' frame may be a useful mechanism to guide policy approaches to target people at points of vulnerability.

43 Many people in suicidal distress may not fit the criteria for mental illness and may be better understood as reacting with intense distress to life events. In these cases, treatment by a mental health specialist may not be needed or appropriate. Moving to a distress-focused, early intervention approach with appropriate care coordination and follow-up care would better meet the needs of individuals and their families. Services need to be available earlier through assertive outreach; engage a mix of clinical, non-

[2] Productivity Commission (2019). *Mental Health: Draft Report*. Canberra: Productivity Commission. https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf

clinical and peer-based workforces; be culturally safe; and be appropriate for the age, gender and broader diversity of the Australian population.

44 All states and territories collect suicide data through their coronial processes which populate data sources like the National Coronial Information System and suicide data and reports prepared by the Australian Institute of Health and Welfare and the Australian Bureau of Statistics. Several States have established suicide registries (Queensland, Tasmania, Victoria) while others are progressing towards this (New South Wales and the Northern Territory). This is a promising development; however, what is required is a nationally integrated suicide, suicide attempt, and self-harm information system. There is also a need to ensure that this data becomes available in a more timely fashion, to enable a more responsive approach to emerging and urgent needs (such as interventions to address 'clusters' of suicidal or self-harming behaviour).

45 There is a need to address critical data gaps, with a broader focus on data sets relating to suicide attempts, self-harm and associated risk factors. There is no national standard on the way emergency departments collect data on suicide attempts and self-injury. The coding of ambulance data, currently completed by Turning Point, is a critical data piece but it is not yet universally available. Collecting data on attempts could facilitate (or enhance existing) alerts for cross-portfolio involvement and can enable more significant engagement with and learnings from those with a lived experience.

46 There is evidence that suggests for each person lost to suicide, 135 may be exposed to further risk, with further research showing that losing a friend or family member to suicide increases a person's own suicide risk, as well as their risk of anxiety and depression. Postvention and bereavement support in Australia is significant but the number and location of service providers, and the availability of these services, is inconsistent and not always well-coordinated. Postvention and bereavement support models would benefit from clarification of responsibilities and an increase in the coverage and coordination of service providers through improved partnerships.

47 Aftercare support should be universally provided. Families, friends and carers are the unpaid workforce of the suicide prevention sector in Australia. The limited availability and variation of aftercare support in Australia means that families, friends and carers are required to provide intensive care coordination despite frequently lacking the expertise, resources and support to do so.

48 For aftercare to work properly, emergency departments, emergency services, outpatient and community mental health services, and general practitioners need to consider the importance of intensive aftercare support and embed this into discharge practices and care approaches. Allied health and non-health services can play an important role in this approach. Models of aftercare need to be effective for target cohorts, including

Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people with complex vulnerabilities (including family relationship difficulties and homelessness).

49 Australia has invested significantly in suicide prevention over a number of years, but the current approaches can be described as reactive and program-based, rather than comprehensive and systematic. This is evident when considering Australia's current suite of services, supports, workforce and data, all of which tend towards responding to the 'crisis' end of the spectrum.

50 Governments at all levels are demonstrating their desire to address this imbalance, through both their strategic approaches and the initiatives they are funding. To move to a more effective suicide prevention model, Australia needs to significantly enhance its capacity to deliver compassionate and evidence-based care to those in crisis, while also moving towards earlier responses and a focus on wellbeing. This will require broadening and deepening data capture (with an urgent need to collect and report attempts and self-harm data), and improvements to workforce and community capacity to appropriately identify and respond to people at risk of suicide.

51 Through my work as the National Suicide Prevention Adviser, I plan to work across governments, with the mental health and suicide prevention sectors, and the community, to deliver a comprehensive national suicide prevention model. The model will clearly define roles, responsibilities, funding, governance and accountabilities. This will enable a platform for more effective, co-designed service delivery, integrated governance, and reduction in service duplication and gaps.

52 Involving all governments in a national approach to suicide prevention is a critical task. The range of levers and mechanisms to effect a change in public policy could include legislative change, new or strengthened policies such as jurisdictional agreements and memoranda of understanding, and dedicated suicide prevention committees and advisory groups.

