Beyond Blue submission to the Royal Commission into Victoria's Mental Health System

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Introduction

Beyond Blue welcomes the opportunity to make this contribution to the *Royal Commission into Victoria's Mental Health System*. Our CEO was honoured to appear as a witness before the Commission, and her witness statement adds more detail to this submission.

We commend the Victorian Government for placing mental health at the centre of its social policy reform agenda and drawing on the highest possible form of inquiry – a Royal Commission – in order to pursue transformational change for the people of Victoria. We were also encouraged to see the Government's strong commitment to act on the findings and recommendations of the Royal Commission.

We also support many of the areas of emphasis in the Terms of Reference – including the focus on: prevention; intervening early in life, early in illness and early in episode; improving access and smoothing system navigation; addressing the needs of family members and carers; delivering person-centred care; and improving support for those who live with both mental health and problematic alcohol and drug use. The guiding principles underpinning the Royal Commission – particularly the commitment to inclusive engagement and respecting the expertise of people living with mental illness – will be critical to achieving high impact and meaningful reform.

As a national organisation, Beyond Blue has made a submission to the Productivity Commission Inquiry into the economic impacts of mental ill-health in Australia. Because the systemic and structural factors related to mental health and wellbeing are shared across the country, and mental health reform can only succeed through coordinated reform by the Commonwealth and the states, most of the content of that submission is included here, except where the Victorian context calls for specific attention. Given the common agenda and shared responsibilities in mental health, Beyond Blue strongly encourages the Royal Commission to work closely with the Productivity Commission to achieve the best outcomes across Commonwealth and State jurisdictions. In Australia's federated structure, this kind of collaboration is critical to reducing fragmentation, increasing efficiency and delivering the best results consistently across the nation. This Royal Commission, along with the Productivity Commission Inquiry, has the potential to mark a watershed moment by bringing together Commonwealth and state governments in much needed and overdue root and branch reform. Around 45 per cent of Australian adults will experience a mental health condition during their lifetimes.[1] Four million experience a mental health condition each year and nearly 6 million people are 'at risk' of developing a mental health condition.[2] The annual cost of poor mental health to the economy is around 4 per cent of GDP.[3] Stigma and discrimination have reduced for common mental health conditions, such as depression and anxiety, but remain stubbornly high for low prevalence conditions. We still need to address self-stigma, in particular.

We know that most of our current systems are too crisis-oriented, costly and overburdened. We should be proactively investing in the big settings where people live their lives to reduce the burden on more acute and specialist services.

There are also inequities in the prevalence of mental health conditions and access to services, which are linked to other social and economic disadvantages in our communities. A fairer system would recognise these connections and be resourced to tackle them.

We lack a coherent, integrated system that is person rather than provider centric; that works across levels of government; and that reaches and supports those in most need. Our current structures often lack the flexibility to accurately match clinical and non-clinical responses to varying levels of need and complexity. Far too often, the services and supports that are needed simply are not there.

Victoria has experienced additional issues, with problems in the recommissioning of state-funded community mental health services in 2014,[4] the transfer of the bulk of the state's community mental health funding into the NDIS and the subsequent failure of the NDIS to include many of the people previously supported by state and Commonwealth-funded services.[5]

However, there has been progress. The community is recognising the limitations of our current systems and wants to see genuine change. Since Beyond Blue was founded, nearly 20 years ago, the public discourse about mental health and mental ill health, as well as the policy and funding landscape, have

changed substantially. Mental health enjoys bipartisan support, growing political attention and funding, especially to increase access to psychological services. There is growing understanding of the scale and impact of mental health issues, along with increasing openness to talk about mental health in families, among friends, at work and broadly in the community. Australia is one of the most mental health literate countries in the world.

We have a lot of evidence, both locally and internationally, about what works and what doesn't. We know that the best services listen to and learn from the voices of people whose own experiences of mental health issues inform practical and compassionate solutions. We can build on this evidence and have the chance to lead the world with innovations that establish the next wave of best practices in mental health prevention, early intervention, crisis management and recovery.

We know that reforming our mental health systems to achieve better outcomes for people and families will take time and sometimes hard choices. There can be no doubt about the scale and significance of the challenge before us. We need a bold vision to drive transformational change, if we are going to fundamentally shift the present situation.

All Australians need an approach to mental health and suicide prevention that sees and acts broadly across the social determinants of health, that prioritises primary prevention and early intervention, but also adequately resources crisis and aftercare services, so that a person's worst day does not come to define their life.

Beyond Blue joins many others in calling for:

- Future investments in the type and range of services and supports that people and families are saying they need.
- A long-term, bipartisan national strategy and financing plan that survives the slings and arrows of election cycles and replaces short-term funding cycles.
- Recommendations that are systemic rather than programmatic.
- Significant structural reforms, including to financing and administrative arrangements.
- A whole of life approach that addresses social determinants rather than just a biomedical, health-centred one.
- A greater focus on prevention and early intervention in community-based settings, without leaving behind those who need acute and crisis support.
- A commitment to a mix, type, distribution and scale of services and support – from self-managed care, to peer-led work, multidisciplinary teams and biomedical interventions – resulting in a more 'balanced portfolio'.
- The development of, and respect for, new workforces.
- A focus on improving equity to supports and services.
- A commitment to meaningful evaluation (focused on outcomes not activity), and adequate funding to do so.

In making this submission, we have taken a population health approach.

Our submission identifies five critical areas for action. We know there are others, however, these areas have been identified by asking our BlueVoices community of people who have lived experience of depression, anxiety and/or suicide. Around 700 people responded when we asked what was important to them and what they wanted to see happen. We also conducted interviews with 30 other expert stakeholders and commissioned detailed evidence checks to better understand what works.

Underlying each area is the need to tackle inequity, dealing with the causal factors that disproportionately impact some groups and ensuring that everyone has access to the services and supports they need.

Overleaf we summarise these five areas and the actions we believe can help everyone in Australia achieve their best possible mental health and reduce the suicide toll.

Submission on a page: Priority areas for action to improve Australia's mental health and prevent suicide

1. Preventing anxiety and depression from the early years	2. Preventing anxiety and depression in workplaces	3. Putting the missing steps in stepped care	4. Reducing Australia's suicide toll
50% of mental health conditions occur before the age of 14 and 75% by age 25. Focusing on healthy childhood development, building resilience and supporting parents and families can avert the onset or mitigate the impact of issues. Prevention and early intervention in the early years will change Australia's mental health trajectory at a population level – fundamentally reducing the incidence of mental ill health. Yet a system to support the mental health and wellbeing of children 0-12 and their families barely exists.	Work can support mental health, giving purpose, meaning and connectedness. The stresses of work can also be a factor in mental ill health. Catalytic action by government can convert goodwill among employers into comprehensive mental health strategies in workplaces across the nation. This will help improve mental health for the 13 million working Australians, while boosting national productivity.	60% of the population are well, 23% are at risk of developing a mental health issue, nearly 15% have a mild or moderate mental illness, and 3% live with severe mental illness. Yet the current population approach incentivises more expensive clinical interventions via universal schemes. Outcomes and recovery rates are not measurable. Services are weighted to where the workforce practice, not where people live. Low intensity prevention and early intervention services – like coaching, digital and self-guided interventions – are cost effective and deliver what most people need. Yet this system is still in its infancy despite the evidence.	An average of 8.6 people take their lives each day in Australia. Around 65,000 people attempt suicide and almost 600,000 think about suicide every year. The impact is devastating, yet most people in suicidal crisis or distress do not get comprehensive, compassionate and effective care.

