Beyond Blue response to the Productivity Commission's Draft Report on Mental Health

23 January 2020

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Executive summary

Beyond Blue welcomes the opportunity to respond to the Productivity Commission's *Draft Report into Mental Health*.

The draft report was released into an environment of unprecedented community and sector expectation. Beyond Blue appreciates the scale and breadth of the Commission's task, its extensive consultation with a range of experts – people with lived experience of mental ill health and suicide, professionals and organisations – and the openness with which the Productivity Commission has invited feedback on its draft report.

Like many others, we believe the Commission's final report must present its overarching vision for reform more clearly.

If there is a single area that stands out for more attention in the final report, it is a greater emphasis on **prevention** via:

- **Primary prevention** – Initiatives and strategies to *prevent the onset or development* of mental ill-health.
- **Secondary prevention** – Initiatives and strategies to *lower the severity and duration* of an illness through early intervention.
- **Tertiary prevention** – Interventions and strategies to *reduce the impact* of mental ill-health on a person's life, through approaches such as rehabilitation and relapse prevention.

Although it is always more effective (for both cost and impact) to tackle health problems as early as possible, and ideally to stop them from occurring in the first place, the proportion of Australia's health budget allocated to Primary Prevention is only 1.34 per cent ($2B).[1] The notion that 'prevention is better than cure' may be well known but we have a long way to go before we can say prevention shapes our nation's mental health investment and measurement strategy.

Our mental health is shaped by individual and environmental attributes and actions which have psychological, behavioural, social, economic, biological and environmental dimensions: "the conditions in which people are born, grow, live, work and age...shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries."[2]

The draft report identifies many of the contributors to mental ill-health and suicidality such as unemployment, poverty, housing insecurity and homelessness, living in disadvantaged communities or belonging to groups that experience systemic discrimination and prejudice. However, we also believe more emphasis must be placed on social determinants and the integration of systems to produce better outcomes for people.

Further, the draft report's focus on the *systems responsible for treating mental illness* means missing the chance to stop the deterioration of mental health before it happens. People who develop mental health conditions should be able to access high quality support and treatment when they need it, wherever they live. But they should also be given the best opportunity possible to live mentally healthy lives free from the avoidable circumstances that give rise to psychological distress. This should be the first and primary goal of any national strategy to tackle Australia's mental health.

Therefore, Beyond Blue challenges the Productivity Commission to keep moving the focus towards prevention and early intervention; to prosecute the case more ardently for solutions which are always more economically beneficial, as well as achieving better outcomes for individuals and society; and, in particular, make recommendations that build up the psychosocial, community-based structures and investments that are significantly lacking in the current 'system'.

Our submission identifies five critical areas for further attention and makes recommendations to address them:

1. Interventions in early childhood and school education

(i) A comprehensive national system to support the social and emotional wellbeing of children 0-12, their parents and carers

No area of policy offers greater potential to change Australia's mental health trajectory than preventing mental health conditions occurring early in life. Around 50 per cent of mental health conditions arise before the age of 14. There are evidence-based approaches that work and deliver very high rates of return on investment, yet a comprehensive and embedded system of prevention and early intervention is yet to be built.

The Commission's recommendations for universal screening of children and parents, and more parent education programs in family and children health services are positive and welcomed. However, much more comprehensive reform is required if Australia is to create a system and culture where parents and caregivers are equipped to support children to thrive across all the transitions in their lives.

In the pages that follow, we provide detailed analysis of the existing system, which extends well beyond parent education in child and family health services. In each of the critical areas – primary prevention, early intervention and support for children and families with higher needs – there are a plethora of programs providing high impact, evidence-based outcomes. Initiatives include online information and support for parents, home visiting, screening, helplines, coaches and much more. Yet the system is fragmented, service coverage is sparse, and programs are funded through a range of piecemeal funding mechanisms across all levels of government and struggle to achieve scale and impact. Collectively, these programs are not strategically and holistically designed in such a way that a powerful national system of support can emerge.

Given what is at stake, a major national policy reform agenda is needed to bring these promising fragments together into a comprehensive national system that supports everyone to raise thriving children and fundamentally shift the prevalence and lifelong effects of mental health issues.

Recommendation 1 (in summary):

- The Productivity Commission sets out a plan for the development of the National Children's Mental Health and Wellbeing Strategy by recommending that Commonwealth, state and territory governments work together to build and fund long-term a comprehensive national system to support the social and emotional wellbeing of children 0-12, their parents and caregivers, including: (i) universal primary prevention; (ii) early intervention; (iii) support for children and families/caregivers with higher needs.
- Australian governments: (i) audit existing services, their funding sources and coverage; (ii) develop the policy and program architecture to deliver a national system of support for children 0-12 and their parents; and (iii) evaluate, continuously learn, and refine as the system is developed.
- The Productivity Commission highlights the risk of the National Children's Mental Health and Wellbeing Strategy focusing predominantly on clinical support after children have become mentally unwell, without substantially reducing the incidence of mental ill health through prevention and earlier intervention.

(ii) Supporting children and young people during their school years

Beyond Blue welcomes the strong focus the Commission gives to supporting children in their school years. However, we note that the Commission identifies the continuing fragmentation in the system, but could provide more powerful recommendations to address it.

Be You provides, for the first time, a unified national framework free to every Australian early learning service, primary and secondary school. Launched in November 2018 and funded by the Commonwealth, Be You aims to support all early learning services and schools to develop the skills and strategies to become

mentally healthy learning communities. It focuses on increasing the knowledge, skills and confidence of educators so they can build stronger social and emotional skills in the children and young people they teach; to embed social and emotional learning in pedagogy and practice; and to lift literacy and action across the whole learning community so children and young people can thrive and be supported to deal with mental health issues. The accredited professional development package is supported by 70 trained staff around the country to help services and schools develop individualised strategies and action plans.

Be You addresses many issues highlighted by the National Mental Health Commission's 2014 review of mental health programs and services, *Contributing Lives, Thriving Communities,* which noted the plethora, and siloed implementation, of initiatives in early learning and schools, and called for better integration and consolidation.[3]

Be You integrates a number of preceding national programs with the explicit aim of establishing one national initiative for the education settings from birth to 18 years. It is integrated and end-to-end across the continuum of age, career stage and need: from the early years to age 18; from pre-service teachers in tertiary studies to the most experienced educators; and from promotion, prevention and early intervention to postvention support in the case of a death or critical incident in a school community.

It is evidence based and is designed to deliver in practice the recommendations of global experts. The 2018 report of The Lancet Commission on Global Mental Health and Sustainable Development states the most effective universal social and emotional learning interventions use a whole-school approach in which social and emotional learning is supported by a school ethos and a physical and social environment that is health enabling involving staff, students, parents, and the local community.[4]

Just 13 months after launch, more than 95,000 individuals and 9,300 early learning services and schools across Australia have registered with Be You (representing one in five of all early learning services and two thirds of all schools) and growing strongly. It has the backing of education stakeholders and influencers, including education departments, who are supporting its governance and evolution.

Be You has confirmed funding to June 2021 and is currently led and managed by Beyond Blue and service delivery partners Early Childhood Australia and headspace. With the explicit backing of all governments, and a commitment of Commonwealth investment for the long term (regardless of who is contracted to deliver it), and planned complementary investments by jurisdictions (especially in more age-appropriate specialist services for children and young people and educator mental health), Be You has the potential over the longer term to resolve the fragmentation of mental health responses in education settings the Commission refers to in its draft report.

Recommendation 2:

The Productivity Commission, to drive a systemic and planned effort to tackle the fragmentation of mental health support in education settings, recommends that:

- COAG Education Ministers explicitly adopt Be You as the overarching national mental health in education framework to support early learning services and schools**;**
- Be You be funded for the longer-term by the Commonwealth, with ongoing review and evaluation of outcomes; and
- states and territories plan with the Commonwealth and Be You providers to make complementary investments (especially in more age-appropriate specialist services for children and young people and educator mental health).

2. Mentally healthy workplaces

Beyond Blue welcomes the workplace health and safety reforms recommended by the Commission but believes much more must be done to support workplaces to go beyond minimum legal compliance.

In particular, employers can help prevent mental health conditions from arising in the first place by developing positive and supportive workplace cultures, policies and practices that help workers to thrive and contribute.

Beyond Blue refers the Productivity Commission to the submissions made by the Mentally Healthy Workplace Alliance for more detail on these arguments. The Alliance's response to the draft report addresses two key themes: (1) Overcoming the barriers to creating mentally healthy workplaces; and (2) Acknowledging the benefits of a thriving workplace.

Many employers are keen to take action but are overwhelmed by the volume of information and confused about what to do and who to turn to for support. The National Workplace Initiative (NWI), funded in the 2018-19 Federal Budget to be delivered by the National Mental Health Commission with support from the Mentally Healthy Workplace Alliance, is the opportunity to address this confusion.

The NWI aims to provide a single integrated framework and implementation support to catalyse adoption of evidence based mental health strategies across Australian workplaces. The NWI will build on the international example of the Canadian Standard for Psychological Health and Safety in the Workplace and the lessons learned from its design and implementation. By supporting Australia's 13 million workers, the NWI has potential to significantly improve mental health, lift productivity and participation (current costs of workplace mental ill health exceed $40 billion per annum). The need for the NWI was identified by several years of engagement and consultation by the Alliance with business of all sizes, the mental health sector, unions, and work safety organisations.

Recommendation 3:

The Productivity Commission recommends that Commonwealth, state and territory governments endorse the development of the National Workplace Initiative as the single national framework to drive adoption of mental health strategies in workplaces across Australia.

In addition, Beyond Blue supports the three recommendations of the Mentally Healthy Workplace Alliance:

Alliance Recommendation 1: Request that the final report references the National Workplace Initiative, funded in the 2019-20 Federal Budget, and recognise the promise of the NWI to strengthen sector collaboration to address fragmentation and confusion.

Alliance Recommendation 2: Request that the Productivity Commission recommend further government support for NWI Implementation assistance in the final report. Implementation assistance is needed early in the project development to maximise usability design, relevance and impact for all businesses in Australia.

Alliance Recommendation 3: That the final report includes a recommendation encouraging an integrated, preventative mental health approach whereby workplaces are supported by appropriate stakeholders to develop beyond existing mandatory Work Health and Safety (WHS) laws that are tailored for specific workplace needs to help create thriving workplaces.

3. Matching the right level and type of care: building the low intensity mental health system

Beyond Blue welcomes the Productivity Commission's: emphasis on the stepped care model and the need to build up the low intensity mental health system; estimate that 450,000 people being treated through Better Access would ideally receive low intensity support; and recognition that while low intensity support is the primary need for large parts of the population, relatively few low intensity supports are available.

However, Beyond Blue urges the Commission to address the following elements in its final report:

- Set out a reform agenda to address the current impediments – including community and provider education and awareness of low intensity options; linkages to and integration with the clinical system; low intensity workforce training, supervision, development and career structures; and accreditation of services – that need to be addressed so a comprehensive national low intensity system can emerge as part of a complete stepped care system. Our analysis below provides more detail of these impediments and how they can be addressed.
- Move past the draft report's recommendation for expansion of just one type of support – 150,000 places for clinician supported online treatment – to the service options the Productivity Commission notes people want, including coaching through three modalities: face-to-face, online and over-the-phone.
- Prosecute fully the case for the value of and opportunities created by low intensity supports. As The Lancet Commission advocates, much of the value of low intensity services comes from the creation of new, non-specialist workforces who deliver high impact, high quality and complementary support at a lower cost than traditional services. This includes: peer-to-peer support, coaches helping people with mild-to-moderate depression or anxiety to recover using evidence-based CBT techniques; or community-based support workers helping people get back on track after a suicide attempt. The important thing is that these workforces are well trained and receive appropriate support and supervision, not that they must always be clinically qualified.[5] The investment in low intensity workforces will also assist with the current maldistribution of current workforces, especially in regional and rural areas, and also supports job creation and participation.
- Recognise the institutional failure in the nation's funding system that is preventing the emergence of low intensity supports. While universal clinical services are essentially demand driven through Better Access and expanding rapidly, PHN funding for low intensity services is capped at a level that can never allow a comprehensive low intensity system to emerge. Requiring providers to seek limited funding from 31 different sources prevents meaningful expansion and the ability to tap the economies of scale that fully realise the cost-effectiveness of low intensity service offerings.
- Include a plan to meet the population's need for services over the longer term.
- Provides the case for, and not understate, the power of CBT coaching. For example, New Access consistently delivers around 70per cent recovery rates and at $84 per session will be cost-effective at scale. The UK's Improving Access to Psychological Therapies (IAPT) experience shows the ability to scale – now operating in all 209 local health regions in England, having served 1.1 million people over 10 years. (See box 3.2 below for full analysis.)

Recommendation 4:

The Commonwealth Government – in partnership with state and territory governments – should commit to, and fund, the development of a national strategy to build a comprehensive low intensity mental health system in Australia, including:

- Developing the key sector microeconomic foundations to address structural impediments.
- National funding to allow for the rapid, cost-effective national expansion of proven low intensity services, while requiring robust outcome measures to ensure only high impact services retain funding.
- Expanding the full suite of evidence-based interventions people want – coaching/support face-to-face, online or over the phone – not simply clinician supported online treatment.

4. Suicide prevention

Beyond Blue welcomes the significant reforms recommended by the Commission in its draft report, including universal aftercare. We believe there are three areas in which even stronger reform could be recommended in its final report.

Recommendation 5:

The Commonwealth Government – in close partnership with state and territory governments – develop a national suicide prevention system including:

- Tailored support for three vulnerable groups: (i) people who have attempted suicide; (ii) the 600,000 people in Australia experiencing suicidal ideation; and (iii) people in pre-suicidal distress.

  Universal aftercare is a landmark reform, but to make further major inroads into the suicide toll, we need to reach further back into prevention, helping people before they attempt to take their lives.

- Ensuring each person in distress has an option that suits their needs: online information; phone/text; community safe spaces including peer-led models and residential support; a distress brief intervention; and co-response teams supporting police, ambulance and emergency services personnel.

  Providing a range of choices and channels and scaling up different models using different workforces is critical to different outcomes. For instance, a recent trial of the use of text by Lifeline showed 42 per cent of service users would not have sought help had text not been available.[6] Expanding the options available is critical to reaching more people with support when they need it most.

- Bringing the suicide prevention sector together to develop a visible national system, available to *anyone* in distress, through a number of integrated, highly visible entry points and supported by a community which feels more equipped and confident to talk about suicide and play an active role in preventing suicide.

  There are two critical drivers for this reform: (i) Too many people die by suicide without the people around them knowing they were suicidal and without having services and supports that may have helped them to keep living. We cannot always expect people in suicidal distress to reach out for help; we need to equip everyone in the community to know how to reach in to them. We need clearly signposted options and entry points to support that everyone knows about. (ii) Australia is set to expand its investment in suicide prevention. It is essential the result is not more programmatic investment, leading to greater fragmentation and confusion, but rather systemic planning and investment.

5. Pursuing equity and tackling discrimination

(i) Aboriginal and Torres Strait Islander social and emotional wellbeing

The Commission could build on its draft recommendations in the following ways in its final report:

Recommendation 6:

The Commonwealth Government should:

- Provide an increase in funding and long-term funding certainty to Aboriginal Community Controlled Organisations (ACCHOs) sufficient for them to meet the demand for locally relevant social and emotional wellbeing supports and services in their communities, including programs that support connection to culture.
- Fund the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017-2023.
- Embed Aboriginal and Torres Strait Islander leadership across the mental health system.
- Fund and foster local partnerships between mainstream services and ACCHOs to increase cultural competence in mainstream services, as well as improve service integration for Aboriginal and Torres Strait Islander people.

- Establish the formal structures necessary to give effect to a First Nations Voice at all levels of government, so that Indigenous Australians can develop policies that affect them in partnership with Australian governments.

The Council of Australian Governments should:

- Ensure the Close the Gap refresh: is developed in close partnership with Aboriginal and Torres Strait Islander people; includes social and emotional wellbeing targets; and delivers comprehensive reform and funding to close the gap in life outcomes, critical in its own right, and central to supporting social and emotional wellbeing.

(ii) **Insurance discrimination**

Beyond Blue welcomes the Commission's proposal for the Australian Securities and Investment Commission (ASIC) to review insurance industry codes and practices but is concerned that the review's outcomes may not go far enough.

Recommendation 7:

- Ensure the proposed review of industry codes by the Australian Securities and Investment Commission (ASIC) also includes consideration of the legal enforceability of parts of the code, as recommended by the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry.
- The findings of ASIC's review must be fully resourced so that future regulation and enforcement of codes of practice are effective and efficient.
- Life insurers should not be supported to fund treatment (DR 24.6) until after the ASIC review is complete, strong regulations are in place and insurers have consistently and comprehensively demonstrated that their industry understands mental health in its diversity and is using valid statistical and actuarial data to support decision making.