53 The conversations about what the national leadership and vision for suicide prevention in Australia will look like are ongoing, but their outcomes will shape the interim and final advice I provide to the Prime Minister.[3]

[3] My initial advice to the Prime Minister expands on my statement and can be found at https://www1.health.gov.au/internet/main/publishing.nsf/Content/CBD1A157EC292D9FCA2584700028CC75/$File/Report%20detailing%20key%20themes%20and%20early%20findings%20-%20for%20discussion.pdf

Service design and development

54 Primary healthcare, and the wide range of clinicians who provide it, play an important role in Vision 2030. Primary healthcare is listed as an essential component of care across all levels of need in the stepped care spectrum. This means providing skilled first points of contact within the mental health system and ongoing physical and mental healthcare for everyone regardless of their mental health status. Primary health clinicians are also an integral part of the multidisciplinary workforce delivering a broad range of other essential components of care depending on their skills, interests and community needs.

55 Vision 2030 highlights a number of key performance enablers which would be key to enhancing care responses, including primary care, to mental health consumers. These include:

- enabling integration of services and individual practitioners with shared responsibilities, connected information and interoperability of information management to enable sharing of information in real time and proactive connection to services, tertiary consultation and psychoeducation for both consumers and professionals
- ensuring workforces are appropriately trained, sufficiently resourced and actively retained with designated frontline education, connection and coordination roles that are recognised and funded as central components of the mental health system
- providing funding mechanisms that are innovative and responsive and adequately facilitate all core components of care, including coordination, consultation and support as well as direct clinical delivery
- enabling a system of data and information management that includes both system-managed and self-managed strategies, to ensure local primary, secondary and tertiary services are connected and able to make decisions based on the needs of individuals, families and communities.

56 Vision 2030 proposes a system of coordinated core components of care along a spectrum of intensity. In a person-led and person-centred approach, individuals' needs may be fluid, moving both up and down in intensity, with ongoing needs for support to lead a healthy life socially and emotionally (including recovery support) throughout their journey. This spectrum of care focuses on a person's whole journey and moves beyond treatment at specific acute periods of care.

57 To facilitate this, each community requires access to a range of essential components of care: the key supports and clinical interventions required to ensure that every individual can access personalised and effective treatment in a timely and coordinated way. Further, there is a growing international expert consensus that mental health services should be placed in the centre of their communities, closely linked or co-located where possible with primary health care, and functionally integrated with hospital-based services.

58 This necessitates a coordinated approach across all levels of government. Roles and responsibilities in the delivery of all core components of care, across all delivery mediums, should be included in national agreements, policy and funding mechanisms. Vision 2030 outlines the core components of the system which should be clearly defined and implementable through formal agreement(s) between the Australian, state and territory governments.[4]

59 A key goal of the framework set out in Vision 2030 is to address the 'missing middle'. In theory, a system that delivers upon the Vision 2030 framework should not have a 'missing middle' regardless of who funds each component of care.

60 A stocktake is required to fully understand the extent of service gaps in the 'missing middle'. This needs to include identification and tracking of all relevant measures to understand actions, impacts and outcomes. Specifically, this piece of work would require information on:

- the full range of health, psychosocial and social services and supports at both Commonwealth and state and territory levels
- program design (including participant eligibility and the extent of consumer and carer involvement)
- intended activities and actions
- funding arrangements (including identification of previous program funding subsumed into other initiatives)
- implementation status
- outcomes being achieved for participants and the system
- evaluation approaches and timeframes.

61 Addressing the 'missing middle' requires a linked-up and stepped approach across the full range of health, psychosocial and social services and supports, not just medical care. Examples of the types of supports that could be provided include:

[4] For further information, see National Mental Health Commission (2020). *Vision 2030; Blueprint for Mental Health and Suicide Prevention.* Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/27e09cfa-eb88-49ac-b4d3-9669ec74c7c6/NMHC_Vision2030_ConsultationReport_March2020_1.pdf

- building insight and individual capacity
- facilitating self-directed ways of living with and managing mental illness
- development of communication and other day-to-day skills and wellbeing
- education, vocational and employment support
- in-reach/outreach – e.g. for homelessness, other non-clinical supports
- housing and residential supports (emergency accommodation, youth residential, short stay mental health residential care)
- transport
- early intervention
- social and recreational respite.