Developing a national system to support the mental health of every child and their family	Embedding Be You, the integrated National Mental Health in Education Initiative, into Australia's education systems	Supporting the National Workplace Initiative to encourage mentally healthy workplaces	Building a national early intervention system of low intensity, non-clinical mental health supports	Building the peer workforce	Building a system of universal support for everyone in suicidal crisis or distress

5. Greater equity and inclusion

Disadvantaged Australians typically experience mental ill-health at rates 2-3 times that of their more advantaged counterparts, yet often access support at rates 2-3 times lower.[6] Without concerted and long-term action – and addressing broader social determinants – people with the greatest needs will continue to miss out.

Improving social and emotional wellbeing in Aboriginal & Torres Strait Islander communities	Prioritising housing as foundational for good mental health	Seeking a fair go inside and outside the justice system

Priority 1: Preventing anxiety and depression from the early years

Developing a national system to support the mental health of every child and their family

Recommendations

The Commonwealth, state and territory governments should develop and fund an integrated national system to support childhood mental health[7] including:

- A network of integrated children's mental health and wellbeing services available online and in local communities across Australia, so that every child and parent can get the support they need to thrive.
- Systematic assessments of children's mental health, using nationally consistent tools, to enable targeted early intervention programs for children and their families.

The national system should be complemented by services that help families to raise mentally healthy children including:

- The development and widespread dissemination of resources and programs to improve mental health literacy among parents and carers, so they know how to look after themselves and foster wellbeing in their children.
- Free, nationwide access to evidence-based parenting programs for families with a child at greater risk of developing a mental health condition.

The case for action

1. The most powerful means of shifting our nation's mental health trajectory is to support the healthy development, wellbeing and mental health of children.

- The first 1,000 days has the greatest potential to impact health and wellbeing throughout our lives.[8]
- Half of all mental health issues emerge by age 14[9] and around three-quarters before the age of 25.[10]
- 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.[11]

2. Many children and parents are struggling but aren't 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.[12]

3. The services children need often don't exist in their local area.

- 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.*"[13]

4. Mental ill-health impacts progress with education, putting at risk their lifetime opportunities.

- Students with persistent emotional or behavioural problems in Year 3, fall a year behind their peers in numeracy by Year 7, with similar, although smaller trends, in reading.[14] This education gap can persist or worsen across a child's education.

5. 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,[15] 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.[16]
- About one in three families don't access the help they need because they don't recognise early warning signs or think the problem might get better by itself.[17]

6. Evidence-based early childhood interventions 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.[18]
- 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.[19]
- 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.[20]

Examples of programs for children and parents

- **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 see: http://whatworksforkids.org.au/program/families-and-schools-together-fast-0
- **Triple P** – This 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 is a media campaign that 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, whereas levels four and five are more intensive individual or class-based parenting programs for families of children with more challenging behaviour problems. For more information see: www.triplep-parenting.net.au and http://whatworksforkids.org.au/program/triple-p-positive-parenting-program
- **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
- **Resilient Families** – This 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 early years of secondary school. Evaluations have recommended the program be implemented for primary school. The program is designed to increase family connectedness as well as improve social support between different families and between families and schools. The program is designed to promote social, emotional and academic competence and to prevent health and social problems in young people. For more information, see: http://whatworksforkids.org.au/program/the-resilient-families-program
- **Coping Cat** – This is a cognitive-behavioural treatment for children with anxiety. It includes four components – recognising and understanding emotional and physical reactions to anxiety; clarifying thoughts and feelings in anxious situations; developing plans for effective coping; and evaluating performance and giving self-reinforcement. For more information see: http://www.cebc4cw.org/program/coping-cat/

Embedding Be You, the integrated National Mental Health in Education Initiative, into Australia's education systems.

Recommendations

- Having established a single, high quality, evidence-based national initiative to support mental health in schools and early learning centres, the Commonwealth and state governments should back Be You for the long haul. This will ensure that educators know where to turn for guidance in supporting mental health, rather than being confused by a plethora of competing and disintegrated options.
- The Victorian Government should ensure that any new initiatives complement, rather than duplicate, Be You. Improving mental health literacy should lead to an increase in help seeking, which relies on the right supports being available and accessible.

The case for action

1. Be You can help children and educators achieve their best possible mental health.

- 40 per cent of parents report schools as place that first identified a child might need support.[21]
- 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. [22]
- The National Mental Health Commission stressed the importance of education settings in prevention and early intervention, but said we need to consolidate the plethora of initiatives in early learning and schools; Be You does this.[23]

Be You was launched in November 2018 with Commonwealth funding of up to $98 million over four years and equips 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.

A seminal reason for establishing Be You was to provide one national mental health initiative to work in schools and early learning centres, so that educators and children have one clear, evidence-based framework on mental health. Be You replaces and builds on the best of – and lessons learned from – successful but disconnected programs: KidsMatter, MindMatters, headspace School Support and Response Ability.

Be You includes an online platform – backed by a trained workforce on the ground – that assists schools and learning centres to:

- **Develop or upgrade their mental health strategies,** generally involving:
  - A pulse-check to identify mental health-related issues and prevalence in a service or school, educator professional development needs, engagement with parents and links to service providers.
  - Action teams involving leaders, educators, parents and young people to drive implementation using a plan-do-review cycle.
  - Over 70 expert Be You staff deployed across Australia guide the service or school through strategy development, implementation and review.
- **Empower educators to support the mental health of their students.** The main focus of Be You is to provide information, accredited professional development, advice and support to educators so that they can teach children and young people skills for good social and emotional development, work together with families, and recognise and suggest help for children and young people with mental health difficulties.
- **Create links to specialist services and supports.** This can include: prevention, for instance in areas such as bullying and respectful relationships; and early intervention, for instance assisting children experiencing mental health issues to access services.
- **Involve parents and carers in supporting the mental health of their children and young people.**

- **Respond when a tragedy occurs.** Expert Be You postvention staff provide immediate advice and support to a school in the event of a death, including suicide, in the school community. They support the principal on issues such as: how to talk to students and parents; how to engage the school community; conducting risk reviews to ensure the safety of others; and ensuring staff wellbeing. They prevent suicide contagion and help the school recover.
- **Support educator self-care.** Be You provides educators with tips and practical strategies to look after themselves and foster a culture of wellbeing.
- **Pre-service education.** Over time, Be You will develop mental health content for tertiary education courses, so the next generation of educators is equipped to support the wellbeing of their students.

2. Be You is an effective, evidence-based approach, developed with and supported by key stakeholders.

- Be You builds on the strong foundations created by longstanding programs, such as KidsMatter and MindMatters, which have been supported by independent evaluations.[24] Participating KidsMatter and MindMatters schools and services have been transferred into Be You.
- Be You builds on these programs by providing:
  - integrated and more streamlined guidance that is consistent across the entire education journey;
  - content and teaching methods based on the latest research;
  - information available to educators when they need it, rather than asking educators to work through linear modules;
  - continuous improvement through independent evaluation.
- Be You was established through comprehensive engagement with all relevant stakeholders, including experts from the education sector, universities, social innovators, implementation scientists, Commonwealth, state and 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. In all this has included 380 individuals across 180 organisations.
- Since its launch in November 2018, nationally nearly 63,000 educators have created individual learning accounts and 2,471 early learning services and 4,577 schools have registered to become Be You learning communities. Victoria represents almost a quarter of registered schools and a fifth of early learning services. More than 23,000 individuals have registered from Victoria.

3. We must avoid reintroducing fragmentation and back Be You for the long haul.

A justified criticism of the mental health system is that too often services are not integrated and do not wrap around the people seeking support, so navigating the system and knowing where to turn is harder than it should be. While many good programs have been provided to schools and early learning services, at times in the past educators have had difficulty knowing which to utilise.

Be You now provides an integrated, end-to-end national initiative from the early years to age 18. It is now critical that governments invest in Be You for the long haul, avoiding unnecessary duplication and focussing investments on complementary initiatives, such as providing more effective mental health support for children who need more specialised early intervention services, and psychological services for early learning services professionals, principals and teachers.