1. Interventions in early childhood and school education

Mental health and wellbeing in early childhood and preschool

Beyond Blue welcomes the Productivity Commission's recommendations on *Interventions in early childhood and school education*. We support the recognition of the seminal importance of social and emotional development in early childhood, as well as the recommendations on:

- universal screening for children, parents and caregivers to support early intervention;
- expanding parent education programs in child and family health centres.

However, bolder action is required. The Commission has a great opportunity to guide Australian governments – including in the context of the development of the *Children's Mental Health and Wellbeing Strategy* – on how to build a comprehensive national system to support children 0-12, their parents and caregivers.

Recommendations

1. The Productivity Commission sets out a plan for the development of the National Children's Mental Health and Wellbeing Strategy by recommending that **Commonwealth, state and territory governments work together to build and fund a comprehensive national system to support the social and emotional wellbeing of children 0-12, their parents and caregivers including:**

(i) **Universal primary prevention**

- Preparing new parents for their critical new role – both to protect their own wellbeing in the perinatal period as they adjust to one of life's greatest transitions – and to ensure they have the skills and knowledge to support their child during pregnancy and in the pivotal first 1,000 days of their life;
- Creating a system and culture where every parent and caregiver can consistently access the easily digestible, evidence-based information and support they need to protect the mental health and wellbeing of their children and support them to thrive. A comprehensive, integrated national system should include exceptional online information, education, home visiting and coaching to help parents and caregivers support children through their key developmental transition points.

(ii) **Early intervention**

- Implementing universal screening to ensure we can identify and provide early intervention for children and parents in need of support;
- Providing a national system to enable children to get the support they need to recover from mental health challenges, including through educating and empowering parents and caregivers to support their children's wellbeing.

(iii) **Support for children and families with higher needs**

- A mix of additional home visits, family support, intensive parenting programs, peer support and integrated social services can help children and families with higher needs to stabilise and set goals for a brighter future.

2. **The Productivity Commission should recommend that Australian governments:**

(i) **Audit existing service coverage –** identifying existing programs across each of universal prevention, early intervention and support for families in greatest need; their coverage across Australia; and how they are funded. Our analysis indicates there are programs providing high impact evidence-based outcomes, but the system is fragmented, service coverage is sparse, and programs are funded through a range of piecemeal funding mechanisms across all levels of government. Collectively,

these programs are not strategically and holistically designed in such a way that a powerful national system of support can emerge.

(ii) **Develop the policy and program architecture to deliver a national system of support for children aged 0-12, their parents and caregivers**, including clarity of roles between levels of government, a mechanism to drive and monitor implementation, and a simple funding mechanism to deliver national coverage of the most effective programs in each of the three areas.

(iii) **Evaluate, continuously learn, and refine as the system is developed.** Building this national system will be challenging and complex. In some areas, we can draw on best practice, while in others pioneering approaches which are evidence-informed, rather than proven, will be required to build parts of the system that barely exist. In this context, robust evaluation, learning and refinement will be critical.

3. **The Productivity Commission highlights the risk of the National Children's Mental Health and Wellbeing Strategy focusing predominantly on clinical support after children have become mentally unwell, without substantially reducing the incidence of mental ill health through prevention and earlier intervention.**

Children who develop more severe and complex mental health issues should be able to receive high quality, specialist treatment. However, building a better, more mentally healthy future for children will not be achieved just by adding more clinical capacity to current systems. In many cases, negative developmental trajectories can be avoided by investing proactively, so that parents, caregivers and communities are better equipped to raise thriving children. Addressing the "prevention gap" can significantly reduce the incidence of mental ill health by fostering children's mental health and wellbeing, and addressing the underlying risk and protective factors which contribute to social and emotional development.

What could a national system to improve childhood mental health look like?

The national system should bring together existing services and programs in an integrated child and family health model that includes the following action areas:

Action area 1: **Primary prevention**	Action area 2: **Early intervention**	Action area 3: **Support for children and families with higher needs**
Promoting positive social and emotional development and preventing the occurrence of mental health issues from developing in the first place.	*Enabling early detection and treatment of social and emotional challenges in children as risk factors are identified and at key transition points.*	*Connecting children and families who have higher or more complex needs with the support they need.*
1a. Creating healthy environments for children to grow and develop by addressing risks and investing in local communities 1b. Encouraging parents and caregivers to seek information, advice and support as a normal part of parenting 1c. Expanded community outreach to support parents and caregivers	2a. Supporting parents' mental health 2b. Expanded child health checks 2c. Additional home visiting support 2d. Early intervention parenting programs 2e. Parent helplines 2f. Parent coaches	3a. Additional home visits 3b. Additional family support 3c. Multi-faceted parenting programs 3d. Peer support for parents 3e. Integrated social services
National health promotion campaign to encourage positive parenting		

Detail on elements of the system

Below we set out each of these elements in detail to show that many promising elements of the system exist at small scale, but comprehensive policy work is required to take identify the most high-impact initiatives and build them into a powerful national system to support the social and emotional wellbeing of children across Australia.

Threshold Action: Addressing stigma and building literacy on positive parenting

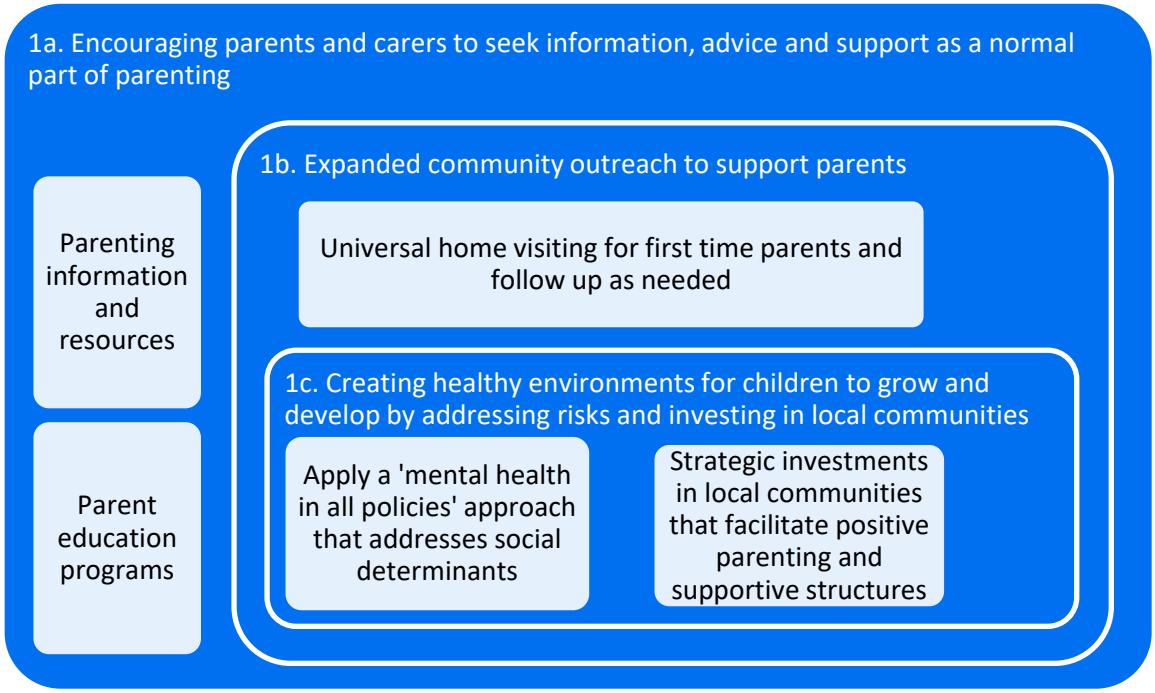
Currently, a widespread cultural expectation that parenting is innate discourages help-seeking and investing in parenting development. In this environment, parents may react defensively, rather than embrace opportunities and empathetic support to improve their skills and capacity. To underpin the acceptance and take up of the national system outlined below, we need **a national health promotion initiative** to encourage positive parenting behaviours, increase mental health literacy and normalise parental help-seeking through peer and professional networks.

Action area 1: Primary prevention

Promoting positive social and emotional development and preventing the occurrence of mental health issues from developing in the first place.

What needs to be done?

There are existing services and programs operating under all three levels of government that provide a solid foundation to build an integrated system of prevention. These include child health checks, immunisations and various parenting programs. However, many do not operate at the scale required, are based on short term funding and are not widely known or accessed – all limitations that could be addressed through the introduction of a national system.



1a. Encourage parents and carers to seek information, advice and support as a normal part of parenting

Underpinning this strategy is the widespread availability of **parenting information and resources**, as well as **parent education programs**. Both of these already exist but require national promotion and funding to bring them up to the universal standard required for more effective prevention.

Parenting information and resources

- Australia has several outstanding parenting websites that provide practical, simple, evidence-based information and advice for parents to help them thrive and support their children thrive from pre-natal to early adulthood.

- While these sites are helping hundreds of thousands of families each year, the key now is to expand access and use, to create a culture where parents routinely seek advice to support children through their key transitions. This can be achieved through: stronger national promotion; ensuring materials are tailored to suit all families; and creating a broader suite of entry points and options (websites, videos, apps, podcasts and social media).

Box 1.2: Examples of successful parenting information and resources:

Raising Children Network provides up-to-date, evidence-based information for parents about raising children, including information on pregnancy and birth, the early years, older children and teens, and children with additional needs. There are specific resources on parent and caregiver wellbeing. Key partners include the Centre for Adolescent Health, Victorian Department of Education and Training, NSW Kids and Families and Stepfamilies Australia.

The Beyond Blue **Healthy Families** website offers parents and caregivers the latest evidence-based information about children and young people, as well as their own mental health. An independent evaluation of the Healthy Families website[7] showed the information has resulted in parents and caregivers taking positive action to support the health of the children in their care. In 2018-19 there were around 420,000 visits to the website, with 80 per cent reporting more involvement in their child's life. In 2019, the Beyond Blue website received over 50,000 completions of the online Mums Mental Health Checklist (the Edinburgh Perinatal Anxiety and Depression checklist).

Parent education programs

- Better parent information should be complemented by more active learning opportunities that encourage peer support and community networks.
- There are many programs that have established a good evidence base, but awareness, availability and cost can be restrictive. Evidence-based programs, such as those listed online by the Australian Institute of Family Studies for Communities for Children[8] and *Nest* – What Works for Kids?,[9] should be scaled up with long-term funding, to improve access for every parent. Examples are provided below:

Box 1.3: Example of successful parenting education programs

Triple P is a universal prevention program that aims to increase the skills and confidence of parents to prevent the development of serious behavioural and emotional problems in their children. Triple P has five levels of intensity. The first level aims to increase awareness of parenting resources and inform parents about solutions to common behavioural problems. Levels two and three are primary health care interventions for children with mild behavioural difficulties, and levels four and five are more intensive individual- or class-based parenting programs for families of children with more challenging behaviour problems. http://whatworksforkids.org.au/program/triple-p-positive-parenting-program

Resilient Families is a school-based prevention program designed to help students and parents develop knowledge, skills and support networks that promote health, wellbeing and education during the school years. The program is designed to promote social, emotional and academic competence and to prevent health and social problems among children. For more information, see: http://whatworksforkids.org.au/program/the-resilient-families-program

1b. Expanded community outreach to support parents

All first-time parents and anyone who requests it for subsequent children should have the benefit of home visits by family and child health services. This is working well in Victoria where reports indicate that almost all children enrolled in Maternal and Child Health Services received the first home consultation and more than 90 per cent received the 4-month old check.[10]

1c. Creating healthy environments for children to grow and develop by addressing risks and investing in local communities

- The policies and actions of many areas of governments can affect the mental health and wellbeing of individuals, so creating the best opportunities for children to thrive should not be isolated to the health

sector. Siloed structures within and between governments can result in fragmented services and fail to build positive, holistic family-oriented communities for raising children.

- Recognising the impact of social determinants on mental health means that preventive strategies that do not take these wider contexts into account can only achieve partial success. People who already experience worse social and economic outcomes become more disadvantaged when preventive health strategies do not address social determinants.
- The National Children's Mental Health and Wellbeing Strategy must recognise and act to address known risks beyond the health portfolio (including housing, food security, family violence, child protection and justice) in order to advance prevention efforts and ensure the best futures for Australia's children.
- The World Health Organization's **'Health in All Policies'** (HiAP) approach is a systematic way for governments to join up health, social and economic policies across government sectors, to deliver greater and more equitable health outcomes for communities and individuals.[11]
- The HiAP approach supports 'win-win' policy actions between health and non-health sectors, bringing together different services to provide better support, at a larger scale and to reduce unintended consequences of isolated policies. It has been applied to a wide range of areas by the South Australian Government,[12] and a specific approach to **'Mental Health in All Policies'** has been developed in Europe to guide joint action on promoting mental wellbeing and preventing mental ill-health.[13]
- A Mental Health in All Policies approach should be reflected in the **National Children's Mental Health and Wellbeing Strategy** and related national strategies under development such as the National Preventive Health Strategy and the National Childhood Obesity strategy. Opportunities to integrate this approach with existing national, state and territory plans, such as the National Framework for Child and Family Health Services and New South Wales Government's First 2,000 Days: conception to five years strategy[14] should also be considered.
- **Community mobilisation** is a community development approach that has been applied in varying contexts around the world to successfully address health and social issues including family violence,[15] youth crime[16] and underage drinking.[17] As a universal primary prevention activity, it alleviates the pressure and stigma placed on parents by more targeted programs, recognising the wider community context in which children are raised and the variety of social and environmental influences that impact child development. It is embodied in the notion that "it takes a village to raise a child".
- Community mobilisation approaches can be used to generate organic conversations about positive parenting strategies in natural environments where parents and children gather including child and family health centres, early learning services and schools, as well as sporting clubs or the local pool. This can help to prepare and equip parents for the task of raising mentally healthy children, as well as ensuring that they attend to their own wellbeing, which is vital to sustaining a positive family environment.
- The Communities for Children initiative shows how place-based approaches can be used to mobilise communities, strengthen families and connect parents with peers, educators and services.

Box 1.1: Communities for Children

A place-based intervention in 45 local communities, Communities for Children initiative was delivered as part of the Australian Government's Stronger Families and Communities Strategy. The model included strong connections with local families and service providers using a place-based approach, to identify and address unmet support for children and families. The model included Facilitating Partners to oversee local planning, and Community Partners to deliver local activities and outreach services.

The Stronger Families in Australia study showed that by focussing on increasing local partnerships to support families, Communities for Children increased the number, type and capacity of services available to support local families.[18]

The case for prevention

1. **Prevention** is the key to raising our most thriving generation of young people and reducing the **incidence** of mental health conditions in Australia.

- Support for families during pregnancy and the pivotal first 1,000 days of early childhood, has the greatest potential to impact health and wellbeing throughout our lives.[19]
- Half of all mental health issues emerge by age 14[20] and around three-quarters before the age of 25.[21] 45 per cent of the population are experiencing mental health conditions in their lifetimes.
- Adverse childhood experiences and trauma have lifelong effects – child maltreatment accounts for between 16 to 33 per cent of depression, anxiety and self-harm in Australian adults.[22]
- Students with persistent emotional or behavioural problems in Year 3, fall behind by about 7 to 11 months compared with those not affected, and this gap widens up to 2.8 years by the time children reach year 9.[23] This education gap can persist or worsen across a child's education. [24]
- Support for families cannot wait until after children are experiencing difficulties. Only *preventing* adverse childhood experiences and other conditions that negatively impact mental health can fundamentally shift the nation's mental health trajectory.
- In addition to tackling risks, attention should be paid to the evidence-based protective factors which are known to help to children thrive – including a strong parent-child bond, feeling safe and valued, sleep, nutrition, movement and physical activity.[25]

2. Parents are a powerful influence on children's wellbeing and should be supported to help their children thrive.

- The family and family environment are the main sources of children's experience and the primary influence on children's development.
- Parents love their children and work hard to help them thrive but raising children can be challenging. To excel, it requires building knowledge and skills – supporting children across a raft of transitions (newborns, babies, toddlers, pre-schoolers, school age, pre-teen and teens) with ever changing development needs requiring understanding across multiple fields (such as nutrition, relationships, mental health, physical exercise, child development, behaviour management, conflict management, safety, role modelling, communication, mentoring, social media, supporting learning and more).
- Currently, we have no system to support parents to prepare for the journey, or help children navigate key transition points and thrive.
- The National Mental Health Commission (2014) reported that: "*There remains a critical gap for children aged from birth to 12 years, both for the child and for parents who need to be supported to maximise their child's development and wellbeing.*"[26]

3. Evidence-based prevention in early childhood can deliver a significant return on investment for individual wellbeing and the economy.