62 Other program design features could include:

- having a low threshold or minimal requirements for engagement. This is particularly important for hard-to-reach groups with other barriers to service (such as people for whom English is not a first language, who experience alcohol and/or other drug issues, or who hold attitudes of fear or distrust of services or institutions)

- diverse, centre-based services, e.g. step-up/step-down facilities, open access clinics, crisis cafes

- mechanisms for accommodating fluctuating needs, such as a relatively quick roll-through process for clients (e.g. supports for 3–6 months, as required).

Governance

63 A number of different governance models exist across jurisdictions and at a national level. As the Royal Commission is aware, several jurisdictions have established independent mental health commissions with varying functions from commissioning mental health services to monitoring system progress and outcomes. Limited evaluation of these differing models has provided some insights, with varying conclusions regarding 'best practice' models.

64 Initial evaluation of models in New South Wales, South Australia and nationally have supported the following approaches:

- a whole-of-government governance approach, recognising the significant system reform required in order to improve mental health services outcomes and the importance of cross-agency collaboration

- combining agencies with overlapping core principles as a way of prioritising mental health promotion across agencies and enabling knowledge-sharing and economies of scale

- the need for clear delineation of standards and safety and quality functions from policy, strategy and operational functions in order to eliminate risks such as a lack of clear accountability and conflicts of interest.

65 The NMHC's current governance structure was established to provide a level of independence from central agencies responsible for administering mental health funding and programs. In a 2017 review of the NMHC, the evaluators concluded that, despite stakeholder perceptions indicating otherwise, this structure is sufficient to permit the NMHC to perform its functions of monitoring and reporting on the mental health and suicide prevention systems with an objective lens.[5]

66 The NMHC has indicated its support for the approach in the Productivity Commission's draft report to strengthening the cross-portfolio and whole-of-government efforts beyond the current health focus and governance structures. In this context, I understand that the Productivity Commission is currently reviewing NMHC's role with consideration of its potential as a multi-jurisdictional body, that is reconstituted as a statutory authority with a national evaluation role.

67 The NMHC also emphasises the need for clarity around how consumers and carers can be directly involved in system planning, design, monitoring and evaluation, which has direct implications for mental health system governance.

Commissioning

68 Mechanisms are required to ensure services are commissioned to meet the needs of the community and are integrated seamlessly from the consumer and carer perspective. Regardless of who is responsible for funding services, commissioning processes should ensure decisions are strategically aligned and coordinated.

69 The existing structures of PHNs and Local Hospital Networks (LHNs) already embedded within communities can be utilised to enable this alignment and coordination in commissioning.

70 Vision 2030 proposes a multifaceted and multi-layered system. This includes governance structures that facilitate a national framework for the delivery of diverse

[5] Deloitte (2017). *Review of the National Mental Health Commission: Final Report*. Melbourne: Department of Health. https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-s-strengthening-national-mental-health-commission

local solutions in a way that is transparent, consistent and measurable (e.g. agreements, legislation and standards).

71 The NMHC supports regional approaches to mental health commissioning but believes this needs to recognise and leverage the federated model of health care funding and care delivery.

72 For a country as geographically spread and regionally diverse as Australia, the 'real world' variations between regions are critical. For governments across all jurisdictions, there is a need for data and advice that relates clearly to the experiences and varied needs of different sub-populations and communities, within a national policy framework.

73 Vision 2030 describes a system with flexibility and responsiveness to local need, underpinned by strong national governance structures. The implementation of these structures will be considered in the accompanying Roadmap.

74 Funding is a performance enabler in Vision 2030. Vision 2030 outlines that funding models and mechanisms will consider a balanced, mixed model approach which appropriately uses program, activity and person-centred funding packages to ensure services are capable of meeting need while maximising flexibility and choice for consumers.