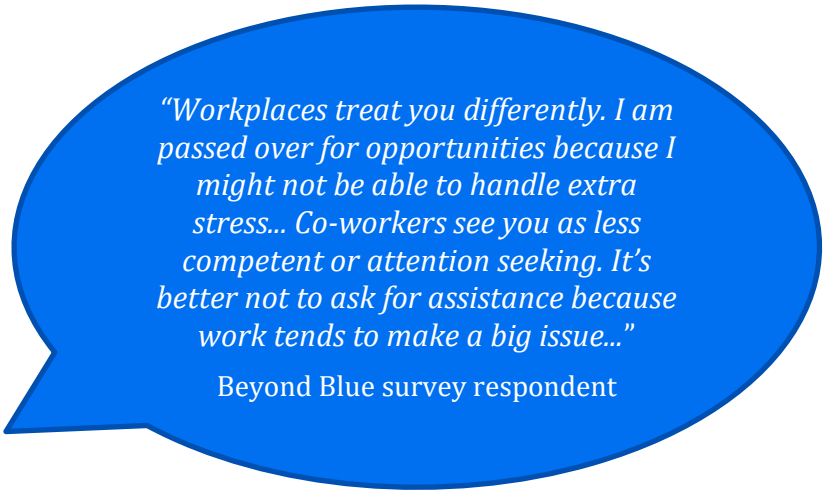
Some positive examples of complementary investments in Victoria over the past 12 months include $51.2 million for a **Mental Health in Schools program** and a $7 million **Victorian Anti-Bullying and Mental Health Initiative**. **Smiling Mind** received a Victorian Government Grant **to work with Victorian primary school principals and deputy principals** to take a system-level approach to collaboratively improve school culture and climate and enhance workplace protective factors associated with principal wellbeing and mental health. These programs illustrate the value that can be added when a foundational approach like Be You is in place.

Priority 2: Preventing anxiety and depression in workplaces

Supporting the National Workplace Initiative to encourage mentally healthy workplaces

Over the last five years, many Australian employers have become convinced that creating mentally thriving workforces can help them attract and retain skilled staff, lift innovation and drive productivity. There is clear evidence that participation in meaningful work is good for our mental health and wellbeing. Employment can provide financial independence and a better standard of living; improved physical and mental health by helping us to recover when we are unwell; and gives us purpose, meaning and connectedness.

Employers who have recognised this are already taking action or are planning to do so. However, many employers report being confused about what to do and overwhelmed by the quantity of information provided by government agencies, NGOs and commercial offerings.



The **WorkWell** initiative, from the Department of Health and Human Services and WorkSafe Victoria, is a great example of the high-quality work happening in some states and territories to provide more clarity and support for workplaces.

Another good example is the **Victorian Workplace Mental Wellbeing Collaboration** between SuperFriend, WorkSafe and VicHealth, which focuses on the positive aspects of workplace health (creating positive and supportive cultures) via a website (leading well) and regular breakfast events.

A nationally consistent approach is needed to support workplaces – micro-small, medium to multinational – to capitalise on these efforts to promote good mental health: a **National Workplace Mental Health Initiative** (NWI) endorsed by governments, regulators, business, unions and the mental health sector will provide consistent, simple, trusted, practical advice and implementation support to every Australian workplace.

Beyond Blue has welcomed the 2019 Federal Budget commitment of $11.5 million over four years for a NWI,[25] which was called for by the Mentally Healthy Workplace Alliance[26] and will include:

1. **A definitive online resource for workplace mental health, detailing 'what works' and clear, step-by-step processes for taking action.** All employers will be able to voluntarily choose a level of commitment that reflects their maturity and aspirations from 'meets legal obligations' to 'meets best practice', which may be attractive for employers looking to reap the full benefits of a thriving workforce and becoming employers of choice.
2. **Simple, practical implementation guidance material**, including a suite of online tools and guides to assist workplaces convert their mental health strategies into action.
3. **Implementation support.** Implementation experts to help workplaces navigate, develop, implement and measure workplace mental health strategies, and to identify workplace mental health champions who will showcase their positive experiences to encourage adoption across the economy.

Recommendation

The Victorian Government can support the work of the Mentally Healthy Workplace Alliance in rolling out the National Workplace Mental Health Initiative (NWI) by:

- engaging in consultations to ensure the NWI is well designed, promoted and implemented in Victoria;
- ensuring that the Government's own workforce initiatives complement, rather than duplicate, the NWI.

The case for action

1. Driving strategic transformational change in mental health.

- Intervening in the big settings where people live their lives – at work and in education – creates scope for population-wide, systematic, transformational, cost-effective change.
- The workplace is an effective setting for preventing harm, protecting mental health and supporting people with mental health conditions in their recovery.
- 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.

2. An agenda for every Australian worker and business owner.

- The NWI can support Australia's 13 million workers and more than two million business owners to achieve their best possible mental health, no matter their starting point. Workplaces can create meaningful work for their employees through effective job design. Proactively promoting wellbeing in our nation's workplaces can help everyone to thrive. Early intervention can support rapid recovery from stress or mental health conditions.

3. An agenda for every Australian employer

- The NWI will be tailored to support action by every type of employer – from sole traders to multinationals, and from entrepreneurial start-ups to those operating in the gig economy – by:
  - Allowing employers to voluntarily choose their level of commitment across several levels.
  - Providing bespoke pathways for each type of employer, including customised online 'how to' materials and online and individualised implementation advice, so that every workplace gets support suited to their needs.
  - Developing the NWI with business and people with personal experience of a mental health condition so the guidance and support meets their needs.

4. 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. One estimate indicates that each year in Australia, $12.8 billion is foregone from lost productivity and job turnover due to mental health conditions. KPMG (2018) estimate that implementing a select group of evidence-based workplace interventions could save $4.5 billion a year.[27]
  - **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.
    - Almost one-quarter of the workforce experience mild symptoms of depression that leads to absenteeism of 50 hours per person per year. A further 8 per cent experience moderate to severe symptoms of depression that leads to absenteeism of up to 138 hours per person per year.[28]

- People with mental health conditions are three times as likely to be unemployed as the general population, and more likely to be working in less secure roles.
- 51 per cent of respondents to a 2015 survey reported having left a job at least once 'because it was a poor environment in terms of mental health and wellbeing'.[29]

- **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.[30]

5. A strong return on investment

- PwC and Beyond Blue (2013) estimate an average ROI of 2.3:1 for workplace mental health interventions. This is supported by international evidence that suggests an average ROI of 4.2:1.[31]

6. 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.[32]
- In developing the NWI, the Alliance will 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;
  - Having robust evaluation from the start to drive performance improvement.

Towards mentally healthier workplaces – the example of police and emergency services

Police and emergency services (PES) workers put themselves on the line to protect the community, but their mental health is suffering. In 2018, Beyond Blue released *Answering the Call: the National Mental Health and Wellbeing Study of Police and Emergency Services*, summarising findings from a survey of 21,014 current and former police and emergency services staff and volunteers.[33] Answering the Call reported:

- one in three employees experience high or very high psychological distress - much higher than just over one in eight among all adults in Australia;
- more than one in 2.5 employees and one in three volunteers report having been diagnosed with a mental health condition in their life compared to one in five of all adults in Australia;
- employees and volunteers report having suicidal thoughts at rates over two times higher than adults in the general population;
- more than half of all employees experienced a traumatic event that had deeply affected them during the course of their work;
- one in four surveyed former employees experience probable PTSD, 28 per cent had seriously considered taking their lives, and around one fifth experience very high psychological distress.[34]

Good workplace mental health strategies, positive workplace culture, and proven prevention and early intervention services can make a real difference to the mental health of our police and emergency services workers across Australia.