- The prevalence and impact of mental health issues in our nation's youngest are enough alone to justify urgent and decisive attention. However, there is also a compelling economic argument. KPMG's *Investing to Save* report, commissioned by Mental Health Australia (2018), suggests that reducing childhood mental health issues could save around $48 billion per year, a return on investment of $7.90 for every dollar invested.[27]
- A range of high-quality systematic reviews have demonstrated that preventative approaches have consistently significant effects in reducing anxiety, depression and internalising symptoms and disorders in children and adolescents.[28]

Action area 2: Early intervention

Enabling early detection and treatment of social and emotional challenges in children as risk factors are identified and at key transition points.

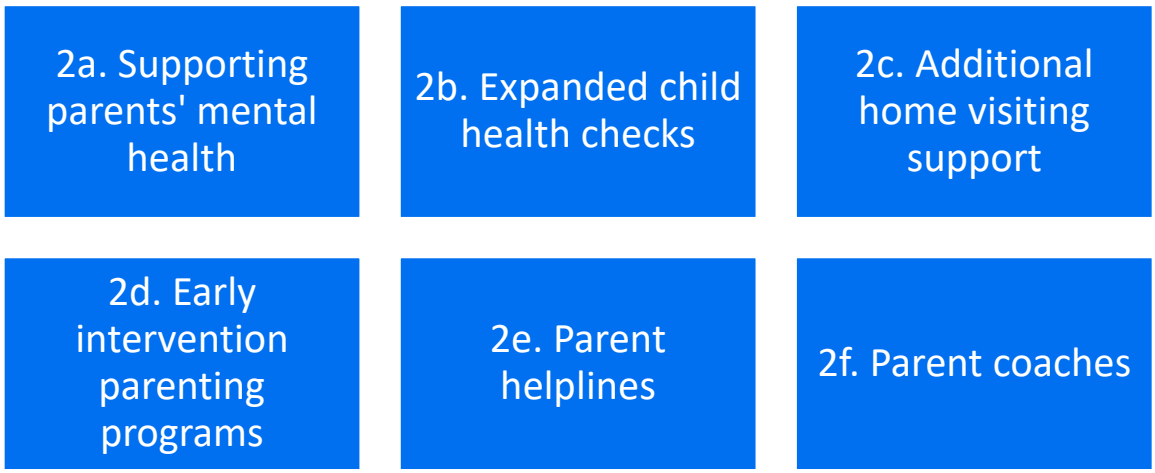


Figure 1: Expanding the range of early intervention opportunities

What needs to be done?

A critical part of an integrated system of support is detecting known risk factors and linking families who need help with **early intervention.** While the achievement of universal wellbeing checks for all new parents in Australia would be a significant step, connecting families to comprehensive support is also required to enable more parents to access the right information and resources they need to raise happy and healthy children. The national health promotion initiative mentioned above will play a crucial role in tackling the stigma, shame and fear of judgement and institutional intervention that often act as barriers to parental help-seeking.

2a. Supporting parents' mental health

Mental health and wellbeing are critical for new parents, and for the mental health of their children. Beyond Blue supports the Commission's recommendation to include mental health checks for new parents through existing child and mental health services and channels including online screening to promote universal access.

- Mental health checks could also be integrated into existing prenatal and perinatal health services, such as antenatal classes, early parenting education and assessments by allied health professionals.
- Mental health checks should be complemented by priority access to mental health support for parents, when it is required. A range of prenatal and perinatal mental health resources should be widely available to inform parents and to ensure best practice approaches are offered by family health professionals such as General Practitioners and Child and Family Health Nurses.

2b. Expanded child health checks

The Commission's recommendation to expand children's health checks to include social and emotional development milestones is a welcome proposal that finally recognises the importance of mental wellbeing alongside physical development. Expanded children's health checks should:

- Be conducted sensitively, as part of existing child health checks, with a focus on supportive and inclusive services for families.
- Be framed positively as tools to support children's development rather than judgement on family functioning.
- Be linked to a range of accessible resources and supports so that all families get the help they need to invest positively in raising mentally healthy children. All visiting families should receive information about trusted sources of parenting advice, as well as options for support, in-person, on the phone and online.

2c. Additional home visiting support

- One of the supports available to families when indicated through screening (or on request) should be additional home visits by family and child health staff. Home visits can make support more accessible for families at greater risk and those that might struggle to get to family and child health centre appointments. It also allows responses to be tailored to the specific home environment.
- Additional home visiting, such as the right@home program, which is provided as part of existing early childhood services has been shown to benefit child development during the early years. The right@home program identified and assisted women at greater risk of adversity during pregnancy. A randomised trial showed that additional home visiting over the first two years, resulted in improved key outcomes including parenting care and responsivity, and in the home learning environment for families at risk of adversities.[29] See also Box 1.6 in Section 3a.

2d. Early intervention parenting programs

- Effective, **early intervention parenting programs** for children and/or families, can improve resilience and children's social and emotional development.
- There are many programs that have established a good evidence base, but awareness, availability and cost can be restrictive. Evidence-based early intervention programs, including those compiled by the Australian Institute of Family Studies (AIFS) for Communities for Children[30], should be scaled up and funded, so that every family experiencing early or emerging challenges with children's social and emotional development gets support and guidance without current accessibility barriers.

Box 1.4: Examples of evidence-based early intervention parenting programs

- **Exploring Together** – This is a short-term, multi-group, early intervention program for children at risk of developing serious emotional and behavioural problems, their parents/carers and teachers. It targets children between **6 and 14 years of age**. The program focuses on developing children's social skills and reducing their problematic behaviour, enhancing parenting practices, and strengthening family units. For more information, see: www.exploringtogether.com.au and http://whatworksforkids.org.au/program/exploring-together-primary-school-program
- **Families and Schools Together** – This is a multi-family **after school program** intended to increase parents' involvement in school and their child's education, increase parent-child bonding and communication, and enhance parents' self-efficacy. Groups of 8 to 12 families meet weekly for eight consecutive weeks. Sessions last about 2½ hours and take place after school or early in the evening. Trained facilitators conduct the meetings, which involve experiential learning, parent-child play, and a shared meal. The initial eight weeks are followed by two years of monthly parent-led meetings. For more information: http://whatworksforkids.org.au/program/families-and-schools-together-fast-0

2e. Parent helplines

- While each state and territory has a parenting helpline, it is not clear that these are utilised or resourced to be as effective as possible. A Victorian study showed that less than 20 per cent of parents surveyed had ever used a phone helpline.[31]
- Helplines have potential to cover the full spectrum of advice and support, from universal wellbeing to families in crisis requiring more intensive support.
- Having a single national phone number that was linked to back-end supports with follow up capacity for more severe and complex cases could significantly help struggling parents at critical times. For instance, a father experiencing difficulties with his teenage daughter might be connected to ReachOut Parents or, if the issue was related to an eating disorder, the Butterfly Foundation. A single entry-point would also enable national promotion and coordination, increasing cost effectiveness through scale efficiencies.

2f. Parent coaches

- While **parent coaching models** are available privately for those that can afford them, the benefits of coaching including peer-to-peer models could be explored more widely.
- Experienced parents and carers – such as those whose children are grown up and may have left home – as well as grandparents, have decades of parenting experience, but this experience lies largely latent.

- Coaching roles would allow a significant group of people to draw on their experience – combined with training on evidence-based approaches – to support parents to raise thriving children.
- The peer model is attractive for many people who appreciate being able to get practical, down-to-earth advice from experienced parents.
- As structural changes in work, family, culture and suburban life are reducing our social capital,[32] our society is under-utilising powerful community assets – family, grandparents, neighbours, friends, and local organisations – that could be doing more to help raise children. Parent coaching is a way to bring more support around family and children in the modern world, helping to 'bring the village to the child'.
- In turn, this work is likely to support the wellbeing of middle and older Australian coaches, who would: experience significant satisfaction passing on their knowledge to parents, and playing a role in supporting the development of future generations of children; and appreciate ongoing active participation in the community and the economy.

Box 1.5: A proposal - Piloting parent coaching

- A network of parent coaches would provide simple, practical advice to parents and carers in person, online, through video chat or on the phone to help them raise thriving children.
- Coaches would receive training over two months – based on the information in the Raising Children Network and Healthy Families – enabling them to provide evidence-based advice.
- Coaches could be peers – experienced parents, carers and grandparents – able to pass on their experience.
- Coaches would receive supervision from staff qualified in child development.
- The pilot could test an online marketplace or app to connect parents to coaches.

The case for early intervention

1. Many children and parents are struggling but are not getting help.

- One in seven Australian children aged 4-11 years has had a mental health issue in the last 12 months but less than half of these children connected with services to help with their emotional or behavioural problems.[33]

2. The services children need often do not exist in their local area.

- Despite strong evidence for the efficacy of some programs, they are not widely available, so families miss out. In around 40 per cent of cases, the barrier for parents seeking help was service accessibility: not knowing where to get help; not being able to afford help; and not being able to get an appointment.[34]

3. Many parents have limited understanding of the nature and importance of their children's mental health.

- Only 35 per cent of parents are confident that they could recognise the signs of a psychological problem in their child,[35] and 44 per cent report being confident that they would know where to go for help if their child was experiencing social, emotional or behaviour difficulties.[36]
- About one in three families do not access support because they do not recognise early warning signs or think the problem might get better by itself.[37]

4. Missing opportunities to intervene earlier at known points of vulnerability is expensive, inefficient and does not lead to good outcomes

- A recent analysis revealed that the total cost of services for children and young people experiencing significant issues, including mental ill health, is $15.2bn every year.[38]
- By intervening earlier, we can reduce the number of children and young people who develop more serious issues and need expensive, high-intensity crisis services.[39]

Action area 3: Support for children and families with higher needs

Connecting children and families who have higher or more complex needs with the support they need.

What needs to be done?

For children and families with high or complex needs, including more severe mental health issues, all levels of government can reduce the cost of tertiary services, institutions, child protection and out-of-home care, by investing in proven models of intervention[40] to stabilise family life, so that families get the help they need when they need it most.

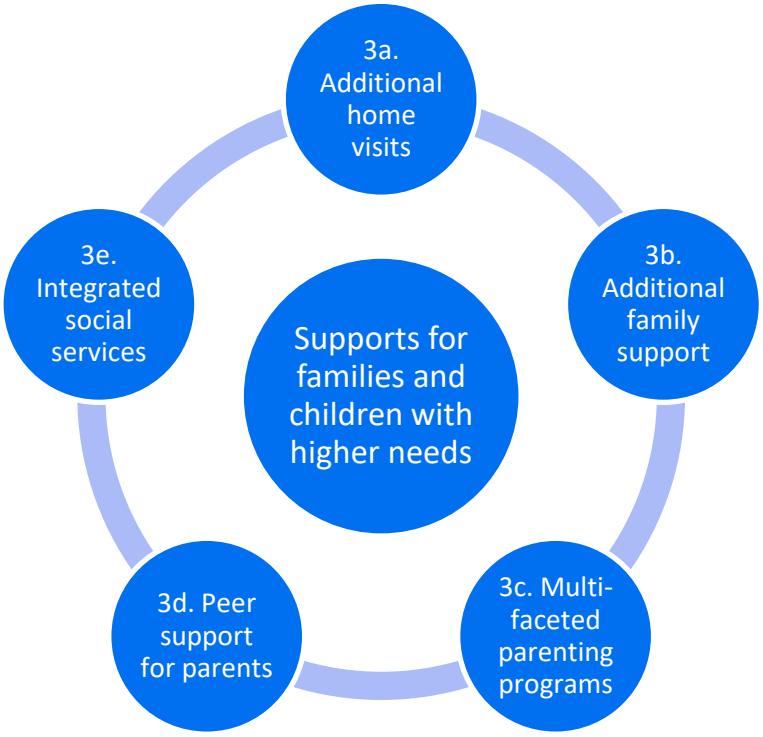


Figure 2: More supportive structures around children and families with higher needs

3a Additional home visits

- As in prevention and early intervention, home visiting is a proven strategy for families who need extra support to manage risks to a child's social and emotional development. At this level, more targeted responses can be tailored to specific family and child needs, such as positive parenting or connecting to support services (see 3e below).

Box 1.6: Example of additional wellbeing home visits

- **Right@home –** a program adapted for families experiencing adversity from existing Child Health Nurse home visiting programs. Visiting from a multi-disciplinary team including social workers can been expanded up to 25 visits. Successful outcomes include improvements in both positive parenting behaviours and the home learning environment[19]

3b Additional family support

- Outside the home environment, welcoming centres in local communities can bring families and services together, so that both professional and peer supports help to strengthen families.
- Place-based approaches in local communities have been shown to be effective in increasing accessibility and enhancing proximate networks of support.
- **Integrated mental health care** for children requiring specialist clinical care should be accessible and prioritised to ensure families are immediately connected with the right level of services to match the needs of their child.

Box 1.7: Example of a place-based approach

The **Tasmanian Child and Family Centres** – a place-based approach, codesigned with the local community to provide early intervention in higher risk communities. Families reported the services were more accessible and fostered a non-stigmatising approach.[41]

3c Multi-faceted parenting programs

- As family and children's needs increase, more complex problems require better coordinated and more comprehensive solutions. Generic parenting programs are less likely to fulfil these criteria. However, effective multi-faceted programs have been shown to be effective but need to be more widely available.

Box 1.8: Example of evidence-based parenting programs

- **Strengthening Families Program** (SFP) – This is a nationally and internationally recognised parenting and family strengthening program for high-risk and regular families with different age versions from **birth to 17 years of age**. SFP is an evidence-based family skills training program of 7 to 14 sessions depending on the risk level of the family. SFP has been found to significantly reduce problem behaviours, delinquency, and alcohol and drug abuse in children and to improve social competencies and school performance. Child maltreatment also decreases as parents strengthen bonds with their children and learn more positive parenting. For more information see: https://strengtheningfamiliesprogram.org/ and http://whatworksforkids.org.au/program/strengthening-families-program

3d Peer support for parents

- A successful strategy to tackle the stigma and parental fear often associated with government interventions, such as those by child protection agencies, is to draw on the strengths of a peer workforce.

Box 1.9: Helping families avoid crisis - An example program for children and parents

- **Family by Family** is a peer-based program that links 'seeking families' – families who want something in their lives to be different – with 'sharing families' – families who are thriving despite having been through difficulties in the past. Sharing families are supported and guided by professional coaches. Link-ups may last 10, 20 or 30 weeks with specific goals set for participating families. Pairs of seeking and sharing families then organise the things that they will do together, known as link-up activities, which are designed to help families achieve their goals for change. The program was specifically created to reduce the number of families involved with child protection systems. For more information see: https://familybyfamily.org.au/

3e Integrated social services

- Children's social and emotional development is strongly influenced by their immediate environment, so parental unemployment, unstable housing, family violence, mental health issues, drug and alcohol abuse or gambling may need specific attention.
- Families that are in crisis or facing multiple challenges simultaneously may not have the resources or capability to coordinate diverse responses themselves. **Family support coordinators** would help parents and caregivers to draw upon the resources needed to stabilise family life and ensure that interventions aimed at improving children's social and emotional wellbeing have the greatest chance of success. For instance, these coordinators would connect families with housing services or financial counselling, offer support through a critical time such as a court case or hospital stay, or they might help to get an NDIS package in place.

The case for supporting children and families with higher needs

1. Better outcomes for children start with better support for families

- Having multiple adverse childhood experiences (ACEs) is known to be a key risk factor for the development of mental health conditions in adulthood.[42]
- We can expect families to struggle in the absence of secure housing, a reliable and sufficient income stream, access to physical and mental health care or social and emotional support. These fundamental elements of family life often belong to fragmented systems that do not talk to each other and it is left to those who are already in crisis to try and piece them together.
- Most state and territory child protection systems acknowledge that better outcomes are achieved by investing in family wellbeing and stability, yet too often such investments are too narrow, too short or never occur at all.[43]

2. The right level and length of support should be matched to individual and family circumstances

- Children and families with higher needs should be able to get more support in accordance with the challenges that they are facing, as well as helping them to draw on the strengths and resources that they do have available. This means paying proper attention to the social determinants of mental health and wellbeing. It also requires more thorough connections between services and systems, so that those who are most vulnerable do not fall through the gaps.

3. Unfair burdens are being placed on many parents who, in addition to being primary carers, are also required to act as system navigators, case coordinators, advocates and educators.

- We know that there are additional vulnerabilities and challenges in some families. Children with high or complex needs are often not well served by current systems and services. Parents and carers struggle with the task of patching together disparate and disconnected services including the NDIS, psychologists and psychiatrists, occupational therapists, family counsellors, childcare and schools. For some, this can be at least as demanding as a full-time job, with major impacts on their own ability to maintain their place in or re-enter the workforce.

Supporting children and young people during their school years

Beyond Blue welcomes the recommendation for the COAG Education Council to develop a national strategic policy on social and emotional learning in the Australian education system.

However, Beyond Blue is concerned that while recognising the purpose of the National Education Initiative, Be You, as bringing together previously disconnected programs to avoid duplication, the analysis in the draft report highlights the fragmentation of the system, without recognising the progress Be You has made in supporting system integration. Be You has emerged as a whole of school and early learning service framework to support the mental health of children and young people. With ongoing support from stakeholders, Be You can be the much-needed single national framework for schools and early learning centres over the long term.