75 Funding models and mechanisms will:

- ensure that all services are affordable and available to everyone in an evidence-based manner
- support mental resilience within a whole-of-government system
- enable long-term funding cycles to facilitate consistency, sustainability and quality improvement
- relate to data on community need, population distribution and local gaps in service accessibility
- link funding to the demonstration of standards and achievement of outcomes
- work in coordination across sectors to ensure funding is targeted and not unnecessarily duplicated.

76 The NMHC has heard from PHNs that there is a need for commissioning services to be appropriately funded to fill service gaps and facilitate cross-sector local planning and accountability structures that incorporate consumer perspectives.

Leadership and reform

77 Over the last few years, the NMHC has prioritised work to better understand and develop a national view of lived experience engagement and participation in relation to

Australia's mental health and suicide prevention systems. Engagement and participation in practice, culture, and service delivery, which places the voice of lived experience at the centre of decision-making, is a key component of driving and leading change in mental health and suicide prevention.[6]

78 The NMHC's project *Engage and Participate in Mental Health* sought to inform, support and enhance opportunities for engagement and participation of people with a lived experience of mental ill-health and/or suicidality in decisions that impact them. A key outcome of this work was capturing the core values and principles around engagement and participation and presenting these in the form of a practical, good practice guide for use by mental health consumers and carers and by people working within the mental health system at all levels.[7]

79 A key enabler of successful engagement and participation is leadership. To create an inclusive organisational culture, this needs to come from all people and at all levels of a system but particularly from those at the top. This includes leaders from within the lived experience community and from the highest levels of organisations – board chairs, CEOs, senior clinicians, senior policy makers and research leads.

80 The guide details an approach to leadership culture and the key role that mental health consumer and carer leaders have to play to develop an inclusive culture. Strong leaders need to work together to champion engagement and participation for mental health consumers and carers. They identify opportunities, support activities and monitor the processes and outcomes. Responsibility for carrying out engagement and participation activities should be shared across an organisation, but it is the leaders who are accountable for setting the culture and modelling best practice.

81 The contributions of people with lived experience to policy, planning, service design, delivery and evaluation are central to the success of mental health reform, including the Fifth Plan. Engagement with consumers and stakeholders has been reported by PHNs as a key enabler to progress their implementation of actions under the Fifth Plan. Some examples from the PHN network (provided in the context of the NMHC's monitoring of the implementation of the Fifth Plan) reported that effective engagement with consumers and carers was a critical influence for planning, governance, and the development of frameworks. A number of PHNs also reported the willingness of consumers and stakeholders to consult and collaborate as crucial for driving change to improve mental health programs and services. This includes utilising existing formal

[6] National Mental Health Commission (2018). *Engage and Participate in Mental Health: Summary Report.* Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/7e043ebb-3618-4a0f-a1ee-300119806e21/Engage-and-Participate-in-Mental-Health

[7] National Mental Health Commission (2019). *Consumer and carer engagement: a practical guide.* Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/afef7eba-866f-4775-a386-57645bfb3453/NMHC-Consumer-and-Carer-engagement-a-practical-guide

arrangements with service providers, committees, alliances and collaborative structures to leverage work in integrated planning and delivery.[8]

82 The NMHC notes the increasing commitment, both in Australia and overseas, to move towards a whole-of-government approach to addressing wellbeing. The Productivity Commission inquiry into mental health is considering ways to coordinate a whole-of-government approach to mental health policy.

83 There is currently a fragmented approach to dealing with social determinants and their influence on mental health, with responsibility for mental health-related policies and programs dispersed across Australian Government portfolios. Lack of policy integration, pooled funding, and cross-sector accountability mechanisms impedes the development of integrated solutions. Changing these factors will require collaborative leadership across all levels of governments and across sectors.

84 Mental health and social determinants policies should not be created in silos. Under a whole-of-government approach to addressing the social determinants of mental health:

- mental health policies in portfolios relating to social determinants would be created in collaboration with different agencies and following reciprocal consideration of relevant policies
- consumers and carers, community organisations and other relevant non-government stakeholders would be appropriately consulted, and their views considered in the development of new policies
- policy outcomes would be independently monitored and reported on, with results of these processes used to refine or improve the policy and inform future policies.[9]

85 At an international level, there is collaboration between mental health and disability sectors through International Initiative for Mental Health Leadership (IIMHL) and the International Initiative for Disability Leadership (IIDL). IIMHL is an international collaborative of eight countries (Australia, Canada, England, New Zealand, Republic of Ireland, Scotland, Sweden and USA) that focuses on improving mental health, addiction and disability services and aims to provide better services to consumers and families.