All governments – federal, state and territory – should work together on a **national policy approach and funded action plan to support workplace mental health and wellbeing in the police and emergency services sector**. This should include:

1. **Funding for workplace mental health support**, including funding to:

- address mental health service gaps and developing a stepped care model of effective, affordable therapeutic services, with clear pathways for referral;
- provide communication initiatives, evidence-informed professional development, education and access to resources to address mental health literacy and risk and protective factors;
- enable agencies to respond to emergency events and manage workplaces to ensure no individuals or teams are regularly stretched beyond reasonable expectations and have time to implement healthy coping strategies after a traumatic event.

2. **A national centre of excellence** to fund research and identify best practice interventions and programs for mental health and wellbeing in police and emergency services. Victoria has recently funded a Centre of Excellence for emergency worker mental health, which should work alongside and in a complementary way with any similar national initiatives.
3. **Reform to the workers' compensation processes** to ensure they support rather than hinder recovery. Among those who have been through the process, 61 per cent report a negative impact on their recovery and 69 per cent report that they received limited to no support during the claims process. The most recent Victorian Budget indicates steps in the right direction, including a provisional acceptance payment scheme pilot to enable emergency workers with a work-related mental health injury to access medical expenses during their claim assessment period.
4. **Support for former employees**, including a proactive approach prior to personnel ending their service, appropriate transition support and funding for clinical and psychosocial services and supports for transitioning and former employees.

Priority 3: Putting the missing steps in stepped care

Building a national early intervention system of low intensity, non-clinical mental health supports

Recommendations

The Commonwealth Government – working in close partnership with state and territory governments – should:

1. Maintain and strengthen the seminal work of Primary Health Networks (PHNs) in commissioning innovative, locally-relevant low intensity services using local providers and employing local people. These services should measure and report outcomes and recovery rates, so we know the investment is in interventions that improve people's mental health.
2. Commit to, and fund, the development of a national strategy to support the continued growth and maturation of early intervention supports, underpinning the stepped model of care.

- Much of the responsibility for driving far reaching mental health reforms – including the building of a low intensity mental health services sector – has been devolved to PHNs but with insufficient attention given to the supporting architecture (such as workforce training, development and career structures, and accreditation of services) needed to build a new sector in the Australian economy.

3. Fund a national expansion of proven early intervention services, to ensure that many more Australians at-risk or with mild to moderate conditions have access to services, without the need for a referral or cost acting as barriers.

- 10 million Australians each year have a mental health condition or are at risk of experiencing a mental health condition,[35] yet most of the low intensity service system remains yet to be built.
- Provision of limited funding to PHNs and requiring service providers to compete for funds from 31 different PHN funders, cannot deliver the massive expansion in service provision needed by our population in a timely manner.
- A competitive tender to fund services that have emerged as the most evidence-based and effective across the nation – in areas such as low intensity coaching, digital support, and self-guided interventions – could rapidly expand access to services our population desperately needs.

4. Build the community's knowledge and understanding of early intervention services through mental health literacy initiatives and the provision of easily accessible service information.

The case for action

1. Low intensity prevention and early intervention services are what the great majority of our population needs to protect their mental health.

- 60 per cent of the population are well, 23 per cent are at risk of developing a mental health condition and nearly 15 per cent have a mild to moderate mental health condition.[36]

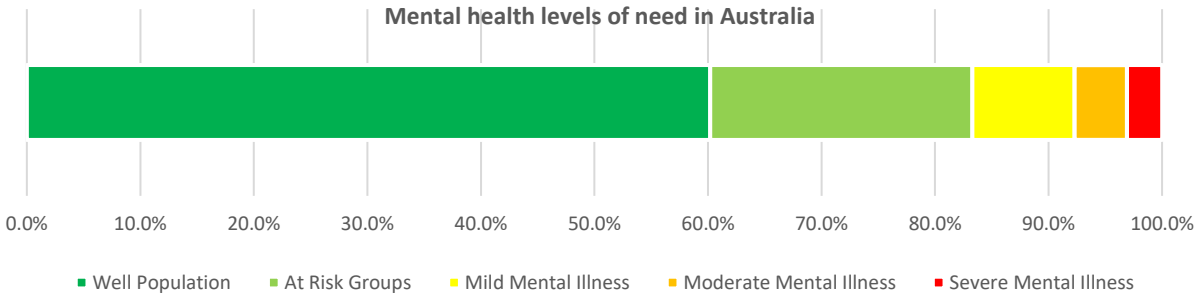


Figure 1: At risk, mild and moderate mental health conditions represent the vast majority of need

- The support they need is low intensity, prevention and early intervention, as detailed in the stepped care model being promoted by PHNs. Services such as coaching, digital support and self-guided interventions can match the level and complexity of needs with the right service type and level.

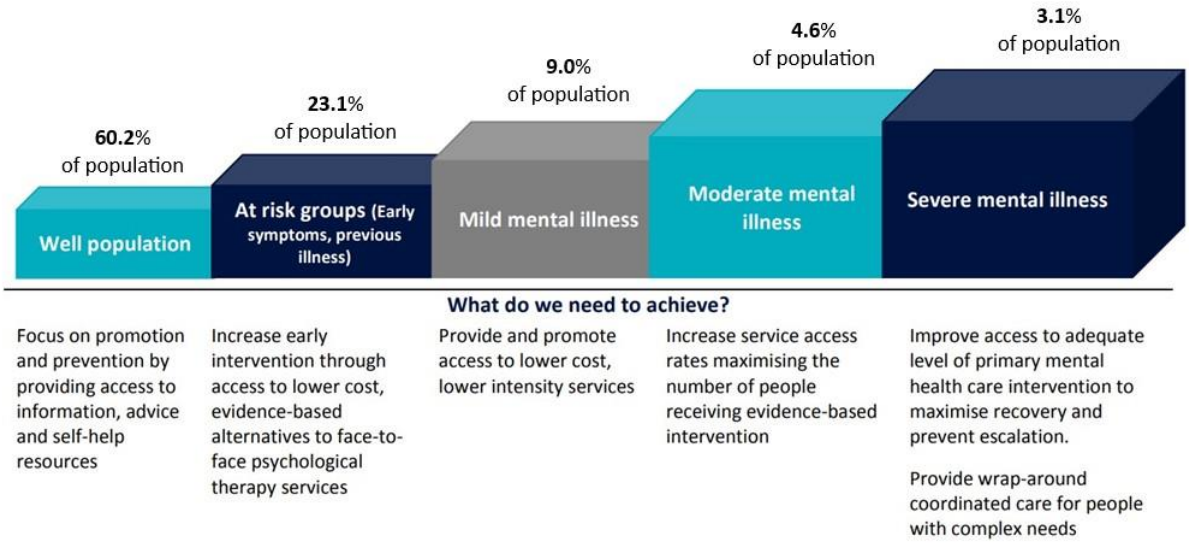


Figure 2: Stepped care model[37]

2. Most mental health issues can be dealt with effectively if the right supports are received early.

- Prevention support can help the well population and those at risk to avoid mental health conditions and assist those with conditions to recover.
- Early intervention services can also make a huge difference in mental health. Many people never seek treatment or spend years suffering before they do. For those at risk or with mild to moderate conditions, early intervention can often help people to restore good mental health relatively quickly.