Recommendations

The Productivity Commission, to drive a systemic and planned effort to tackle the fragmentation of mental health support in education settings, recommends that:

- COAG Education Ministers explicitly adopt Be You as the overarching national mental health in education framework to support early learning services and schools**;**
- Be You be funded for the longer-term by the Commonwealth, with ongoing review and evaluation of outcomes; and
- states and territories plan with the Commonwealth and Be You providers to make complementary investments (especially in more age-appropriate specialist services for children and young people and educator mental health).

Be You, the National Education Initiative is already established as a single national framework:

- **It was specifically designed to establish one national mental health initiative** to work in schools and early learning services, so educators have one clear, evidence-based framework on mental health which supports access to a trusted source of social and emotional wellbeing information and professional learning. Be You builds on the best of successful but disconnected programs: KidsMatter Early Learning, KidsMatter, MindMatters, headspace School Support and Response Ability.
- **It has been funded nationally for four years until July 2021, having launched in November 2018.**
- In 14 months, already **6,331 schools (67 per cent of all Australian schools) and 3,021 learning centres (19 per cent of all services nationally) have signed on**, and 95,000 individuals (mainly educators) have created learning accounts.
- **It builds on an established evidence base.** Be You has already combined multiple successful but disconnected initiatives: KidsMatter Early Learning, KidsMatter, MindMatters, headspace School Support and Response Ability. These programs had been world-leading programs based in early learning services and schools, strongly supported by independent evaluations.
    - An evaluation of the national KidsMatter pilot by Flinders University found it was associated with statistically and practically significant improvement in students' measured mental health, reducing mental health difficulties and increasing mental health strengths.[44]
    - Be You is building on the success of these programs by providing:
        - integrated and more streamlined guidance that is consistent across the entire education journey of children and young people
        - content and practice examples based on the latest research
        - information and accredited professional development available to busy educators when they need it, rather than asking educators to work through linear modules
        - continuous improvement through independent evaluation.

- **Be You accords with the Lancet Global Commissioners recommendations** about universal social and emotional learning interventions that promote children's social and emotional functioning, improve academic performance and reduce risk behaviours. The Commissioners conclude the **most effective** universal social and emotional learning interventions use a whole-school approach where social and emotional learning is supported by a school ethos and a physical and social environment that is health enabling involving staff, students, parents, and the local community.[45] This is the approach of Be You.
- **It is linked to federal, state and territory mental health and wellbeing frameworks, policy objectives, teaching standards, and national curriculum and quality standards.**
- **It has an established evaluation framework in place.**
- **The foundational partnerships and relationships for both service delivery and with education departments across the country are already in place and working well.**
    - **Be You has strong support from stakeholders including Commonwealth, state and territory education departments** with representatives on the Be You National Advisory Council.
    - Be You was **established through comprehensive engagement** involving 380 individuals across 180 organisations: experts from the education sector, universities, social innovators, implementation scientists, Commonwealth and State/Territory governments, health and education departments, Independent Schools, Catholic Education, Primary Health Networks, Aboriginal and Torres Strait Islander organisations, peak bodies, Mental Health Commissions and Children and Young People Commissions.
- **It is linked to curriculum and professional development frameworks in all Australian states and territories.**
- **It provides school principals and early learning service managers a national centralised portal for evidence-based and evaluated social and emotional wellbeing programs (Programs Directory).[46]**
- To re-open the question of alternative social and emotional learning frameworks in early learning services and schools risks undoing the substantial progress that Be You and over 9,350 early learning services and schools have already made. COAG Education Council endorsement could embed Be You as the unifying national framework over the longer term.

Box 1.10: What is Be You?

Be You aims to equip Australian early learning services and schools with the skills and strategies they need to ensure that every child, young person and staff member can achieve their best possible mental health. Be You includes an online platform – backed up by a trained workforce of 70 staff – that assists schools and early learning services to:

- Develop or upgrade their mental health strategies
- Empower educators to support the mental health of children and young people through provision of information, accredited professional learning, advice and support
- Create links to local service providers
- Involve parents and carers in supporting the mental health of their children and young people
- Respond effectively and appropriately when suicide or critical incidents occur
- Support educator self-care
- Promote and provide Be You materials and resources for pre-service educators and tertiary institutions so our next generation of educators are equipped to support the wellbeing of their students as well as themselves.

Be You and wellbeing leaders in schools

The Commission's proposal for schools to employ dedicated wellbeing leaders is encouraging, but may not be the best solution for many schools, especially those in remote and regional areas who already struggle to attract and retain staff. With an estimated cost approaching $1 billion, it will be important to engage closely

with the education community, especially principals, to further test the utility of the proposal. It is possible, for instance, that a variety of approaches will be needed to suit the very different school and environmental contexts arising across the nation.

Should the wellbeing leader proposal proceed, Be You can provide professional learning and facilitate easy access to tools and resources in relation to mental health. This would have the following advantages:

- Being able to develop and offer tailored online professional learning for personnel in these roles to ensure they have the mental health literacy, confidence and readiness to undertake their role. This would be teacher endorsed/accredited for teacher registration purposes.
- Alignment of the online professional learning to state and territory policies and frameworks for mental health and wellbeing.
- Access to significant resources and tools to support their role in relation to all developmental stages of children and young people and their mental health.
- Additional access to ongoing professional learning in mental health via webinars and national/regional check-ins.
- Engagement in established and emerging localised and national mental health communities (Be You learning communities and networks of schools and early learning services). This will be advantageous in supporting the transitional stages through education for children and young people and allow for connection to early learning services that are feeder services into primary schools.

Box 1.11: Response to Productivity Commission query on Be You capacity

At a Productivity Commission hearing in Melbourne (November 2019), a question was raised about the sufficiency of current staffing levels to deliver Be You nationally to early learning services and schools. Our response is that:

- At the time of writing, 70 Be You Consultants support over 9,350 early learning services and schools nationally. Additional resources will always be welcome.
- We have built the Be You framework and overall initiative as an online platform leading to a virtual environment of knowledge – 24/7 flexible, self-paced, non-linear professional learning modules to ensure tailoring learning to needs, end-to-end (0-18 developmental stages information), equity and relevance nationally.
- Our intention regarding the workforce 'delivering to services and schools' is that it we have a unified delivery workforce approach where the Be You workforce are the enablers – following a community development approach to empowering educators to build their own capacity and those in their environment to live and model behaviours that support 'good mental health' (practice change), as well as providing support in response to a crisis.
- At present, support levels are tailored to match the needs of schools and early learning services as they implement Be You. Typically, time with schools and services is greater as strategies and capabilities are being developed, and then as they become more self-sustaining, support is offered as needed.
- The Be You delivery model is a sustainability-driven one that also facilitates early learning services and schools to connect to one-another in communities of practice and networks.
- Early learning services and schools are generally at different stages of their Be You adoption, so intensity of support and coaching differs and these needs are met through national and regional virtual check-ins, accessing webinars for learning and connection and offerings of onsite network-based professional learning.
- Major capabilities of the Be You workforce are their ability to engage early learning services and schools, to build relationships through online and phone support and coaching and support them, to become mentally healthy learning communities where staff, students and families have the:
  - ability to notice and support families and/students to seek support early
  - understanding of the right support and pathways to it, and
  - ability to support (disengaged/unwell) students to stay connected with early learning services and schools.

2. Mentally healthy workplaces

Beyond Blue welcomes the Productivity Commission's recommendations for workplace mental health, including raising the profile of psychological health, reforms to workers' compensation and the need to tailor programs and resources for small business.

However, Beyond Blue is concerned about the absence of reference to the **National Workplace Initiative** and a missed opportunity to highlight the importance of **proactively investing in mentally healthy workplace cultures** and preventing mental health conditions from arising in the first place, rather than focussing too much on reactive and risk-oriented processes.

Recommendations

The Productivity Commission recommends that Commonwealth, state and territory governments endorse the development of the National Workplace Initiative as the single national framework to drive adoption of mental health strategies in workplaces across Australia.

In addition, Beyond Blue supports the three recommendations of the Mentally Healthy Workplace Alliance:

Alliance Recommendation 1: Request that the final report references the National Workplace Initiative, funded in the 2019-20 Federal Budget, and recognise the promise of the NWI to strengthen sector collaboration to address fragmentation and confusion.

Alliance Recommendation 2: Request that the Productivity Commission recommend further government support for NWI Implementation assistance in the final report. Implementation assistance is needed early in the project development to maximise usability design, relevance and impact for all businesses in Australia.

Alliance Recommendation 3: That the final report includes a recommendation encouraging an integrated, preventative mental health approach whereby workplaces are supported by appropriate stakeholders to develop beyond existing mandatory Work Health and Safety (WHS) laws that are tailored for specific workplace needs to help create thriving workplaces.

Why the National Workplace Initiative?

1. A single national initiative to overcome fragmentation and drive adoption of workplace mental health strategies across the economy.

The Commission's draft report correctly recognises that while many employers understand the importance of workplace mental health, they are overwhelmed by the sheer volume of information and resources. Many are confused about what to do and who to turn to for support.

The National Workplace Initiative (NWI), funded in the 2018-19 Federal Budget, is the opportunity to address these issues of confusion, fragmentation and inconsistency. It aims to provide a single integrated framework and implementation support to catalyse adoption of mental health strategies across Australian workplaces of all sizes, including small business. The intent of the Initiative to provide consistent indicators against which workplace mental health programs can be measured is directly consistent with recommendation 19.5.

2. Building on and surpassing successful international practice

- The 2013 Canadian Standard for Psychological Health and Safety in the Workplace – and subsequent support to workplaces to implement workplace mental health strategies – is the pioneering international workplace initiative which has achieved:
    - **Major reductions in absenteeism:** among organisations implementing the Canadian Standard, an average of 7.4 days is lost due to depression, stress or anxiety, compared to 12.5 days across the economy.
    - **Thriving workplaces:** there has been a 10-percentage point drop in the number of Canadian workers describing their workplace as being psychologically unsafe.

- **Improved understanding of mental health:** A 13-percentage point increase in the number of Canadian employees who feel knowledgeable about mental health.[47]

- Australia can draw on the lessons learned in the Canadian experience to design an even stronger initiative, for instance, by:
  - providing a much simpler, more practical set of best practices that can be easily understood and adopted by business
  - having implementation support available early
  - tailoring engagement to different types of employers
  - recruiting high profile businesses and leaders to champion the initiative, and
  - having robust evaluation from the start to drive performance improvement.

3. Driving prevention and best practice work cultures, not simply compliance with minimum legal requirements

- The focus in the draft report on work health and safety (WHS) reform and meeting minimum legal workplace requirements is positive. The NWI can build on this by encouraging positive workplace cultures and practices that help people to thrive and contribute in the workplace, which can help to prevent mental ill health from arising in the workplace.

4. Driving transformational change in the mental health of the Australian people.

- Intervening in the big settings where people live their lives creates scope for population-wide, transformational, cost-effective change.
- The NWI can support Australia's 13 million workers to achieve their best possible mental health, no matter where they are on the mental health continuum.
- The NWI is the essential 'companion piece' to Be You. Over the life course, the two initiatives will support children and young people, and adults in the workplace, to build mentally healthy communities where people most live their lives – education and the workplace.

5. An economic reform agenda to drive national prosperity

- The NWI can drive reform gains as significant as many of the much-heralded microeconomic reforms of recent decades because it is focused on lifting the performance of the whole Australian workforce. In particular, it will impact the two key drivers of economic growth:
  - **Lifting productivity:** Improving mental health lifts productivity by improving human capital – helping people perform at their best. The draft report estimates the cost of absenteeism and presenteeism due to mental ill health as $13 to $17 billion annually. KPMG (2018) estimate that implementing a select group of evidence-based workplace interventions could save $4.5 billion a year.[48]
  - **Lifting participation:** Improving mental health lifts participation by helping those under pressure to remain in the workforce and those with mental health conditions to gain employment.

- **Reducing outlays:** In addition, a more mentally healthy working population will mean lower outlays on addressing mental conditions and their consequences. Australia is spending around **$29 billion a year** – excluding capital spending – directly addressing mental health issues.[49]

- Deloitte (2017) estimate an average ROI of 4.2:1 for workplace mental health interventions.[50]

6. Conceived and supported by business, the National Mental Health Commission, the mental health sector, unions and work safety organisations

- This proposal was conceived by the Mentally Healthy Workplace Alliance (membership below). The Alliance has identified this reform as **the single most important contribution that can be made to the mental health and wellbeing of the Australian working population**. With widespread stakeholder support, the NWI has momentum to become the national framework to drive change in workplace mental health.

Table: Current membership of the Mentally Healthy Workplace Alliance

• Australian Chamber of Commerce and Industry • Australian Council of Trade Unions • Australasian Faculty of Occupational and Environmental Medicine • Australian Industry Group	• Australian Psychological Society • Business Council of Australia • Beyond Blue • The Black Dog Institute • Comcare	• Council of Small Business Australia • Mental Health Australia • National Mental Health Commission • Safe Work Australia • SANE Australia • SuperFriend

3. Matching the right level and type of support: building the low intensity mental health system

Beyond Blue welcomes the Productivity Commission's:

- emphasis on the stepped care model and the need to build up the low intensity mental health system;
- estimate that 450,000 people being treated through Better Access would ideally receive low intensity support;
- recognition that while low intensity support is the primary need for large parts of the population, relatively few low intensity supports are available.

However, Beyond Blue is concerned that the draft report:

- does not contain a reform agenda to address the impediments – including funding – that are preventing the low intensity sector from emerging at the scale needed to meet the population's need for support;
- recommends expansion of just one type of support – 150,000 places for clinician supported online treatment – rather than the range of services the Productivity Commission notes consumers want, including coaching through three modalities: face-to-face; online; and over-the-phone;
- does not include a plan to meet the population's need for services over the longer term; and
- does not sufficiently recognise the impact and cost effectiveness of CBT coaching.

Recommendations

The Commonwealth Government – in partnership with state and territory governments – should commit to, and fund, the development of a national strategy to build a comprehensive low intensity mental health system in Australia, including:

1. **Developing the key sector microeconomic foundations to address structural impediments:** Impediments including consumer awareness, linkages to the clinical system, workforce training, development and career structures, and accreditation of services need to be addressed so a comprehensive low intensity system can emerge (see **Box 3.1:** National strategy to develop the low intensity mental health system).
2. **National funding to allow for the rapid, cost-effective national expansion of proven low intensity services, while requiring robust outcome measures to ensure only high impact services retain funding:** National funding could be provided either via: periodic national competitive tenders to fund the national expansion of services that have emerged as the most evidence-based and cost-effective; or progressively adding proven low intensity services to the MBS items covering Better Access, and asking doctors to refer people to low intensity services when appropriate.
3. **Expanding the full suite of evidence-based interventions people want – coaching/support face-to-face, online or over the phone – not simply clinician supported online treatment.** We recommend expanding the full suite of services consumers want, and closely evaluating cost effectiveness. The recommended information campaign to support online treatment should be expanded to promote broader low intensity support. We address **information request 5.1** regarding low-intensity coaches in **Box 3.2.**

Microeconomic foundations that address impediments to low intensity services

The task of building a low intensity mental health service system could be catalysed through a national strategy to build the architecture needed to underpin the sector. This is described in **Box 3.1** below.

Box 3.1: A national strategy to develop the low intensity mental health system

The Vision

The strategy would work towards a vision: an Australia where people, families and communities understand mental health and take action to protect it and support each other thrive; where seeing a low intensity Cognitive Behavioural Therapy (CBT) coach or working through a digital program is as common and accepted as seeing a fitness coach; where every person in Australia has access to cost effective, low intensity supports that help them to stay well or recover quickly when stress or challenging conditions arise.

The Challenge

As with any sector seeking to become established, there are a raft of substantial structural impediments that must be addressed if the sector is to emerge sustainably.

The impediments a national strategy could address

1. Consumer awareness and trust

Good mental health literacy is still emerging in Australia. Many community members do not have a culture of protecting their mental health. Indeed, around 40 per cent of people with a diagnosable mental health condition have never accessed support.[51]

Awareness and understanding of the benefits of low intensity services are limited. A review of PHN Lead Sites included the suggestion that "there needed to be a consistent national strategy for promoting low intensity services and for this to be resourced at the national level".[52]

"I think we're all facing the same issue around that acceptability of low intensity, knowledge of what it is too and then acceptability that it actually is a really worthwhile service. Once someone gets in there, the recovery rate you know speaks for itself... It's just getting people in there."

Bassilios et al, Primary Health Network Mental Health Reform Lead Site Project Final Evaluation Report, May 2019

The national strategy could consider options to lift community and professional awareness and trust, such as:

- Backing proven initiatives to go national so the efficacy of low intensity services is demonstrated in practice, and service uptake is promoted through 'word-of-mouth' via those who benefit.
- National, regional and local promotion to increase public awareness of the availability and efficacy of low intensity services, including through PHNs at a regional and local level.