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[8] National Mental Health Commission (2018). *Monitoring Mental Health and Suicide Prevention Reform: Fifth National Mental Health and Suicide Prevention Plan, 2018 Progress Report*. Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/475901fc-97d9-4419-9069-1f7bd7c25419/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan-2018-Progress-r.pdf

[9] National Mental Health Commission (2019). *Monitoring mental health and suicide prevention reform: National Report 2019*. Sydney: National Mental Health Commission. https://www.mentalhealthcommission.gov.au/getmedia/f7af1cdb-d767-4e22-8e46-de09b654072f/2019-national-report.pdf

86 The driver behind the establishment of IIMHL was a recognition that national policies and directions have often been focused on clinical practices rather than recovery through mental health leadership. Moving evidence-based practices into the service provider environment requires leaders who have the ability to promote and support the rapid changes occurring in the delivery of mental health services. With greater support for developing and demonstrating leadership, mental health leaders will develop services based on best practices and innovation and will nurture and grow future leaders.

87 In Australia, IIMHL and IIDL work together across portfolios to promote leadership through network opportunities locally and overseas. The Mental Health Principal Committee government members meet the costs of Australia's membership of the IIMHL.

88 From the NMHC's immediate experience, the Mentally Healthy Workplace Alliance provides an example of effective collaboration for mental health. Formed by the NMHC in 2013, it is a broad alliance of 15 organisations, divided between four types: industry peak bodies, mental health bodies, mental health service providers and government agencies. The Alliance came together to promote mentally healthy workplaces in Australia, and has been a key stakeholder in the growth in awareness around this issue during the 2010s.

89 The Alliance has articulated workplace mental health policy and the need for resources from government. It developed a simple action guide for employers, workers and small businesses and partnered with the major service provider, Beyond Blue, on the Heads-Up website and resource development.[10] The Alliance commissioned research on steps to improve Australian workplace mental health and has been funded by the Federal Government to undertake the four-year National Workplace Initiative. While this project is managed by the NMHC, the Alliance takes a leadership role and guides key decision points. It has recently been developing workplace mental health resource guides for the bushfire crisis and the COVID-19 pandemic.

90 Keys to the effectiveness of the Alliance lie in the commitment, influence and expertise of all members, and the willingness of all organisations to negotiate and collaborate, even where their interests differ.

91 The NMHC also plays a key role in supporting leadership in mental health through the Australian Mental Health Leaders Fellowship. The NMHC developed this program in response to an identified need for a leadership program that targets emerging leaders both within and outside the mental health sector. Prior to the development of this

[10] See https://www.headsup.org.au

program, there was no national program for emerging leaders who are working more broadly towards improving mental health.

92 The Fellowship was developed to address this gap in skills and knowledge, through a program that incorporates experiential learning, reflective practice and group activity. The NMHC engaged the University of Melbourne to deliver a custom education solution, based on robust academic research with tested and validated teaching methods.

93 This program supports those outside the traditional mental health sector boundaries, including emergency service workers, students and early career researchers, professionals in industry and finance and those working in the justice system. Participants learn how to influence positive and meaningful change through their exposure to contemporary evidence-based leadership theory, operational effectiveness principles, consumer engagement principles and involvement in reflective practice, mentoring and industry placements.

94 In the long term, the NMHC's aim is to create future leaders with the skills and confidence to tackle contemporary mental health challenges in the Australian community.

Mentally healthy workplaces

95 The NMHC agrees with the Royal Commission's description of mentally healthy workplaces, as those which promote a positive and productive workplace culture; minimise risks to employees' mental health; are supportive of people living with a mental illness; and prevent discrimination.