3. Most of the low intensity system we need is yet to be built.

- The National Mental Health Commission's landmark review of mental health programs and services (2014) found that our mental health system is broken, backwards or just beginning. In particular, most funding goes to high cost acute care after people have developed severe conditions, rather than providing prevention and early intervention through low intensity supports.[38]

4. Non-clinical, low intensity early intervention services are proven to be effective.

- The UK National Institute for Health and Care Excellence (NICE) Guidelines recommends low-intensity interventions as a first-line treatment for people with mild/moderate mental health conditions, and the Improving Access to Psychological Therapies (IAPT) program in England currently treats over 560,000 people a year, with 48 per cent of people receiving low intensity cognitive behavioural therapy.
- An evidence review check commissioned by Beyond Blue in 2018 revealed that internet and mobile-app delivered interventions were effective for managing mild to moderate depression and anxiety.
- New Access, Beyond Blue's early intervention CBT coaching service, is delivering average *70 per cent recovery rates* from just six sessions at 22 service sites across Australia. New Access employs and trains local people to be coaches. They are clinically supervised. Sessions are free and can be delivered face to face, over the phone or by Skype. No GP referral is necessary. Psychological distress, wellbeing and recovery rates are measured and reported at every point of contact with the client.

5. Providing affordable, cost effective care.

- Our community engagement indicated many people still struggle to access services or find their cost prohibitive. A major need for our mental health system is a large increase in the supply of affordable services tailored to our population needs. Ideally, this should be achieved with the minimum necessary budgetary outlays. Neither goal can be achieved by expanding expensive high-end services. Only low intensity services can deliver the twin goals of affordability for individuals and affordability for the budget.

6. Primary Health Networks can ensure that the right services are delivered to match local needs.

- Australia's geographic and social diversity means that national approaches may need to be tailored to more effectively meet the distinct needs and resources of local communities. PHNs have shown that linking direct understanding and experience of local communities to mechanisms for research and service commissioning can be a successful way to roll out critical health initiatives.
- It is essential that there is policy and funding stability in mental health, with the role of PHNs in the system maintained and strengthened. This will require moving beyond short-term contracts and insufficient funding levels with which PHNs are currently struggling.[39]

7. The need for a national low intensity services strategy.

- The work of PHNs – and the broader 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.
- As with any sector seeking to become established, there are substantial structural impediments that must be addressed if the low intensity mental health sector is to grow to provide comprehensive and effective support to help people maintain their mental health. For instance:
    - **Consumer awareness and trust:** Good mental health literacy is still emerging in Australia, and awareness of newly-emerging early intervention services is limited. Many community members either simply are not aware of services that could help them, or don't know whether they can trust what's on offer.
    - **A national workforce, with career structures, and structured education and training pathways:** The new workforce to underpin this sector is still emerging. The structured education and training pathways and career structures that would build a large, high quality workforce to run the low intensity system are yet to be built.
    - **Accreditation of services:** While work has commenced on accreditation, a system of accreditation that would give funders, the community and traditional health workforces confidence in the effectiveness of services, appears to be years away from being established.
    - **Funding:** Funding for PHNs is insufficient for them to meet the need for services among the population.[40]
    - **Integration and referrals from the clinical system:** Some doctors lack awareness of low intensity services, or are slow to recognise their utility, so do not refer people to services that could help them.
    - **Demand and cost-effectiveness:** These factors mean service providers can't do national promotion, and demand for services is lower than it would otherwise be. Without economies of scale and with services being used at lower than full capacity, unit costs are higher than they could be.

8. Funding the best and most critically needed services to go national.

- With PHNs playing the seminal role in driving local innovation and allowing new services to prove themselves in practice, there is a need to complement this work with funding to allow the best proven and most critically needed services to go national.
- The need to balance regional autonomy and national consistency has been recognised.[41]
- Requiring service providers to seek funding from 31 different sources – each with limited funding (an average of around $12 million a year) – makes it near impossible for services to roll out nationally.
- Waiting for under-funded PHNs to roll out the national system we need will take too long for those in need now.
- A national funding mechanism is needed to support rapid national expansion of the most effective services rapidly. A national competitive tender could support service delivery in the most critical areas such as low intensity coaching, digital support and self-guided interventions.
- Such funding rounds could be repeated every few years to back the most promising services being discovered through local PHN commissioning.

Examples of early intervention services

MindSpot

MindSpot is an established service that provides telephone and online supported CBT for the treatment of anxiety and depression. Individuals are assessed using the MindSpot Online Screening Assessment and are supported to complete an 8-week evidence-based CBT online course. They access weekly contact from an experienced therapist. Progress and safety are monitored, and individuals receive a check in three months after completing a course. Research has shown that the online courses have been found to be effective in more than 45 clinical trials with over 10,000 participants. To date, it has provided services to more than 40,000 Australians with 82 per cent of participants not otherwise in contact with mental health services. Most people find symptoms of anxiety and depression reduce by 50 per cent, with the majority (95 per cent) of people reporting that they would refer a friend.

MoodGYM

MoodGYM is an e-mental health CBT-based program, with a strong, established evidence base for its efficacy. The online self-help program is designed to help people prevent and manage symptoms of depression and anxiety. There are five modules, which each contain information, exercises and quizzes, and printable summaries. It is available worldwide in five languages.

The BRAVE Program

BRAVE is an online self-help program that contains both resources and information for children, teenagers and their parents, which has strong evidence to support its efficacy. It is designed specifically to help young people with anxiety to overcome their worries and improve the quality of their lives. There are programs tailored for children as young as three, right through to 17 years of age. It is intended to be completed weekly, with each session taking around 30 to 45 minutes. It is free throughout Australia.[42]

This Way Up

This Way Up is an established e-clinic that provides online learning programs, education and research in anxiety and depression. Their high completion rate (75 per cent) is helped by sending reminders, offering choices of course and timing, and imposing a modest financial cost, which contributes to improved adherence. The review found the provision of educational material holds promise, with a small but significant benefit. It addresses the need to reach many people, to increase mental health literacy and to encourage help-seeking. Good mental health literacy has been positively associated with the use of low intensity interventions.

NewAccess

NewAccess is Beyond Blue's low intensity CBT program, based on the successful IAPT model in the UK. It is an Australian-first initiative, using coaches to deliver evidence-based low intensity non-clinical support to people with mild to moderate depression and anxiety. It operates within a stepped-care framework, ensuring people can be stepped up if they require more intensive treatment and support. An independent evaluation of the pilot found:

- **High referral acceptance and retention rates:** 88 per cent of all people referred to the program proceeded to treatment, and 72 per cent continued treatment to completion.
- **High recovery rates:** 67.5 per cent of people who participated in the trial were below the clinical threshold for anxiety and depression when they finished treatment. Recovery rates in current services are now lifting to 70 per cent and beyond.
- **The program is cost effective:** the indicated cost-benefit ratio is 1.5. It also reduces the level of demand on upstream services.[43]

Building the peer workforce

Recommendations

Building on the work of the National Mental Health Commission, Australian governments should develop a **national peer workforce strategy** focused on:

1. **Continuing to build the supply of a trained, professional peer workforce**, including:

- The development of clear roles, remuneration and career pathways;
- Subsidised training to prepare for peer work, such as the work being done by Roses in the Ocean to identify, train and establish a peer workforce to work in suicide prevention, or the Certificate IV in Mental Health Peer Work.

2. **Rapidly embedding the peer workforce across mental health service settings**, including:

- Advice to services on how to best draw on and support deployment of peer workers.
- Peer workers in every hospital Emergency Department, to provide support to people experiencing psychological distress and/or suicidality, and identifying suitable roles in community mental health services.
- PHNs funding peer brokers, who act as 'connectors' between people experiencing mental health conditions and appropriate services.
- PHNs being required to commission peer support across the stepped care model.
- Education on the value of peer workers among mental health professionals and the community.
- Research – potentially through an NHMRC funding stream – into the effectiveness of different models to determine best practice models of peer support.

3. **Supporting national leadership and co-design**, including:

- Establishing and funding a national peak body for peer workers, to ensure that peer workers are represented in health workforce planning and strategy and can contribute to the ongoing development of the peer workforce.
- Making co-design the standard practice in development of major mental health initiatives.