2. Integration and referrals from the clinical system

Despite New Access being rigorously piloted and evaluated, and achieving up to 70 per cent recovery rates in excess of 10,000 participants over 6 years of operation, some health and mental health professionals have had trouble trusting the effectiveness of coaches, or doubt the effectiveness of their training and clinical supervision.

The national strategy could consider options to improve referrals from primary care and other referral points, including:

- Ensuring flagship low intensity providers share positive outcomes with GPs to encourage referrals. Some NewAccess providers have lifted referral rates by sharing the strong recovery rates with GPs.
- Education to encourage GPs to consider and make patients aware of evidence-based low intensity options – not just clinical options – when they are developing mental health plans for people at risk of developing, or with mild-to-moderate mental health conditions.

3. Accreditation of services

A key challenge for community members and clinicians is to know which low intensity supports to trust. A national strategy could incorporate a system of accreditation, so people can choose providers knowing they can be trusted to support recovery and clinicians can refer people to evidence-based programs with confidence.

4. A national workforce, with career structures, and structured education and training pathways

In established industries, enterprises seeking to grow can draw on readily available staff, often underpinned by clear career structures and supported by well-established education and training pathways. By contrast, service providers seeking to roll out pioneering new models of low intensity service delivery often need to develop new roles and workforces, and establish training and career pathways from scratch. For instance, this can include roles for peers, or support coordinators to provide aftercare, or coaches to provide CBT interventions. This adds to the cost and complexity of developing low intensity services.

A national strategy could help develop work roles, career structures and education and training pathways needed to spur the rapid development of the low intensity mental health sector. There are significant numbers of people in local communities who can excel in low intensity roles. With appropriate structures in place, workforce development can progress rapidly.

5. Funding systems to allow for rapid national expansion of proven low intensity supports

A national strategy could develop funding mechanisms to allow proven services to expand across the country, rapidly creating a low intensity system to meet the needs of the population, while ensuring it is done cost effectively through economies of scale.

6. Improving support for PHNs

PHNs have a critical role to play in matching support to local needs, but too much has been devolved to PHNs without adequate national support being provided to underpin their success.

A national strategy could build supporting architecture around PHNs, drawing on the advice of the PHN Advisory Panel report, which noted the need for:

- stronger and consistent minimum data sets
- streamlined reporting requirements
- consistent review of activity and performance data
- improved capacity for regional commissioning and
- greater funding provided on a longer-term basis.[53]

Why is national funding needed?

1. There is a major institutional failure in the funding of mental health that is preventing balanced growth across the stepped care model from occurring.

- The Better Access initiative has dramatically increased the number of people accessing clinical services (psychiatrists, clinical psychologists and psychologists) that are most suitable for people with moderate to severe mental health conditions. In 2017-18, Medicare subsidised clinical mental health services cost $1.2 billion, up from $351 million in 2006-07.[54]
- Meanwhile, funding for low intensity services is tightly capped at a level that can never allow a significant sector to emerge. Although aiming at a much larger target group, funding for low intensity services through PHNs appears to be in the vicinity of $50-60 million per annum, or less than $2 million per PHN.[1]
- Requiring service providers to seek funding from 31 different sources – each with limited funding – makes it near impossible for services to roll out nationally.

2. Many Australians are not getting the early intervention support they need.

- The Productivity Commission estimated that 450,000 people receiving Better Access could be better served through low intensity services. 5.8 million Australians are at risk of developing a mental health condition and 2.2 million Australians have mild mental health conditions. Yet few low intensity supports are available.

[1] Precise PHN expenditure on low intensity services is not known. PHNs receive around $340 million per annum (GST exclusive) to fund six mental health priority areas: 1. Low intensity services; 2. Psychological therapies for underserviced populations; 3. Child and youth services (including services delivered by *headspace*); 4. Services for adults with severe and complex mental illness; 5. Indigenous mental health services; and 6. Suicide prevention. If low intensity services are receiving a one-sixth share, this would be around $57 million or less than $2 million for each of the 31 PHNs.

- The graph that follows shows the lack of balance in the current system, where most of the resources are aligned with severe conditions and most of the population do not have access to a service that matches their needs. In any given year, it is estimated that almost half (46 per cent) of people with mental health conditions do not access the services they need.[55]

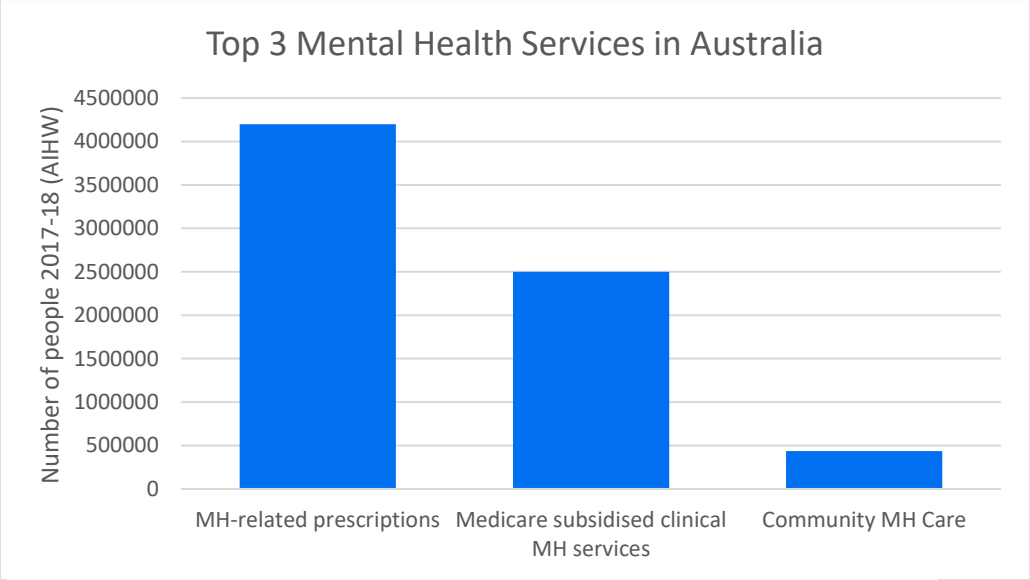


Figure 3: Clinical services and pharmacotherapies vastly outnumber community mental health services, despite most of the need being mild or moderate conditions

3. National funding would allow for the rapid, national expansion of proven services

- A national strategy could develop funding mechanisms to allow proven services to expand nationally, much more rapidly creating a low intensity system to meet the needs of the population, while ensuring it is done cost effectively through economies of scale.
- Just as occurs with other universal services – such as hospitals, GPs, pharmaceuticals and psychologists – national funding mechanisms are needed to supplement regional commissioning, which can never drive the largescale expansion of service delivery required.
- By facilitating national marketing and reach, low intensity services can build the scale needed to fully realise their cost benefits and advantage, while maintaining their strong recovery rates.
- The Commonwealth Government could periodically run procurement processes that encourage partnerships, integration and better outcomes (e.g. competitive dialogue processes), with a view to supporting Australia's most impactful low intensity interventions (such as low intensity coaching, digital support and self-guided interventions) to roll out nationally.
- A thoughtful approach to procurement and commissioning would deliver significant benefits:
  - Providing much needed cost-effective services to better support the mental health of the population;
  - Flagship initiatives would demonstrate the effectiveness of low intensity support, increasing people's awareness and take up of cost-effective low intensity support.
  - People with mild conditions would receive lower cost support that appropriately meets their needs, rather than more expensive supports.
  - Stronger more consistent service standards could be delivered across the nation.
  - Improved data tracking would allow for better measuring of outcomes from the government's investment.
- Alternatively, the Australian Government could support the expansion of the low intensity system by progressively adding proven low intensity services to the MBS items covering Better Access and asking doctors to refer people to low intensity services when appropriate.[56]

Expanding the full suite of evidence-based interventions

- The Productivity Commission notes 450,000 people receiving Better Access could be better served through low intensity services. 5.8 million Australians are at risk of developing a mental health condition and 2.2 million Australians have mild mental health conditions. This indicates service expansion needs to extend beyond 150,000 additional places for clinician-supported online treatment.
- The Commission notes that a range of other mental health organisations, including Rural and Remote Mental Health, view online treatment as but one option and that the preference for face-to-face treatment is strong. Also noted is evidence showing up to 77 per cent of people prefer this modality.[57]
- A range of low intensity coaching, digital supports, and self-guided interventions are proven to be effective, and only low intensity services can deliver the expansion in support needed by the population in ways that are affordable for people and governments.
- This should include CBT coaching – such as New Access, which is a proven model, delivers powerful recovery rates and is cost-effective at scale.
- The Commission's final report should give more emphasis to non-clinical low intensity supports. As international practice and The Lancet Commission advocate, much of the value of low intensity services is the creation of innovative, new, non-specialist workforces who deliver high impact support at a lower cost than traditional services. This includes: peer-to-peer support, coaches helping people with mild-to-moderate depression or anxiety to recover, Support Coordinators helping people get back on track after a suicide attempt, or wellbeing staff supporting children in schools. The important thing is that these staff are well trained and clinically supervised, not that they must always be clinically qualified.[58]
- With the development of the low intensity sector in its infancy – and the Productivity Commission seeing the need to radically expand low intensity places – it makes little sense to recommend expansion of one type of service to the exclusion of all others.

Box 3.2: Response to information request 5.1

NewAccess: A successful model of low-intensity therapy coaching

NewAccess is an evidence-based, safe and scalable low intensity Cognitive Behaviour Therapy (CBT) service. It is based on the successful IAPT model in the UK.

NewAccess was originally developed, trialled and evaluated by Beyond Blue and is now being commissioned on an ad hoc basis by PHNs and other agencies like Comcare and the Department of Defence. Commissioning bodies engage local service providers, with Beyond Blue licencing the model to them for free. There is an implementation fee (which contributes to Beyond Blue's implementation and marketing costs and is subsidised by Beyond Blue). Beyond Blue provides advice, quality assurance and model fidelity oversight, some data collection and coordination of a national community of practice network.

The service is currently commissioned by 14 PHNs in locations across Australia.

Non-clinical coaches (with clinical supervision) deliver up to six sessions of free, low intensity support to people with mild to moderate depression and anxiety.

Following an initial assessment, sessions can be delivered face to face, online or by phone.

NewAccess operates within a stepped-care framework, ensuring people can be stepped up if they require more intensive treatment and support.

Integration into the clinical system occurs at a number of levels, including:

- through coaches ensuring general practitioners receive feedback about client treatment following an initial assessment and at completion of treatment; and
- NewAccess being commissioned by PHNs as a critical component of their population planning and stepped care models

The program model is unique in the Australian mental health sector for several reasons:

- It is specifically designed to **reduce stigma** associated with accessing "mental health services". Promotion talks about life problems like money worries and relationship issues.
- People can **self-refer** – a health professional referral is not required.
- All sessions are **free of charge**. There is no co-payment.
- Sessions can be delivered in a **variety of formats**: face-to-face, via telephone or telehealth.
- **High referral acceptance and retention rates:** 88 per cent of all people referred to the service proceeded to treatment, and 72 per cent continue treatment to completion.
- **High recovery rates**: The average national recovery rate for all current services is around 70 per cent.
- **Timely access to treatment:** services are required to deliver an initial assessment within one week of client referral.
- It uses a **new, affordable workforce,** employing local people who understand local contexts and who are recruited to reflect their community demographics and needs.

The NewAccess workforce is specifically trained to deliver low intensity interventions, with seven weeks of intensive training prior to being able to see clients, then ongoing training and supervision over 12 months. This complements the specialist skillsets of psychiatrists and psychologists, who can be freed up to concentrate on more severe and complex cases. Coaches are recruited for compassionate and effective communication skills and their ability to work within the parameters of a highly-prescribed governance and clinical safety framework.

The program is highly effective with improvements in mental health outcomes – as highlighted below.

Improvement in mental health outcomes

NewAccess uses an empirically supported psychological therapy – Cognitive Behavioural Therapy – which is widely accepted to have a positive impact on mental health.[59]

NewAccess demonstrates improvements in mental health outcomes achieving a **consistent recovery rate of around 70 per cent**.[60] Very few Australian mental health services provide funders with readily-accessible, clinically-validated macro and micro outcomes data – pre- and post-treatment and at every point of contact between a coach and client during a treatment course, by service and against national data. This outcomes data is available in real time to clinical supervisors, coaches and clients to track recovery and respond as necessary. Clients report seeing their progress as highly motivating.

The new Australian Government PHN guidance on 'Low Intensity Mental Health Services for Early Intervention'[61] promotes NewAccess as an effective, evidence-based low intensity model. The guidelines highlight the model's critical success factors (e.g. self-referral, program fidelity) and recommend PHN's commission low intensity services that are underpinned by these factors. [62]

The IAPT program, on which NewAccess is modelled, has shown great success in the UK, achieving a 50 per cent recovery rate (Australia = c. 70 per cent). Ten years into program implementation, access to IAPT services is 960,000 patients per year, representing 16 per cent of the community prevalence of depression and anxiety disorders.[63] Over 560,000 people a year complete treatment, with 48 per cent receiving low intensity cognitive behavioural therapy.[64]

Cost effectiveness

New Access is cost effective: the indicated cost-benefit ratio is 1.5. It also reduces the level of demand on upstream services.[65]
National funding would allow NewAccess to achieve national coverage and tap economies of scale.

If NewAccess is implemented at scale, the cost per session[2] would likely fall to around $84 with no out of pocket cost for the consumer (compared with $148 MBS-rebated clinical psychology treatment – Item no.80010 – on top of which there are often substantial additional costs for the consumer).[66]

The cost per intervention is also favourable: $418 and no out of pocket costs for the consumer using New Access compared to $851 (plus any out of pocket costs) for a clinical psychologist under Better Access. This is a conservative estimate based on the average number of five sessions under Better Access plus GP consultation. The NewAccess intervention is based on the average of five sessions.[67]

International practice shows low-intensity coaching can be done at national scale. In the UK, where the service is universally available throughout England and supported by infrastructure and systems, 24 in every 10,000 are accessing IAPT.[68] (In Australia less than 1 in every 10,000 are seeing a NewAccess coach).

UK economists estimate savings to health services would exceed the cost of a course of IAPT treatment and provide savings to Treasury (in increased tax revenues and reduced benefit payments for people returning to work).[69]

The chart below shows how the costs of NewAccess that are impacted by scale and efficiencies improve over time as demand grows. The costs per session fall as fixed program management costs are spread over rising numbers of users. Additionally, marketing spend will also reduce over the life of the program and efficiency of service delivery and training will improve over time.

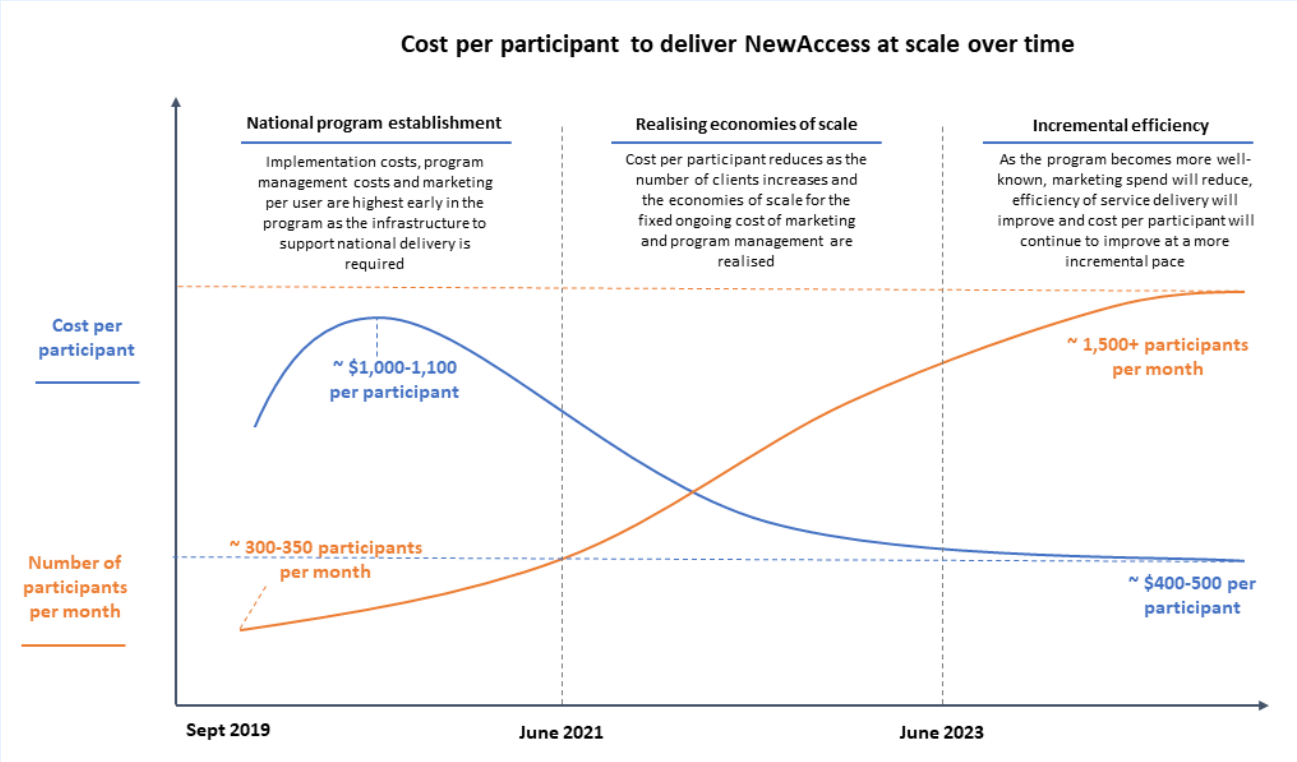


Figure 4: Realising economies of scale in a low-intensity coaching service

[2] This is defined as the ongoing cost of direct service delivery to the population. It includes the cost of the coach and a portion of supervision and management that is directly linked with service delivery. If delivered at scale, implementation costs will be incurred at the beginning of the program. Program management costs will be fixed despite the number of users and the cost per session to deliver NewAccess will reduce over time as more and more users come to the service

People who would most benefit

New Access is a universal offering suitable and applicable for high prevalence disorders like depression and anxiety impacting the whole population, regardless of their socioeconomic status or location.