96 This description covers the three-pronged focus that all participants in mentally healthy workplaces need to sustain. Firstly, action is needed to promote the positive aspects of work including people feeling fulfilled, connected and contributing. Secondly, potentially harmful aspects such as bullying and discrimination must be managed and where possible, eliminated; and thirdly, people with mental illness (pre-existing or not) need to be supported.

97 Psychosocial conditions comprise a category of workplace illnesses that is expensive for employers and workers, and often has unsatisfactory outcomes. With a disproportionate share of compensation claims rejected,[11] and poor return-to-work outcomes for those accepted, the workers compensation system by itself is not an effective means to stimulate good workplace mental health.

[11] The Productivity Commission's 2019 draft report draws on State and Territory workers compensation data indicating that 35 to 45% of workers compensation claims related to mental health are rejected in comparison to between 6 to 10% of non-mental health claims. The Commission notes that the Australian Government's workers compensation scheme, Comcare, indicates rejection rates on average of nearly 60% for mental health related claims and 18% for non-mental health related claims (p. 750).

98 There is also growing evidence that the productivity of Australian workplaces is adversely affected by workplace-induced stress and psychosocial conditions, even when these are not reported or compensated. As noted in the draft report of the Productivity Commission's inquiry into mental health, some studies have estimated that the cost of unhealthy workplaces to business in Australia is in the order of $11 billion to $12.8 billion each year.[12]

99 Beyond business imperatives, Australian work health and safety requirements, workplace relations and international human rights law reinforce the fundamental principle that people's health should not be compromised by their work.

100 People with mental illness, and those who care for them, are more able to find meaningful employment in a mentally healthy workplace. Poorly-designed workplaces can exacerbate mental health symptoms. Australia has a continuing major problem in this area, with a 20% employment gap between those with mental ill-health and those without. There is a strong imperative to make Australian workplaces those where people can thrive, including those with mental illness.

101 Responsibility for workplace mental health is fragmented. Workers compensation and workplace health and safety are mainly state and territory matters, while workplace relations and international human rights obligations are Commonwealth responsibilities. Mental health services generally do not address workplace mental health issues, although this is changing.

102 The Organization for Economic Cooperation and Development (OECD) and, more recently, the Productivity Commission, have criticised the fragmented nature of workplace mental health policies and programs. The OECD has observed that:

- action to improve the employment prospects of people with mental health conditions is insufficiently integrated with mental health services and support
- the role and responsibilities of employers in protecting and improving people's mental health is under-recognised and under-valued
- young people with mental illnesses' critical transition from school to work is poorly monitored and assisted
- frequently, the federal government's role is to initiate projects and stimulate innovation, but these are too often not sustained or comprehensively integrated into the world of work.[13]

[12] Productivity Commission (2019). *Mental Health: Draft Report*. Canberra: Productivity Commission. https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf
[13] OECD (2015) *Mental health and work: Australia*. Paris: OECD Publishing. https://www.oecd.org/australia/mental-health-and-work-australia-9789264246591-en.htm

103 The National Workplace Initiative is designed to address the fragmentation of advice and resources and catalyse implementation. It will provide a high-level national framework for workplace mental health and establish a workplace hub where employers, workers and all workplace participants can easily locate resources and assistance that is evidence-informed and useful for them. A communication campaign and network of mental health champions will accompany the new hub.

104 One of the biggest challenges that the National Workplace Initiative will seek to overcome is the diversity of businesses and workplaces. Both the framework and other resources will need to balance the need to be universally applicable with being flexible and adaptable to business and workers in workplaces of widely different sizes, industries, locations and demographic compositions.

105 Australia is on the cusp of significant change in the workplace mental health area. There is more awareness of the issue, and Employee Assistance Programs (EAPs) are reporting increased usage with workplace issues now the single most common reason people give for approaching an EAP. Focus is shifting from the reactive management of sickness absence, to a more proactive effort around employee engagement and preventative initiatives. This is especially evident in large organisations where corporate leaders are implementing impressive corporation-wide policies and initiatives.[14]

106 The COVID-19 pandemic is likely to increase the momentum of this dynamic. Because of the pandemic's near-universal impact, advice about how employers and workers can manage the psychological issues associated with changed work conditions (including job loss) is very widespread. The forms of isolation required in the current period can be a risk factor for some mental health conditions, as well as the trauma and workplace stress being experienced by frontline workers in health and emergency services.