The case for action

1. Peer workers offer something unique and valuable.

People in psychological distress and/or suicidal crisis value and benefit from being supported by peer workers. They know they are immediately understood by someone with a lived experience; they often feel more comfortable sharing their story; they know they aren't being judged; and they appreciate the empathy, wisdom and the modelling of hope and recovery that people with lived experience provide.

Peer workers are increasingly forming part of multidisciplinary support teams, and their professional contribution can complement the service delivery offered by others such as paramedics, police, clinicians and other staff in emergency departments.

> "[I want *to be] able to speak with others who are currently on and have been on their own path to recovery. It always helps to be reminded about the light; we all often forget it gets better when the clouds are overhead."*
>
> Beyond Blue survey respondent

Embedding peer workers in a raft of health settings can also build the mental health literacy and empathy of other staff and help drive improved practice.

2. Cost effective service delivery.

In a significant number of settings – such as supporting people in suicidal crisis in emergency departments, providing low intensity support, or helping people to navigate the mental health system – peer workers can deliver equal or more effective outcomes and do so more cost effectively than clinical staff. People with lived experience are also excelling in a variety of broader non-peer mental health roles.

Examples of effective peer support models

Peer Operated Service, Flourish Australia (Qld)
Flourish's Peer Operated Service (POS) was launched in Hervey Bay, Queensland, in 2011. It is a community based mental health support model with workers and volunteers, all of whom have a lived experience of a mental health issue. *"The POS is 100 per cent peer-operated which often attracts people to the service initially. This makes it unique in Hervey Bay and through the consultations we discovered many thought being 100 per cent peer-operated was one of the key drivers of success. People accessing the service have told us that it is very compelling and motivating to see other peers on a pathway to transition to employment and doing well in employment."* Pamela Rutledge (former Flourish CEO).

Preliminary results suggest that the POS is forecast to deliver a Social Return on Investment (SROI) ratio of 3.27:1 based on the investment across ten years between 2016-17 and 2025-26. The results of the SROI evaluation to date suggests excellent social value for the investment, providing evidence of the efficiency of the service.

In NSW, Flourish Australia has been awarded with the delivery of a social benefit bond to prevent hospital readmission. Peer work will be a core component of this program. A study in the UK has found that people involved in a peer support program following admission to acute care were significantly less likely to be readmitted to hospital.[44] Of those who were readmitted, the time between admissions was longer.

Roses in the Ocean Peer Support Program
Roses in the Ocean is an Australian organisation building a lived experience workforce to contribute to suicide prevention. Roses in the Ocean works to identify, train and implement a peer workforce to create a suicide peer support community.[45]

The Roses in the Ocean Peer Support Program contributes to a better understanding of the perspectives of people with mental health conditions. The peer workers have the knowledge and skills to engage with people in stress and distress. That enables people to navigate their next steps together.

Beyond Blue Connect
Beyond Blue Connect is a peer supported program funded by the South Eastern Melbourne PHN.[46] The program provides a low-intensity service for adults in the Greater Dandenong region with, or at risk of, mild to moderate depression and/or anxiety. The area has high rates of socio-economic disadvantage and cultural diversity. The peer workers, or 'mentors', in the program speak a range of languages including Arabic, Dari and Farsi.

An evaluation of the pilot found that participants in the program reported reduced symptoms of depression and anxiety, and increased knowledge and understanding of how to cope with these symptoms. Peer mentors also reported that their experience of participation in the pilot was positive, with the ability to support people from similar backgrounds being incredibly rewarding.[47]

Priority 4: Reducing Australia's suicide toll

Building a system of universal support for everyone in suicidal crisis or distress

Recommendations

Australian governments should work together to build a system of universal suicide prevention and response, including:

1. **Compassionate care for every person who experiences suicidality (ranging from pre-suicidal distress, to suicidal ideation, to post-attempt** (as shown in Figure 3 below):

- **For people who have attempted suicide**, we need universal assertive aftercare – such as The Way Back Support Service – available in every emergency department in the country, to ensure people being discharged from hospital do not simply walk back into the circumstances that contributed to their crisis.
- **For people experiencing suicidal ideation**, we need a network of tailored, welcoming community settings, where people in crisis can attend and receive support from peers, coaches, counsellors, rather than going to the emergency department.
- **For people in pre-suicidal distress**, we need to trial and scale up a brief intervention for treating early signs of distress that can be accessed through self-referral or referral by community gatekeepers (GPs, nurses, mental health workers, and police). This needs to be accompanied by rigorous systems of referral and follow up to ensure that once stabilised, people do not return to crisis.

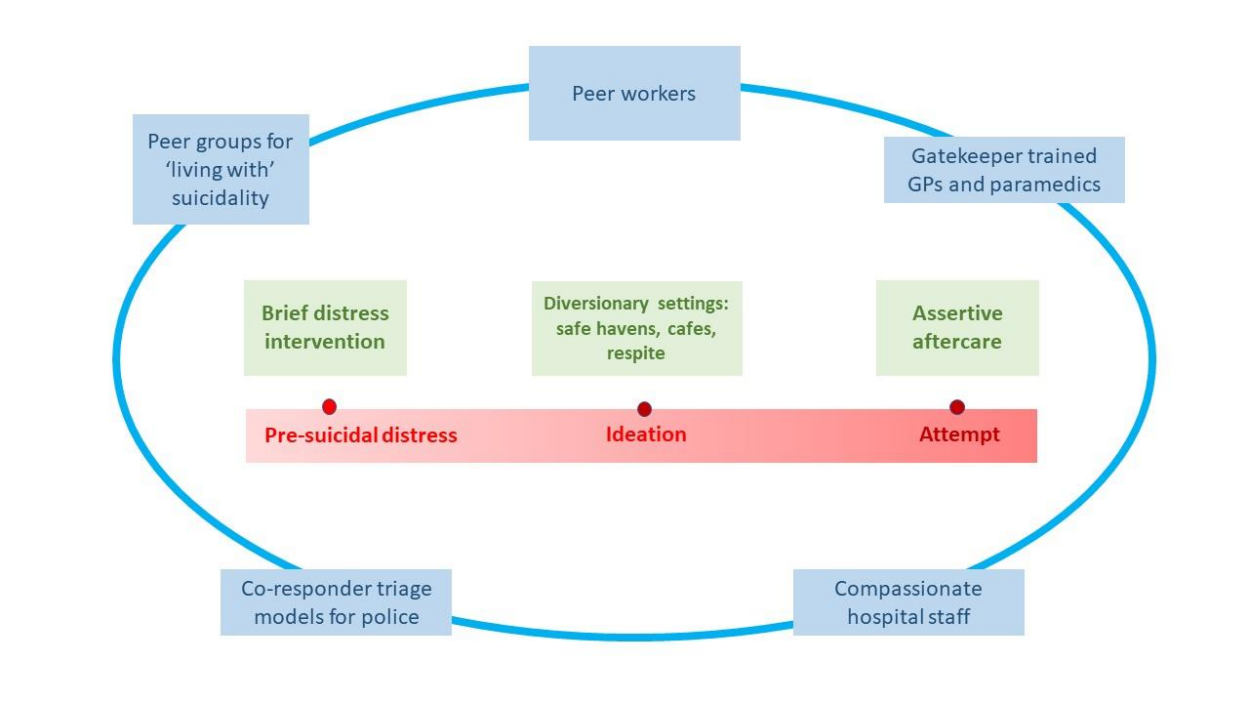


Figure 3: Proposed universal suicide prevention system - integrated services delivered along the spectrum of suicidality by compassionate workforces

2. **Embedding person-focussed workforces that infuse the system with compassion**, including:

- Suicide specialist peer workers in every emergency department in Australia.
- A national system of suicide gatekeeper training for GPs and paramedics embedded into tertiary curricula and continuing professional development.
- Robust measures of compassionate care in hospitals that can be applied, monitored and enforced.
- Co-responder police triage units in every police station in Australia, so that those who call police in moments of crisis are assisted by mental health workers.
- Peer support groups and networks for people who live with chronic suicidality, for whom suicidal thoughts and behaviour are a permanent feature of life.