Through its practical and non-stigmatising approach, it also breaks down barriers for 'hard to reach' population groups. This includes men, and people in rural and remote communities where access to and uptake of services is lower.[70]

NewAccess is unique in that coaches are recruited and selected for their fit with the demographics and needs of the local areas. Coaches have a range of backgrounds and experience. They include Aboriginal and Torres Strait Islander people, rural life/agricultural experience and youth. Services aim to have a mix of coach gender and Indigenous representation. For example, Marathon Health in NSW employs an Aboriginal coach from the local area who understands the small local community: *"I have witnessed first-hand of people in the community, workplace and friends … that are suffering from mental health issues"*.

NewAccess has been shown to be successful in specific community groups including:

- Culturally diverse communities – evaluation in the culturally diverse Brisbane South area found an average 10-point reduction in the level of psychological distress and participants reported a positive experience with the program; improved relationships and increased ability to cope during stressful life events[71]
- Regional and remote communities are delivering recovery rates at least as good as their metropolitan counterparts (close to 70 per cent) and have higher rates of retention (by at least 20 per cent)

Improving Access to Psychological Therapies (IAPT) – low intensity effective at scale in the UK

In the UK, the IAPT program, on which NewAccess is modelled, illustrates the benefits of a stepped care model at scale, achieving its goal of a 50 per cent recovery rate with two thirds showing reliable improvement. In contrast to Australia's Better Access scheme, which channels almost all people seeking mental health support to the most expensive layer of treatment, IAPT has two distinct levels (low and high intensity) designed to match individual needs and symptoms. Most people start with low intensity, unless screening indicates higher needs, and about half recover successfully without the need to be stepped up to high intensity services.

- In 2018-19, ten years into program implementation, around **1.1 million people** received treatment from IAPT services, representing 16 per cent of the community prevalence of depression and anxiety disorders.[72]
- More than three quarters of those completing a course of IAPT treatment have at least one session of low intensity (Figure 6).

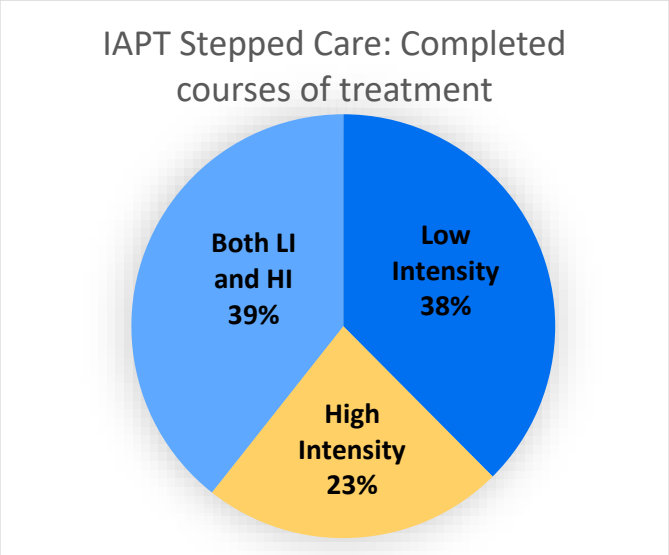


Figure 5: Source - Annual report on the use of IAPT services 2018-19

- Services have been established in all 209 of the local health regions in England with over 7,000 new therapists trained. Over a third of the IAPT workforce are Psychological Wellbeing Practitioners (PWPs) or other professionals trained to deliver low intensity treatments.[73]
- 24 in every 10,000 people in England are accessing IAPT services.[74] In Australia less than 1 in every 10,000 are seeing a NewAccess coach.
- UK economists estimate savings to health services would exceed the cost of a course of IAPT treatment and provide savings to Treasury (in increased tax revenues and reduced benefit payments for people returning to work).[75]
- Two independent evaluations of IAPT services showed that low intensity interventions were being delivered at just **42-44 per cent of the cost of high intensity treatment**.[76]
- One of these evaluations indicated that taking into account the full course of treatment through to recovery, the **difference could be as high as 64-65 per cent**.[77] This distinction highlights the inefficiency of Australia's 'one size fits all' Better Access system, which overservices people with lower needs at high costs.
- The differences between costs for low intensity and high intensity IAPT services are illustrated in the following two graphs:

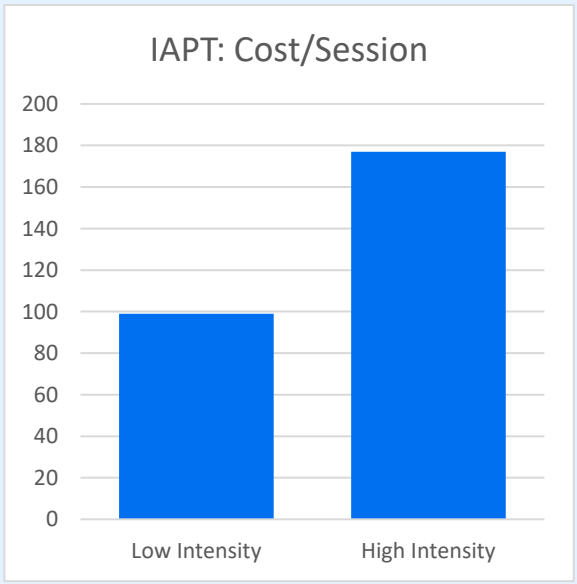


Figure 6: Source - Radhakrishnan, M et al, 2013

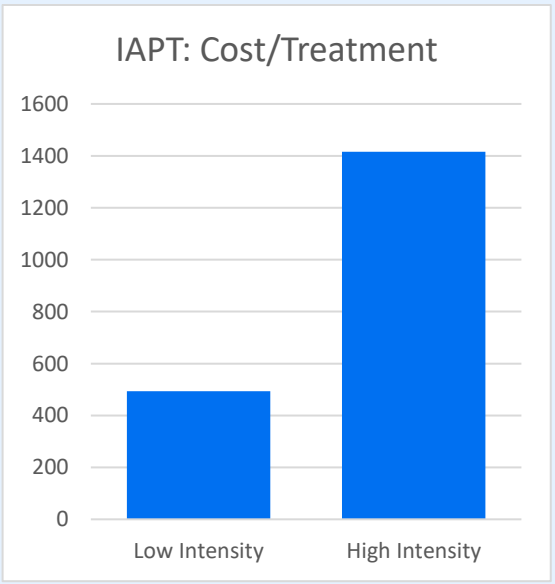


Figure 7: Source - Radhakrishnan, M et al, 2013

4. Suicide prevention

Beyond Blue welcomes the Productivity Commission's recommendations for:

- universal aftercare for every person in Australia, accessible not just through hospitals but GPs and other services in the community
- a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and implementation plan, specifying that Indigenous organisations should be the preferred providers of local suicide prevention activities for Indigenous people
- a National Mental Health and Suicide Prevention Agreement between the Commonwealth, state and territory governments that can deliver a truly whole-of-government approach to suicide prevention
- nationalising co-response initiatives that enable police, health and ambulance services to collectively respond to mental health crisis situations
- professionalising and expanding the peer workforce
- improving peoples' experiences in the emergency department
- exploring best practice approaches to providing paramedics with access to mental health resources when undertaking medical assessments in the field.

We also welcome the Productivity Commission's finding that school-based suicide prevention programs are cost effective in reducing suicide and that evidence-based programs should be accredited.

However, Beyond Blue is concerned that the Commission's draft report:

- lacks a vision and blueprint for how the elements of the system (including initiatives recommended by the Commission) can be drawn together in a national, integrated system of entry points
- does not focus sufficiently on people in distress or experiencing suicidal ideation, so misses the opportunity to support people before they attempt to take their lives, and
- does not recommend development of a full national market of suicide prevention supports that would ensure all people in distress or suicidal crisis could choose support that suits them.

Recommendations

The Commonwealth Government – in close partnership with state and territory governments – develop a national suicide prevention system including:

- **Tailored support for three vulnerable groups**: (i) people who have **attempted** suicide; (ii) people experiencing **suicidal ideation**; and (iii) people in **pre-suicidal distress**.

  Universal aftercare is a landmark reform, but to make further major inroads into the suicide toll, we need to reach further back into prevention, helping people before they attempt to take their lives.

- **Ensuring each person in distress has an option that suits their needs**: online information; phone/text; community safe spaces including peer-led models and residential support; a distress brief intervention; and co-response teams supporting police, ambulance and emergency services personnel.

  Providing a range of choices and channels and scaling up different models using different workforces is critical to different outcomes. For instance, a recent trial of the use of text by Lifeline showed 42 per cent of service users would not have sought help had text not been available.[78] Expanding the options available is critical to reaching more people with support when they need it most.

- **Bringing the suicide prevention sector together** to develop a visible national system, available to *anyone* in distress, through a number of integrated, highly visible entry points and supported by a community which feels more equipped and confident to talk about suicide and play an active role in preventing suicide.

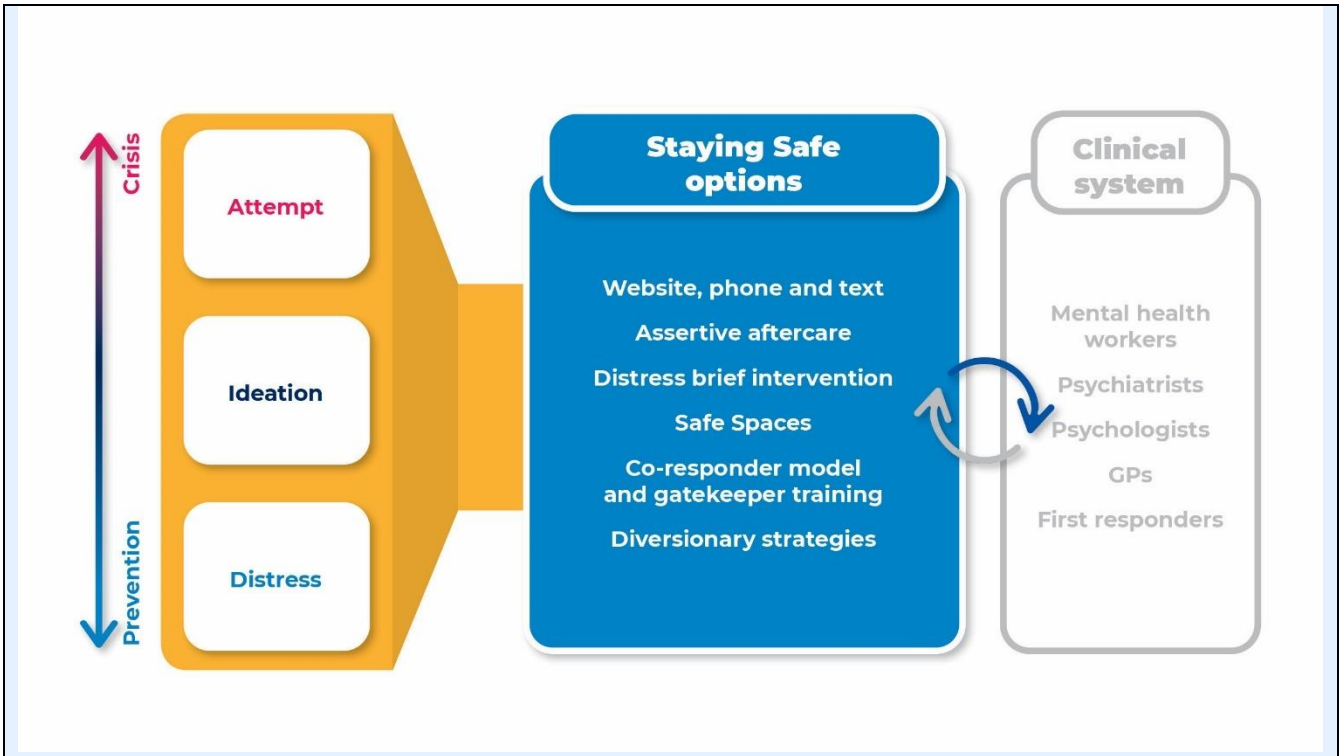


Figure 8: Diagram of a national model within the existing suicide prevention system.

Key parts of the system include:

- **A primary national website**: a well understood 'first port of call' for those who prefer to seek information anonymously and as a referral point for further information and services.
- **An integrated phone, webchat and text service**: some people may prefer more direct access to help when in crisis. Specially trained staff can provide immediate assistance and refer people to other services such as an appropriate safe space, the distress brief intervention, or clinical treatment. Government could look to the work done in New Zealand that has brought together a range of crisis and help lines to provide a seamless entry and referral path for people to readily access support anonymously on their smartphone, home phone or online.
- **Trained gatekeepers**: paramedics, GPs and police are often the entry point into the system for someone in suicidal crisis. One of our best preventative measures is to equip existing personnel with the skills to deliver compassionate care to people who might otherwise wait hours in the emergency room. We need pre-service tertiary-level education for paramedics in mental health and suicide prevention, and compulsory, nationally accredited training for GPs. Better equipped gatekeepers will keep people safe by recognising the signs of distress and crisis early, diverting people from ED and triaging them into the distress brief intervention, a suitable 'safe space', or into clinical care.
- **A Distress Brief Intervention:** we need an assertive early intervention initiative like aftercare that is primarily for people who are distressed but not yet in crisis. A Distress Brief Intervention offers people experiencing emotional distress the potential to receive care early, before their distress escalates into suicidal crisis. In this intervention, a person in distress is assessed by gatekeepers (police, ambulance, nurse, GP) and, if consenting, referred to trained coaches who provide 14 days of community-based psychosocial support, such as problem solving, wellness and distress management planning and connections to further supports. The Distress Brief Intervention involves principles and methods similar to assertive aftercare, including, specially trained staff that guide a person through safety planning and referral to services. However, whereas Beyond Blue's The Way Back Support Service is primarily for people who have tried to take their lives, the Distress Brief Intervention is less intensive and primarily prevention focussed. Based on a model currently being delivered by the Scottish Government, a Distress Brief Intervention offers the hope of getting a person's life on track before they become suicidal.[79]

- **A network of 'safe spaces' that divert people from the emergency department, drawing on the pilot being undertaken by Independent Living Australia and the work of Roses in the Ocean, including:**
    - Low-key community based drop-in options – like cafes – under a national banner. The highly successful 'safe haven café' operated by St Vincent's Hospital in Melbourne provides a scalable and flexible model that can be tailored to local needs, provide substantial savings for hospitals, and save lives.
    - A national network of residential settings where people experiencing suicidal thoughts can rest and be supported by peers and clinicians in a quiet, home-like setting over multiple days. Independent Living Australia's pilot 'SPARC' program (see Box 4.8) is trialling residential support in Australia.
    - Crisis stabilisation centres adjacent to every emergency department in Australia. The 'Crisis Now' model implemented in the United States offers an alternative to the emergency department for people in suicidal crisis. With a 'no wrong door' policy that welcomes everyone no matter their state of crisis (including people affected by alcohol and other drugs), people receive compassionate and attentive support from clinicians and lived experience peer workers in a non-threatening, non-clinical environment.

There are two critical drivers for this reform: (i) Too many people die by suicide without the people around them knowing they were suicidal and without having services and supports that may have helped them to keep living. We cannot always expect people in suicidal distress to reach out for help; we need to equip everyone in the community to know how to reach into them. We need clearly signposted options and entry points to support that everyone knows about. (ii) Australia is set to expand its investment in suicide prevention. It is essential the result is not more programmatic investment, leading to greater fragmentation and confusion, but rather systemic planning and investment.