107 The Australian Government has committed significant resources to mental health supports during the pandemic, and Commonwealth and state health and safety and regulatory agencies are devoting their own funds to resources, advice and implementation assistance. Research organisations have quickly designed studies to monitor and assess people's mental health, including in remote work conditions.

108 The NMHC sees its role as being to support and catalyse where needed and, in relation to workplace mental health, to normalise positive workplace mental health strategies as part of good business practice in the post-pandemic period of rebuilding and beyond.

[14] See City Mental Health Alliance (2019). *Response to the Productivity Commission review into mental health.* https://www.pc.gov.au/__data/assets/pdf_file/0015/241260/sub471-mental-health.pdf. Note that the name of Alliance has been changed to the Corporate Mental Health Alliance.

COVID-19

109 Available evidence suggests that the COVID-19 pandemic may have a significant negative impact on health and wellbeing. Research focusing on the mental health implications of the Severe Acute Respiratory Syndrome (SARS) pandemic, for example, found that the pandemic had significant and persistent impacts on the mental health of SARS survivors and heath care workers.[15] Research also found that the SARS pandemic led to an increased risk of suicide and general distress, especially among some cohorts. For example, one study documented a significant increase in suicide deaths among people aged 65 years and older,[16] with suicide deaths more closely associated with fears of being a burden on families. Combined, this evidence suggests a need to consider the impacts on older Australians, those who contract the illness and the healthcare workforce. It also highlights the critical role of outreach support, community connections and public messaging that reduces perceptions some may have of being a burden on others.

110 The longer-term economic effects of the COVID-19 pandemic may have significant mental health impacts and have the potential to contribute to an increase in suicidal behaviour if not responded to. Research indicates that economic recessions are associated with increases in the incidence of suicide, although the impacts vary depending on the extent to which a country is affected by the recession, and the income and social protection measures available to offset the impacts of job losses and financial hardship.[17] Following the Global Financial Crisis in 2008, for example, there was an increase in suicides in high-income countries, with the impacts greatest for men, especially those ages 45–64.[18] This evidence suggests that unemployment protection measures coupled with support, especially for men, is warranted.

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[15] Lam, M. H. B. et al (2009). 'Mental morbidities and chronic fatigue in Severe Acute Respiratory Syndrome Survivors: Long-term follow-up.' *Archives of Internal Medicine*, 169(22): 2142–47; Mak, I. W. et al (2010). 'Risk factors for chronic post-traumatic stress disorder (PTSD) in SARS survivors.' *General Hospital Psychiatry*, 32(6):590–98; Wu, P. et al (2009). 'The psychological impact of the SARS epidemic on hospital employees in China: Exposure, risk perception and altruistic acceptance of risk.' *Canadian Journal of Psychiatry*, 54(5):301–11.

[16] Yip, P. S. F. et al (2010). 'The impact of epidemic outbreak: The case of Severe Acute Respiratory Syndrome (SARS) and suicide among older adults in Hong Kong.' *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 31(2):86–92.

[17] Gunnell, D. and Chang, S. S. (2016). 'Economic Recession, Unemployment, and Suicide.' In O'Connor and Pirkis, *The International Handbook of Suicide Prevention* (2nd edn). Wiley-Blackwell.

[18] Chang, S. S. et al (2013). 'Impact of 2008 global economic crisis on suicide: time trend study in 54 countries.' *BMJ*, 347:f5239.

111 Public health measures adopted to control pandemics, such as quarantine and physical distancing, can also have a negative impact on health and wellbeing. A recent literature review published in the Lancet found that quarantine measures could have negative psychological effects, including traumatic stress symptoms, confusion and anger.[19] Physical distancing requirements have resulted in people and family units being confined primarily to their homes. Many factors such as increases in overall stress, anger, self or family isolation, children being at home and increases in alcohol and drug use, result in a highly risky confluence of factors. These are all risk factors in their own right but increase significantly in combination, contributing to family violence, risk-taking behaviours and suicidal behaviour.