The case for action

- On average, 8.6 people die by suicide every day in Australia.[48] This is more than double the national road toll. [49]

Suicide is a tragedy for every person who takes their life and leaves ripple effects throughout the community. It is not just about mortality – many people think about and plan suicide long before they make an attempt. By giving everyone who experiences suicidality (those who think about it, plan it, or attempt suicide) help that is compassionate and matched to their needs, we can reverse the trend of suicide in Australia and ensure we are a nation that leaves no one behind in their hour of greatest need.

1. Suicide in Australia is persistently high and devastating for communities.

- **Suicide in Australia is at a ten-year high.** In 2017, 3,128 Australians died by suicide, a 9.1 per cent increase from the previous year. Seventy-five percent of these deaths were men. [50]
- The amount of people who experience suicidal trajectories is also unacceptably high. Estimates suggest around 65,000 people will attempt[51] and almost 600,000 think about suicide, every year.[52]
- The ripple effects for individuals, families, colleagues, communities, and society at large can be devastating and extend long after the event.[53] On average, a person who died by suicide in 2017 lost 34.5 years from their life.[54] **We are losing thousands of people participating in the social and economic life of our nation every year. Many more will struggle to regain their full capacity to thrive.**

2. While governments are taking action, the current approach is piecemeal and much of the service system we need is yet to be built.

- **People experiencing the full range of suicidality rarely get the help they need.** Hospital systems routinely provides rapid response support for people with physical injuries and life-threatening illnesses, with people rushed to emergency departments and provided well-designed clinical treatments. By contrast, for those who may be thinking about or planning suicide, or who are in a state of distress that could escalate into suicide, there are few pathways into help.
- **Despite considerable investment in the last five years, crisis services remain embryonic.** The National Mental Health Commission in 2018 suggested there is "*…a lack of appropriate care and support for people in crisis, and insufficient training on suicide prevention for people working in the health, allied health and community sectors*."[55] Even for our most vulnerable people - those in suicidal crisis or who have attempted suicide - services are fragmented, remain in pilot stages, or are limited in geographical coverage.[56]

3. Care that is stigmatising and lacking in understanding of suicide stops people seeking help early, but compassionate, personalised support makes all the difference.

- **Having an entry point into services and supports is not enough if the care people receive makes them worse.** For a person in suicidal crisis, the experience of sitting for hours on end in the emergency department can be bewildering, triggering and ultimately a barrier to further help-seeking.
- Some experience stigma at the point of entry and many health professionals are not getting adequate support and training themselves. Turning Point's *Beyond the Emergency* research shows that many paramedics and emergency workers lack a level of literacy to enable them to care appropriately for people in suicidal crisis. These experiences exacerbate an already high level of distress.[57]
- Leaving people to recover alone also doesn't work. Around 50 percent of people who attempt suicide do not take up recommended treatment, and 60 percent drop out after only one session.[58]
- Providing person-centred support does work. Assertive follow-up interventions – tailored to the person's specific needs – can reduce suicidal behaviour among people discharged from hospital following an attempt,[59] including re-attempts by up to 20 per cent.[60]

4. We can prevent the trajectory towards suicide by providing everyone who is at risk compassionate and person-centred support at the right time and at the right level.

Providing a range of tiers of support can ensure support for every person who experiences suicidality (ranging from pre-suicidal distress, to suicidal ideation, to post-attempt. The common characteristic is providing compassionate support in community settings, diverting people from emergency departments. For instance:

- 'Safe haven' cafes in Melbourne and in the UK provide comfort, de-escalation assistance and advice from a peer worker.[61]
- Police co-responder models in Victoria and Queensland.[62,63]
- Support for people in distress, such as the Scottish Distress Brief Intervention, which provides compassionate community-based support to assist people to stabilise and recover from distress.
- Aftercare for people who have attempted to take their own lives, such as through The Way Back Support Service, where support coordinators provide assertive aftercare and practical support for up to three months. This includes planning to help people stay safe, connected with their support network and engaged with health and community services.
- Providing support in a network of tailored, welcoming community settings, where people in distress or crisis can attend and receive support from peers, coaches, and counsellors, ranging from a few hours to a couple of weeks.

5. Suicide prevention delivers a positive return on investment.

- The prevalence and impact of suicide is enough to justify urgent and decisive political action. However, there is also a compelling economic argument. KPMG's *Investing to Save* report, commissioned by Mental Health Australia (2018), estimates that in 2016, **suicide cost the Australian economy more than $1.6 billion in lost earnings over the life course.**[64]
- Strategic investments in suicide prevention can help to reduce this impact. KPMG estimates the investment required **to halve the suicide rate across Australia is $500 million, which would provide $1 billion in savings**. Specific services, like assertive aftercare, have the potential to provide a long-term return on investment of $1.80 per dollar invested.[65]
- Other countries – such as Scotland and Japan – have seen significant reductions in national suicide rates by adopting strategies that target prevention and provide entry points across the spectrum of suicidal experience.[66,67]

Suicide prevention evidence check

Diversionary settings (ranging from lowest to highest intensity)

- Drop-in style **safe haven cafés** where someone in distress can receive comfort, de-escalation assistance and advice from a peer worker. Examples are the highly successful cafe in **Aldershot, North East Hampshire**[68] and the new Safe Haven Café at **St. Vincent's Hospital in Melbourne**.[69] An economic evaluation by PwC found that the St Vincent's café saved the hospital $225,400 in avoided admissions to ED and has significantly improved the outcomes for people living with mental illness in the community.
- Residential homes staffed by peer workers alongside clinicians. 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.[70] An evaluation 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.[71]
- Coordinated respite centres. **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, and a 24/7 mobile crisis team that collect people and bring them to the centres. 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.[72]

Support for people in distress

- The **Scottish Government is piloting a Distress Brief Intervention** program in four sites. The intervention is a time-limited and supportive problem-solving contact with an individual in distress. It involves a two-level approach. At level 1, a person presenting in distress to accident and emergency, Police Scotland, Scottish Ambulance Services and primary care, is offered a compassionate interaction and a referral into Level 2. At level 2, the person is contacted within 24 hours of referral and provided with compassionate community-based support, including problem solving, wellness and distress management planning, and signposting, for up to 14 days.

Assertive aftercare

- Beyond Blue's **The Way Back Support Service** provides non-clinical assertive aftercare in the first three months following discharge from hospital for a suicide attempt or suicidal crisis. An evaluation of the Darwin pilot showed the model delivered positive patient outcomes and could be scaled up. The service is currently available in seven sites and could be expanded to up to 25 sites with funding allocated by the Federal Government in the 2018-19 budget.

Peer workforces in the emergency department

- Evidence shows that people involved in a peer support programs following admission to acute care are significantly less likely to be readmitted to hospital.[73] Some hospitals in the US are beginning to implement programs for trained 'patient safety assistants' to sit with people in crisis while they wait.