The case for action

1. The momentum towards universal aftercare is promising, but we need to reach further back into prevention, helping people before they reach crisis and go on to attempt to take their lives.

- **It is easier and more effective to help people by getting them back on track before crisis hits.** This includes helping the many thousands of people in Australia who are thinking about suicide, and people who experience levels of distress that could, if left untreated, lead to suicidality.

2. People need a range of options to suit them otherwise they may not seek help.

- **Neither a piecemeal nor a one-size-fits all approach will work to prevent suicide.** We need a multiplicity of options to reduce suicide in Australia. Many people feel ashamed or scared about seeking help.
- **The key is to provide options, so everyone has a path, and all are encouraged to seek support**. Some will prefer the anonymity of accessing website information or receiving support via a phone call. Other people in crisis will prefer or need face-to-face support, or online, mobile phone videocalls, in the home or a residential setting. Choice is critical to ensuring we can assist as many people as possible to receive support.

3. Easy access to support through a simple, integrated, visible national system

- **A high profile and widely promoted national system of integrated support options will ensure everyone knows more about suicide and where to seek help.** The community is deeply concerned about suicide but feel ill-equipped to play a role in preventing it.[80] Current support options are limited and fragmented and do not reflect the reality of what it feels like to be in suicidal crisis. People and their support networks need to be able to turn to one front door, rather than navigate a complex system.
- **A powerful national effort on suicide prevention is critical for people in crisis, their families and communities**. This requires more than implementing a collection of disparate and unconnected strategies and programs nationally or across states and territories, health services and non-government organisations. It requires a coordinated and planned investment, led by the Commonwealth. Countries that have seen reductions over time in their national suicide rates – like England, Scotland and Japan – have done so through integrating services across jurisdictions and industries to ensure no person falls through the gaps.
- **'Quiet risk' is a major challenge.** Many people die or attempt suicide before family, friends and workmates realise the extent of the crisis. People with lived experience of suicide tell us there are numerous reasons they don't talk about it or seek support because they:
  - Do not fully understand what is happening
  - feel guilt and shame about their situation
  - may not want to burden others
  - may feel worthless and that they are a lost cause.
- **Pulling the sector together to work with government is a powerful way of overcoming fragmentation**. With a significant number of suicide prevention initiatives set to be rolled out in the next decade, there is a very strong risk that a fragmented, disconnected and confusing system could develop. If suicide prevention is to be effective in Australia, the sector must pull together under the guidance of Christine Morgan, Suicide Prevention Advisor to the Prime Minister to jointly develop a coherent, integrated suicide prevention system. This is urgently required to ensure we work collectively and cohesively to prevent suicide.

Detail on elements of the system

- A primary national website could provide a first port of call for many people in suicidal distress. Increasing evidence shows that some people prefer to seek help anonymously. Multimedia platforms are returning promising results in keeping people safe.
- For some, the complexity of online navigation or the limits of internet connection mean a phone or text line is the fastest way to get help when they need it. Much like 000 is used to triage people into emergency clinical care, people need a single number to call or text to receive help from non-clinical options as their first port of call.
- In November 2015, the New Zealand government established a National Telehealth Service to provide access to digital telehealth services that offer health, mental health and addiction support. Known as 'Homecare Medical', the Service provides a single entry point into support that is free and available 24/7, every day of the year. There are helplines for depression and anxiety counselling, poisons advice, and alcohol and other drugs support. The Service is owned by two primary health organisations and co-funded by the Ministry of Health, the Accident Compensation Corporation (ACC), the Health Promotion Agency (HPA), the Ministry of Social Development, and the Department of Corrections.[81]
- Moderated online forums offer a safe and anonymous online space for people to receive support from peers who have lived experience. As shown in Box 4.1, online forums reach a wide audience and have proven utility in reducing the severity of symptoms.

Box 4.1: Beyond Blue's online forums

Beyond Blue's online forums provide a safe, anonymous discussion space for seeking support around anxiety, depression, suicidal thoughts and related life issues.

Around 1.4 million people a year seek advice and support from others with similar experiences. Our research shows that as a direct result of using the forums, 67 per cent of people felt less depressed or anxious, 38 per cent contacted a health professional, and 69 per cent made a positive lifestyle change. Of all users, 26 per cent were experiencing a suicidal crisis.

Communities in greatest need are active users of the forums. Groups that indicate a higher likelihood of visiting the forums due to suicidal thoughts include younger people (aged 18-24), Aboriginal and Torres Strait Islander people, LGBTIQ+ people, and unemployed people.

Forum users are more likely than the general population to live in a regional, rural or remote area.

Most users (56 per cent) have lived with a mental health condition for over ten years.

Distress Brief Intervention[82]

- Many people experience forms of psychological distress that may serve as early warning signs of suicidality.
- We need to reach back into early intervention to help people before they escalate into crisis. People need a compassionate and effective response that helps them engage with and stay connected to services or support that may benefit them over time. By intervening early, we can prevent suicidality before it develops.
- As shown in Box 4.2, the Scottish Government is piloting a Distress Brief Intervention in four sites around Scotland, over five years. The intervention aims to address the gaps in the system for people experiencing distress that is not otherwise treated through medical pathways.
- A similar pilot in Australia – with a view to national roll out if successful – has potential to help many people in Australia to deal with distress before it escalates into suicidal crisis.

Box 4.2: Scottish Distress Brief Intervention

The Scottish Government's Distress Brief Intervention (DBI) program offers a time-limited and supportive problem-solving contact with an individual in distress. Its 'ask once, get help fast' approach has two levels. At Level 1, a person (aged 16+) presenting in distress to a frontline service (emergency department, police, paramedics, and primary care, including out of hours), is offered a compassionate interaction and a referral into Level 2. At Level 2, the person is contacted by a service provider within 24 hours of referral and provided with compassionate community-based support, including problem solving, wellness and distress management planning, and follow up support for 14 days.

The DBI program defines 'distress' as *'an emotional pain for which the person sought, or was referred for, help and which does not require (further) emergency service response'*. The DBI does not replace existing arrangements for anyone in distress who requires further medical treatment; it is an additional option for frontline staff.

The overarching aim of the DBI program is to provide a framework for improved inter-agency collaboration to support the delivery of an effective and compassionate response to people in distress, so they will engage with and stay connected to services that may benefit them.

Evaluation results are due in 2021. In the meantime, the following observations can be drawn from six-monthly engagement and routine performance data:

- **The training programmes build workforce skills, knowledge and confidence.** Staff delivering both Level 1 and Level 2 report improvements in collaborative working, a better culture of compassion, and improved workplace experience from being able to meet the needs of people in distress.
- **The DBI reduces psychological distress.** A total of 2,845 people were referred to the DBI Level 2 service across the four pilot sites up to the 30 April 2019. There was a high level of engagement by those referred, with levels of distress reducing from 8 out of 10 (extreme distress) at time of referral to 4 at last contact. Those who had presented in distress prior to the DBI also reported a much-improved experience through the DBI.[83]

Safe spaces

- **Australia needs a tiered network of 'safe spaces' in the community that divert people from the emergency department**. The full range of suicidal experiences need to be matched by a full range of support options, including alternative, safe spaces that target different levels of need, from early suicidal ideation to high intensity distress. For some, a drop-in style café may provide the compassionate setting they need to stay safe and well. Others in higher levels of distress or crisis may require a residential stay or a sub-clinical retreat centre operating close to the emergency department. Establishing a network of these settings would offer people tiers of support that cater to different levels of need, be available without referral or cost, and be accessed through the website, via gatekeepers (police co-responder units, GPs, paramedics), or on a walk-in basis.
- **A structured approach is required**. Based on a proposal by lived experience organisation, Roses in the Ocean, the Commonwealth Government is scoping a trial of tiered settings that range from quiet spaces for people to have a safe conversation, to residential centres and drop in cafes that provide direct alternatives to the emergency department. Beyond Blue supports such an approach, building on the fundamental principle that the spaces must be accessible, compassionate and cater to a range of intensity levels, as set out in the diagram below.

Figure 9 A tiered model of safe spaces

Tier 1 – Community support groups

- **Having the freedom to talk openly about suicide may be the most effective support for some people.** Some, particularly those living with chronic suicidality, may simply want a safe place to discuss their suicidal ideation within a supportive and supervised group setting.
- **Some may be afraid of talking openly about their suicidality to loved one for fear it will upset them and could trigger a crisis response that may be unwarranted.** The fear of attending an emergency department or a compulsory admission can result in some people remaining silent. Community support groups give people safe spaces to talk openly.
- **Facilitated community groups offer an additional option to talk safely about suicide and an avenue for people to cope with their feelings and concerns.** Many may not feel comfortable talking with their family and friends. The national suicide prevention campaign *#YouCanTalk* tells us that community concern about suicide is high but myths about suicide prevail and general literacy about what everyday people can do to support others is poor. For instance, Beyond Blue funded research by the University of Melbourne showed that 50 per cent of people believe that you need to be a health professional to talk to someone safely about suicide, and 30 per cent of people believe discussing suicide could encourage a person to consider planning suicide. However, the research showed that people with lived experience of suicide found it most helpful for others to 1) ask how they are feeling and explain any changes they have noticed in their behaviour, 2) listen without judgement and without trying to advise them how to 'fix' their situation, and 3) ask direct questions about whether the person is thinking of suicide and has a plan.[84]
- **In addition to improving social attitudes and general suicide literacy, people experiencing suicidality in Australia need places to go to connect and talk without judgment.** As shown in Box 4.3, community groups are an emerging option in Australia, and one that offers promise for intervening early in people's distress trajectory.

Box 4.3: Lifeline's Eclipse Support Group[85]

Eclipse is a support group for adults who have survived a suicide attempt. The group provides an opportunity to meet and talk with others who have survived a suicide attempt. Participants may learn skills that assist in coping with feelings and thoughts of suicide in order to stay safe in the future.

At three locations across Sydney and the mid-coast of NSW, the group runs two-hour sessions over eight weeks, co-led by a facilitator and a peer survivor. Referrals are not required but clinician support is recommended. Since the group offers support not therapy, Lifeline recommends group participants have additional resources outside of the group, such as counsellors or therapists.

Eclipse is an Australian version of the 'Survivors of Suicide' model operating in the United States, which aims to reduce suicidality, increase resilience and facilitate help seeking behaviour. Lifeline piloted its group in the mid-coast of NSW in 2017, alongside the University of New England. Participant feedback revealed improvements across a range of areas, including resilience, problem solving, perceptions of burdensomeness, reduced severity of depression and suicidal ideation.

Tier 2 - Peer workers in every emergency department

- **Installing lived experience peer workers in every emergency department in Australia creates a safe space within an otherwise busy and noisy environment**. At Beyond Blue's community engagement workshops with The Australian Centre for Social Innovation, people who had attempted to take their own lives told us that before or after their attempt they would have hugely valued speaking to someone else with an experience of suicidal crisis.
- Peers are crucial because people in crisis immediately know they are understood and are not judged. They are also more likely to talk about the problems that have long been troubling them – about which they may feel guilt or shame. Saying aloud your problem to another person is a big moment, and a critical first step on the road to recovery.

Box 4.4: Peer workers in the emergency department

'Michael' is the first lived experience peer worker to be assigned to the emergency department in Victoria. He is employed by the St Vincent's Safe Haven Café (see Box 4.6) and is tasked to build the pathway for people in the ED into the café. Michael works the same hours as the café and reports to the consultant in charge on shift. Because he doesn't have a mental health 'badge', he can sit with anyone without the risk of stigma. Often, he will sit with someone with physical injuries and simply listen to their stories. In many cases, there is more to their injury and if it is suitable, he may invite them to visit the café following discharge for additional support.

Tier 3 - Safe haven cafes

- **Diversionary settings that provide direct alternatives to the emergency department are returning promising results.** Highly successful examples include 'safe haven cafes' where someone in distress can receive comfort, de-escalation assistance and advice from a peer worker. Instances of this model exist in Aldershot, North East Hampshire[86] and, as shown in Box 4.5, the new Safe Haven Café at St. Vincent's Hospital in Melbourne.[87]

Box 4.5: St Vincent's safe haven cafe[88]

The St. Vincent's Hospital campus at Fitzroy, Melbourne (in partnership with Better Care Victoria) is home to Melbourne's only Safe Haven Cafe. The St Vincent's Safe Haven Cafe provides a safe alternative to the emergency department for adults (18+) experiencing loneliness, personal difficulties, or simply seeking social connection. The cafe is open on Fridays from 6pm-8pm and Saturdays and Sundays from 2pm-8pm and is located in the art gallery at St. Vincent's Hospital Fitzroy.

Designed by people with a lived experience of suicidality, the Safe Haven Café offers a compassionate alternative to attending the emergency department. It offers respite in a caring and respectful environment with an emphasis on peer support to empower people looking for assistance but not needing acute care. Guests are welcomed with free tea and coffee, invited to sit with peer workers and other guests to unwind and feel safe.

The Safe Haven Café is modelled on a successful service operating in Hampshire, UK since 2014. It has been shown to reduce social isolation for vulnerable people and to help them maintain their mental health on an ongoing basis.

An economic evaluation by PwC found that the St Vincent's Safe Haven Café saved the hospital $225,400 in avoided admissions to the emergency department and has significantly improved the outcomes for people living with mental health illness in the community.[89]

Tier 4 - Stabilisation centres adjacent to the emergency department

- **People who need clinical assessment and treatment in hospital should have the option of an alternative to the emergency room.** Crisis stabilisation centres provide that option. Located away from the stressful and confronting atmosphere of the emergency room, stabilisation centres offer a warm, calm environment where a person can receive help from trained and specialist staff, comprising a mix of peer and clinical workers.
- **Stabilisation centres are higher intensity diversionary option.** They are located closer to the emergency department and, unlike safe haven cafes or community groups, are typically attended by people in crisis who might otherwise be treated in the emergency department. As shown in Box 4.6, stabilisation centres have the potential to deliver significant savings for the hospital system in diverted resources, as well as providing potentially life-saving support for people in crisis.

Box 4.6: Crisis stabilisation centres in the United States[90]

Crisis.Now is a diversional program run in Arizona, US that comprises short-term, sub-acute residential crisis programs, a centralised call centre to triage calls from people in need, and a 24/7 mobile crisis team that collects people from where they are and delivers them to the centres. The 'no wrong door' policy means people are accepted in whatever condition they arrive in (including affected by alcohol or other drugs) and no one is turned away.

Early results indicate Crisis.Now saved $37 million in ED costs, reduced psychiatric waiting times by a cumulative 45 years, and diverted an equivalent of 37 FTE police officers away from conveying people to hospital.

Tier 5 - Residential spaces

- **People in crisis should also have the option of attending residential settings where they can receive compassionate care from peer workers.** The Maytree Suicide Respite Centre in North London is a residential sanctuary offering free 4-night/5-day residential stays for people in suicidal crisis.[91] An evaluation of the service revealed positive qualitative and quantitative results after three years of operation. Guests showed a statistically significant reduction in problems and risks on exit, and the majority of ex-guests surveyed had improved from "clinical" to "normal" within three months.
- As shown in Box 4.7, Independent Living Australia, in collaboration with Roses in the Ocean, is bringing the Maytree model to Australia.

Box 4.7: Independent Community Living Australia's 'Suicide Prevention and Recovery Centre'[92]

Independent Living Australia is co-designing, trialling and evaluating a non-clinical 'Suicide Prevention and Recovery Centre' (SPARC), with Roses in the Ocean. Backed by $1.25 million funding in the 18-19 Federal Budget, the trial will be based on the Maytree model and will be NSW's first non-clinical residential support and care centre for people experiencing a suicide-related crisis.

Located in Bondi, Sydney, the SPARC will provide accommodation for five days and four nights for up to four guests at time, with an option to return. The physical environment will be a welcoming 'homelike' space, where daily household activities like cooking and gardening run 'in the background' and guests can participate in relaxing activities like art/yoga/beach walks/open dialogue. The SPARC will be free of charge and not require a referral – guests will be selected following a 'befriending' conversation in which their needs and compatibility for the home will be assessed.

Roses in the Ocean is leading the co-design of the operational model and will provide training to the lived experience staff. Peer workers will form the majority of staff at the SPARC accompanied by a mix of mental health and support workers.

Gatekeeper training

- **We need better trained staff to care for people experiencing suicidality.** Evidence of effectiveness of gatekeeper training in reducing suicidality is still emerging but is promising.
    - A recent simulation study showed that GP training is likely to be one of the most effective strategies for reducing suicide in Australia, being associated with a six per cent reduction in suicide.[93]
    - Preliminary findings from *Beyond the Emergency*, a study conducted by Turning Point in collaboration with Beyond Blue on a national sample of male paramedics are striking: while some paramedics provide appropriate care for people in suicidal crisis, a significant number stigmatise people, further exacerbating their condition. Moreover, many paramedics report low mental health literacy, feeling ill-equipped to carry out a mental health assessment, or even identify suicide-related symptoms.[94]
- **The benefits of gatekeeper training are not limited to the person receiving support.** Research conducted on police and emergency services staff revealed that many experience trauma and poor mental health, often for long periods of time.[95] If frontline staff are able to recognise and address their own mental health issues, then they are better able to provide support and compassionate care to the people who need them most.