112 Strong evidence exists to show that public messages and communication, including media reporting, can influence suicidal behaviour.[20] Cluster and contagion behaviours have been well researched, showing that communication and portrayal of suicide can foster a social dynamic for more suicides. Media portrayals which are explicit in descriptions of suicidal behaviour and the circumstances in which it occurs can influence those who associate with the circumstances. This indicates that public messaging from governments, as well as the broader mental health and suicide prevention sector, needs to carefully considered. Suicide should not be communicated as an inevitable outcome of the pandemic.

113 There is currently limited research evidence available about the impacts of the COVID-19 pandemic on the mental health of the Australian population. However, initial surveys suggest that the pandemic has had a negative impact on mental health and wellbeing. For example, the COVID-19 Monitor study found that reported feelings of despair, fear, anger, boredom, loneliness, anxiety and stress increased significantly between March and April 2020; while feelings of optimism and happiness decreased over the same period.[21]

114 While mental health needs appear to be increasing, there has not been a commensurate increase in the number of people accessing mental health support. National mental health helplines such as Beyond Blue, Lifeline and the Kids Helpline have reported a spike in the number of people seeking mental health support, with much of this increase attributed to the COVID-19 pandemic. However, the number of people accessing mental health services has decreased. The NMHC is advised that mental health presentations to hospital emergency departments have reduced.

[19] Brooks, S. K. et al (2020). 'The psychological impact of quarantine and how to reduce it: Rapid review of the evidence.' *The Lancet,* 395(10227):912–20.
[20] See, for example, Pirkis, J. et al (2018). *Suicide and the news and information media: A critical review.* Mindframe and Everymind. https://mindframe.org.au/suicide/evidence-research
[21] Hayne, J. (2020). 'Mental health services are seeing a drop in usage amid coronavirus, despite increased anxiety.' *ABC News,* 29 April. https://www.abc.net.au/news/2020-04-29/mental-health-coronavirus-impact-beyond-blue/12196922

115 The COVID-19 pandemic has led to significant changes in the delivery of mental health services, the most notable of which has been the major expansion of telehealth services. This is a practical measure to facilitate continued access to mental health services at a time when face-to-face service delivery has become more challenging. The telehealth expansion may have the added benefit of providing increased access to mental health services in areas where local services are limited, have lengthy waiting lists or are non-existent (such as in rural, regional and remote areas).

116 The NMHC acknowledges, however, that telehealth services will not fully address mental health needs of the Australian community during the pandemic. Lack of adequate technology and facilities (such as equipment, internet and mobile data access, and a safe and private space from which to participate) and limited digital literacy may hamper access to telehealth services for some individuals. In addition, while telehealth offers an effective means of providing mental health support in some circumstances, it is not necessarily appropriate for all kinds of mental health services (particularly services for people experiencing more severe and enduring mental health challenges).

117 The impacts of the COVID-19 pandemic will continue to be experienced after the initial spread of the virus has been contained. The process of recovery will require a long-term response, of which mental health must be a central component. The NMHC is working with Australian, state and territory governments to develop a National Mental Health Pandemic Response Plan to facilitate a coordinated response to supporting the mental wellbeing of Australians during and after the pandemic. It is likely that Australia's mental health response will need to adapt and evolve over time, as the full extent and nature of mental health needs become apparent.

118 The pandemic has further highlighted (or exacerbated) some of the deficits in the existing mental health system, including the 'missing middle'. It is important that any new measures implemented to respond to the pandemic align with the principles of broader reform work currently underway. The cumulative mental health impacts of successive national crises (such as the prolonged drought and recent catastrophic bushfires) will also be a key factor affecting Australia's response.

119 The changes made to the way people access or deliver mental health services at this time, if sustained long term, hold opportunities for new approaches to mental health care – flexible in its delivery, accessible more broadly to the community, focused on the person holistically, interconnected and able to adapt quickly.

120 As Australia moves into the recovery phase, the development of responses that address social determinants and improve coordination between service sectors (such as health, housing, justice and social security) will create an opportunity to build an integrated approach to mental health that focuses more broadly on social and emotional wellbeing. These opportunities align with the focus and aims of Vision 2030.

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