Box 4.8: Mental health training for GPs and paramedics

Models of gatekeeper training should include:

- **A suite of integrated training modules for prospective, pending and established paramedics**, focusing on building paramedics' communication skills and mental health responses, which can be delivered during pre-service education and on-the-job continuing professional development. This could be achieved by incorporating **mental health content into undergraduate training courses** for paramedics, into qualified paramedic **professional development/training days** and **authority to practice (ATP) training requirements**. This would align with the industry's conceptual transition from transport logistics to the health profession.
- **Training that targets GPs**. GPs play an important 'gatekeeper' role in assessing risk, redirecting people towards appropriate care, and reducing stigma, being the first point of call for many people suffering from suicidality. A 2018 simulation study using a decision-making tool developed by Sax Institute predicted GP training as the most effective strategy for reducing suicide between 2015 and 2025 in Australia, followed by coordinated aftercare.[96] GP training is part of the Black Dog Institute's *LifeSpan* trials currently throughout New South Wales and the ACT.[97] Evaluation results will provide greater insight into the effectiveness of the training, and any opportunities for investment.
- Content that is **accessible, practical and non-stigmatising**, which could be delivered online as part of credentialing requirements.
- **Infrastructure to support the training that promotes help-seeking**, including **a website for professionals**, a **referral card** that encourages frontline professionals to take action by being informed, exploring self-help strategies and seeking professional support.
- Expanded and deeper research on the suicide literacy of frontline workers, in particular GPs and paramedics.

5. Pursuing equity and tackling discrimination

Improving social and emotional wellbeing in Indigenous communities

Beyond Blue welcomes the Productivity Commission's recognition of the distinctive approach of Aboriginal and Torres Strait Islander peoples to social and emotional wellbeing. Particularly noteworthy are:

- a strong understanding of the holistic approach of Aboriginal and Torres Strait Islander people to social and emotional wellbeing, with emphasis on connection to land, sea, culture, ancestry, family and community
- reflections on reconciliation, self-determination and the community support for constitutional recognition as drivers for better outcomes for Aboriginal and Torres Strait Islander people
- support for traditional healing practices and exploring the intersection between these and mainstream clinical approaches.

However, Beyond Blue is concerned that the recommendations to improve Aboriginal and Torres Strait Islander social and emotional wellbeing do not go far enough:

- the underfunding of social and emotional wellbeing services in Aboriginal Community Controlled Health Organisations (ACCHOs) is an urgent problem that must be addressed, as recognised by the Royal Commission into Victoria's Mental Health System
- the implementation of national strategies and plans needs to be properly resourced
- the structural, systemic and historical contributors to Aboriginal and Torres Strait Islander ill-health, social and economic disadvantage, should be more decisively addressed.

Recommendations

The Commonwealth Government should:

- Provide an increase in funding and long-term funding certainty to Aboriginal Community Controlled Organisations (ACCHOs) sufficient for them to meet the demand for locally relevant social and emotional wellbeing supports and services in their communities, including programs that support connection to culture.
- Fund the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017-2023.
- Embed Aboriginal and Torres Strait Islander leadership across the mental health system.
- Fund and foster local partnerships between mainstream services and ACCHOs to increase cultural competence in mainstream services, as well as improve service integration for Aboriginal and Torres Strait Islander people.
- Establish the formal structures necessary to give effect to a First Nations Voice at all levels of government, so that Indigenous Australians can develop policies that affect them in partnership with Australian governments.

The Council of Australian Governments should:

- Ensure the Close the Gap refresh: is developed in close partnership with Aboriginal and Torres Strait Islander people; includes social and emotional wellbeing targets; and delivers comprehensive reform and funding to close the gap in life outcomes, critical in its own right, and central to supporting social and emotional wellbeing.

The case for action

1. The social and emotional wellbeing crisis in many Aboriginal and Torres Strait Islander communities must be prioritised, taking a strengths-based approach and led by communities.

Social and emotional wellbeing in Aboriginal and Torres Strait Islander communities is a more holistic approach to thinking about mental health, which includes physical, psychological, social and spiritual dimensions that are influenced by an individual's connection to land, sea, culture, ancestry, family and community.[98] The impact of colonisation in Australia has led to widespread disruption and disconnection across these dimensions. The social and emotional wellbeing of Indigenous communities has been harmed where people have experienced intergenerational trauma, are separated from family and community, are unable to participate in their culture, experience socio-economic disadvantage or are subjected to repeated discrimination and racism. Consequently, Aboriginal and Torres Strait Islander peoples are:

- three times as likely to report high or very high levels of psychological distress as non-Indigenous Australians
- two and a half times more likely to be hospitalised for intentional self-harm than non-Indigenous Australians
- twice as likely to die by suicide as non-Indigenous people in Australia.[99] In 2017, suicide was the fifth leading cause of death among Aboriginal and Torres Strait Islander peoples.[100]

2. Social and emotional wellbeing services delivered by Indigenous health organisations need urgent funding attention.

- Mental health/social and emotional wellbeing services constitutes the top health services gap, reported by over 60 per cent of ACCHOs.[101]
- Aboriginal-led services foster self-determination, positioning ACCHOs as best placed to deliver care that is holistic, culturally safe, and trusted. ACCHOs must have long-term funding certainty to develop sustainable models of care to support their community. Internationally, the Organisation for Economic Co-operation and Development identifies short-term funding as a major risk for reforms in Indigenous self-governed sectors.[102]
- Primary Health Networks (PHNs) receive hypothecated funding to deliver programs and services for Aboriginal and Torres Strait Islander people, however there is no requirement to commission ACCHOs to deliver these services. Further, mainstream tender processes can undermine relationship building and create a potential barrier for local services to be considered.
- The Royal Commission in Victoria recommended a structured approach to expand the reach of social and emotional wellbeing teams across the state through training, long term indexed funding, and support for the peak body, Victorian Aboriginal Community Controlled Health Organisation (VACCHO), to develop, lead and host an Aboriginal Social and Emotional Wellbeing Centre.

3. The implementation of national strategies cannot succeed without sufficient funding

- The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 sets out a compelling and culturally appropriate stepped care model and is a critical part of ongoing reform to the mental health system. The Productivity Commission's recommendation to see this Framework driven by an appropriate implementation plan is supported, but implementation must be adequately funded to make a significant difference.

4. Developing a strong Closing the Gap agenda in partnership with Aboriginal and Torres Strait Islanders can deliver better social and emotional wellbeing outcomes

- Closing the Gap in life outcomes is essential in its own right and can foster social and emotional wellbeing.
- Causation also runs in the other direction. Targets and action on mental health and suicide prevention is a lynchpin to achieving Closing the Gap targets in all other areas, notably education, labour market participation and mortality. Without good mental health, it is hard for children to learn, or for adults to get jobs and excel at work. People with poor mental health die significantly earlier than average.

5. Establishing a First Nations Voice at all levels of government is a vital element of reform

- Aboriginal and Torres Strait Islander peoples should have a clear say in policies and legislation that impacts upon them and their communities.
- The Australian Constitutional Values Survey released by the Centre for Governance and Public Policy at Griffith University (2017) found 61 per cent of respondents would vote "yes" in a referendum to add an Indigenous voice to Parliament.[103]

6. Stronger Indigenous leadership and governance is essential to ensure the system meets the needs of Aboriginal and Torres Strait Islander people.

- The evidence in Australia and overseas is compelling. When Aboriginal community organisations receive the support they need and deserve, and have strong purpose and governance, they successfully address the effects of colonisation, dispossession and inter-generational trauma, which are still part of the lived experience of many Aboriginal and Torres Strait Islander peoples today.
- The Royal Commission into Victoria's Mental Health System illustrated how this could be done by:
    - ensuring that ACCHOs have recurrent funding for social and emotional wellbeing teams across the state
    - creating scholarships to develop the necessary qualifications and experience for Aboriginal leadership in clinical services
    - recurrently funding an Aboriginal Social and Emotional Wellbeing Centre for the whole state that joins Indigenous leadership and governance with clinical research and expertise to provide practice guidance and build on the evidence for better outcomes.

7. Indigenous people should have access to culturally competent services, regardless of where they live.

Research supports the notion that strong cultural identity is a central element of social and emotional wellbeing.[104] Practising culture can involve a living relationship with ancestors, the spiritual dimension of existence, and connection to country and language.[105] Aboriginal and Torres Strait Islander peoples with strong attachment to culture have better self-assessed health, and among those who speak an Indigenous language and participate in cultural activities, mental health is significantly better.

The Productivity Commission's support for an expanded role for traditional healers reflects an understanding of the types of services that may best meet the social and emotional wellbeing needs of communities as well as the value of Indigenous-led solutions. Traditional healers personify a holistic approach to good health. Their work alongside western medicine practitioners also demonstrates the opportunities for greater collaboration and for greater learning by non-Indigenous communities from Aboriginal and Torres Strait Islander people's approach to wellbeing.

Continuing to build the cultural competence of mainstream services is vital. Some promising practices emerging in health settings include:

- employing workers, paraprofessionals and professionals who are culturally competent, and supporting all staff to complete training, where required
- having trauma-informed staff available in services supporting Aboriginal and Torres Strait Islander communities
- developing culturally safe protocols
- designing and evaluating mental health programs and services in genuine partnership with Aboriginal and Torres Strait Islander people.

Health services should be encouraged to build their cultural competence through partnerships with local ACCHOs. This not only provides a mechanism for greater learning, but can support better transitions for Aboriginal people between acute care and the community.

Addressing insurance discrimination

Beyond Blue welcomes the Productivity Commission's recognition of the discrimination people with a mental health condition face in accessing and making claims from insurance products. The recommendation for the Australian Securities and Investments Commission (ASIC) to evaluate insurance industry standards and practices is especially noteworthy. Beyond Blue believes people with a mental health condition are entitled to fair and equitable access to insurance products, to protect themselves and their families against financial stress and uncertainty.

However, Beyond Blue is concerned that:

- Self-regulation continues to be seen as a viable option despite examples of systemic discrimination being raised to the Productivity Commission, the Parliamentary Joint Committee on Corporations and Financial Services Inquiry into the Life Insurance Industry, the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry and the Senate Economic References Committee Inquiry into the Regulatory Framework for the Protection of Consumers in the Banking, Insurance and Financial Services Sector.
- The ASIC review may not achieve the results necessary for widespread change across the insurance industry due to a lack of resourcing of regulation and enforcement.

Recommendations

- Ensure the proposed review of industry codes by the Australian Securities and Investment Commission (ASIC) also includes consideration of the legal enforceability of parts of the code, as recommended by the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry.
- The findings of ASIC's review must be fully resourced so that future regulation and enforcement of codes of practice are effective and efficient.
- Life insurers should not be supported to fund treatment (DR 24.6) until after the ASIC review is complete, strong regulations are in place and insurers have consistently and comprehensively demonstrated that their industry understands mental health in its diversity and is using valid statistical and actuarial data to support decision making.

The case for action

1. Self-regulation has not been effective; stronger enforcement provisions are needed

- Major inquiries over the last few years – including the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry and the Parliamentary Joint Committee Inquiry into the Life Insurance industry – have been highly critical of insurance practices. These inquiries found that the life insurance industry generally has poor legal consumer protections, a poor claims handling practice, the need for a specific mental health code of practice and that the industry already has too much access to personal medical information. They have noted that self-regulation is not working to prevent poor practice. Consequently, at a minimum, a co-regulatory model is needed for the code of practice to become effective.
- For the proposed ASIC review into insurance industry Codes of Practice and standards to have its desired effect, the enforceability of the codes must have legal effect – a recommendation made by the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry.
- The implementation of ASIC's recommendations must be properly resourced, including coverage for those insurers who aren't governed by the FSC industry standards, to ensure its findings have broad impact.

2. In the absence of much stronger regulation and evidence of improved practice, the role of insurers in health treatment and decisions should not be increased

- To date, there has been little evidence to suggest the life insurance industry has a comprehensive understanding of mental health issues, how this might impact their underwriting and risk assessment, and their response to applicants and claimants. Change in the sector continues to lag behind consumer expectation, and the changes that have been made are generally piecemeal.

- Treating all mental health conditions as a homogeneous group without adjustment for diagnosis, prognosis, risk and protective factors and individual variation, is like treating all chronic physical conditions – heart disease, cancer, diabetes and arthritis – as a single group of conditions and making decisions relating to insurance accordingly.
- Cases of discrimination appear to be driven by an under-reliance on available statistical and actuarial data and an over-reliance on views of the nature of mental health conditions, often based on deeply flawed understanding of these conditions. Policy wording commonly refers to symptoms (e.g. stress, insomnia) or risk factors (e.g. family history) as proxies for a diagnosed mental health condition. Our long-term engagement with the community suggests insurers may also attribute a mental health condition to someone who has seen a counsellor or psychologist, even if this contact was unrelated to a mental health condition (e.g. relationship counselling, career counselling).
- Further, there is an inherent power imbalance and conflict of interest in a relationship where a for-profit entity is paying the tab for treatment services – as distinct from prevention activities. It is also the entity with a vested interest in returning a person to work faster to reduce the overall payout, which may include income protection for the period a person is away from work. Anecdotal evidence about insurer interactions with customers, both at the point of application and claim, also shows their practice must be improved to prevent further stress and harm.
- In light of the above points, the recommendation to permit life insurers to fund mental health treatments is not supported by Beyond Blue. Proposing for ASIC to work with the industry is not a sufficient safeguard. However, subsequent to the proposed ASIC review and any consequent changes in legislation or regulation, future changes along these lines should be considered if the industry's track record in dealing with mental health demonstrates substantial positive change.

About Beyond Blue

Beyond Blue is a national, independent and bipartisan not-for-profit organisation. Our vision is for all people in Australia to achieve their best possible mental health. We work to create change to protect everyone's mental health and improve the lives of individuals, families and communities affected by depression, anxiety and suicide.

Six priority areas for strategic impact

Beyond Blue delivers a package of integrated initiatives across six areas that we believe are essential to improving Australia's mental health.

Impact area	Major initiatives
1. Prevention and early intervention where people live, work and learn	• **Healthy Families:** providing practical resources to build children's resilience and support mentally healthy parents and carers. • **Heads Up**: facilitating the adoption of workplace mental health strategies in organisations across Australia; lifting resilience, recovery and productivity. • **Be You:** Australia's national education initiative, working to change the mental health trajectory of Australia's children and young people.
2. New service innovation to support reform of the mental health system	• **NewAccess:** an affordable new type of early intervention, using a new localised workforce to coach people with mild-to-moderate symptoms of depression and anxiety; delivering a recovery rate of 70 per cent and a cost-benefit of 1.5. • **The Way Back**: supporting people after a suicide attempt with one-on-one, non-clinical care and practical support in the community; achieving significant reductions in reattempts and suicide deaths. • **BeyondNow:** A digital suicide safety planning tool for people to make their own shareable plan. The plan is a click away to keep them safe when they experience suicidal thoughts.
3. Changing the conversation - improving mental health literacy, stigma & discrimination	• **Campaigns**: e.g. 'Know When Anxiety is Talking', a national campaign to help people to recognise and take action on anxiety conditions and the collaborative #YouCanTalk initiative. • **Traditional and social media:** Beyond Blue reaches millions of Australians through our newsroom contacts, media releases and opinion pieces. Beyond Blue also has over 600,000 social media followers – the largest of any Australian mental health not-for-profit.
4. Supporting people in need	• **Beyond Blue Support Service**: helping over 190,000 people a year with free advice and immediate counselling from trained mental health professionals. • **Online peer-to-peer forums**: helping over 1.4 million people a year seek advice and support from others, with measurable, positive outcomes. • **Beyond Blue website**: helping almost 13 million people in the past year with information and tools to recognise and recover from depression, anxiety and suicidal thoughts.
5. Policy advocacy and research to drive system change	• **Policy advocacy:** delivering high quality policy propositions through expert analysis, strategic insights and collaboration with key stakeholders. • **Research:** Since 2002, Beyond Blue has invested $70 million in research to identify and disseminate best practice.
6. Partnering with people affected by anxiety, depression or suicidality	• **blueVoices:** an online reference group of more than 7,000 people who have been personally affected by depression, anxiety and/or suicide. They provide expert advice and insights to inform all aspects of Beyond Blue's work. • **Speakers and Ambassadors:** 22 Ambassadors and over 300 Speakers undertake more than 1000 engagements a year across Australia, lifting mental health literacy and smashing stigma.

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