Gatekeeper training

- Gatekeeper training is a key plank of the Fifth Plan for Mental Health and Suicide Prevention.[74] The evidence of gatekeeper training in reducing suicidality is still emerging. 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 6 per cent reduction in suicide.[75]

Co-responder models of police triage

- The **Police Ambulance Crisis Emergency Response (PACER),** a joint venture between the Department of Human Services and Victoria Police bringing together mental health clinicians and police officers. Stations using PACER were shown to have fewer referrals to hospital emergency departments and more timely access to mental health assessment for the person in crisis. The first responder unit was released in about one third of the time, enabling them to meet other emergency response calls.[76]
- In Queensland, **Cairns Mental Health Co-responder Project** brings police and mental health practitioners together for joint rapid responses to mental health crises in the community. On evaluation, the model showed positive results, including less use of force and reduced stigmatisation towards people in crisis, improved inter-agency collaboration, and improved safety for both parties.[77]

Priority 5: Greater equity and inclusion

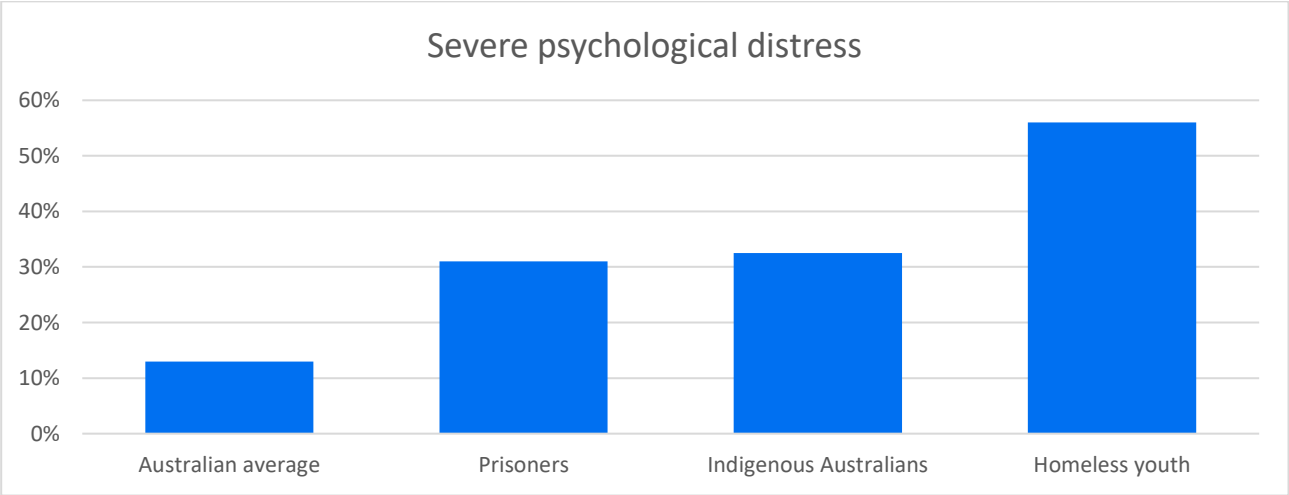
1. Disadvantaged groups experience mental ill-health at much higher rates than their more advantaged counterparts.

Many Australians grow up and live in difficult socio-economic circumstances that limit their opportunities in life. This includes:

- three million Australians – including 730,000 children - living in poverty;[78]
- people unable to access quality education or living in insecure housing;
- people excluded due to factors including gender, sexuality, culture and/or physical capability;
- people exposed to violence, adversity and trauma (e.g. child abuse and family violence); and
- the one in four Australians who feel lonely,[79] which negatively impacts both physical and mental health. [80, 81]

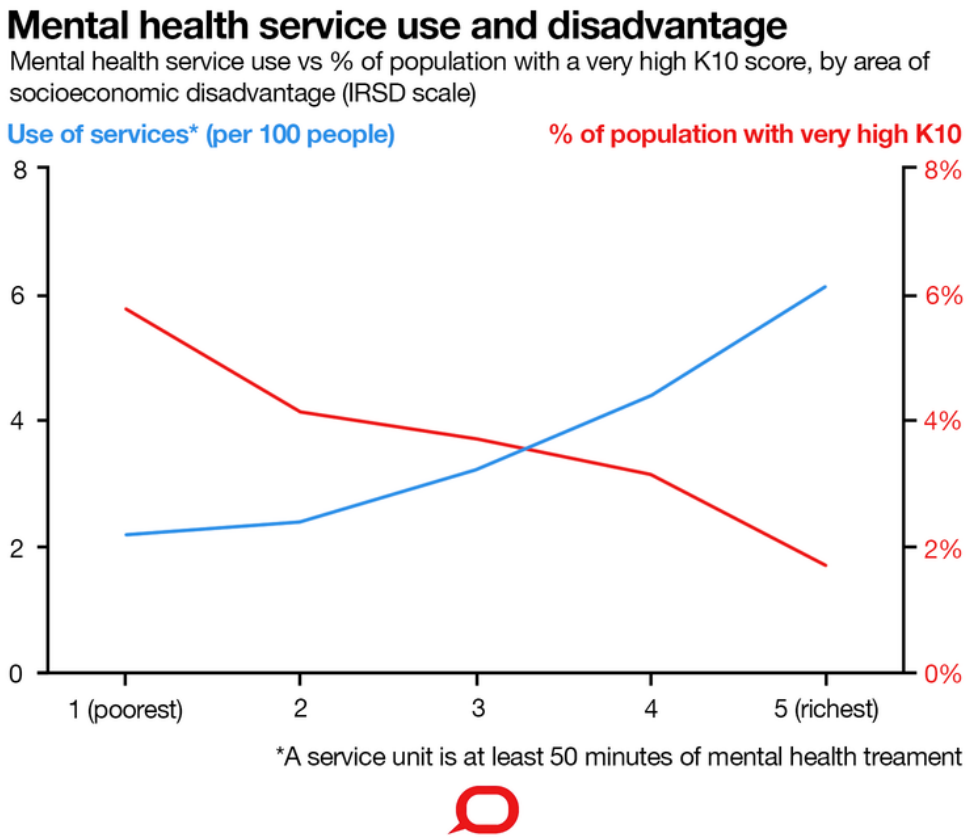
> *"The thing that would help me most in reducing the frequency and intensity of feelings of worthlessness, hopelessness and suicidal ideation would be human connection."*
> Beyond Blue survey respondent

Due to these socio-economic and demographic factors, there are a range of population groups that generally experience mental health challenges at 2-3 times the incidence of the population. The following graph shows the comparative levels of severe psychological distress according to the Kessler scale (K10) measured among these groups compared to the general population.[82]



2. Despite this inequity, these groups typically access services at much lower rates than their more advantaged counterparts.[83]

The following graph illustrates the 'inverse care law', showing that Australians from areas representing the lowest quintile of socioeconomic disadvantage experienced three times the rate of mental distress as their fellow Australians from higher socioeconomic areas, yet accessed Medicare-funded Better Access services at one third of the rate.



3. Transforming Australia's mental health trajectory will only be possible through a national agenda that gives particular weight to providing mental health support to those in greatest need, and to addressing the social-determinants that play a seminal role in creating opportunity for people.

- Collectively, people from low socio-economic backgrounds, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse (CALD) people, LGBTIQ, rural and regional Australians and older Australians comprise a majority of the population. We cannot transform the mental health of Australia without focused and adequate support for these groups.
- The social determinants of health approach taken by the Productivity Commission's Issues Paper is a vital step in understanding the reasons for inequities in mental health and beginning to address them. The intersection between mental health status, social determinants and population groups that experience higher levels of stigma and discrimination creates a nexus of disadvantage that cannot be ignored if the current inequities in Australia's mental health are to be addressed.
- For the purposes of this submission, Beyond Blue has focussed on Aboriginal and Torres Strait Islander communities, housing and justice systems as key examples that should be considered. They are indicative, rather than exhaustive, illustrations of health inequality in Australia.

Improving social and emotional wellbeing in Aboriginal & Torres Strait Islander communities

The Victorian Government has taken some significant steps towards self-determination, including transferring housing to Aboriginal Housing Victoria, shifting the care of Aboriginal children under child protection orders to Aboriginal Community Controlled Organisations (ACCOs) and engaging in a process to establish treaties across the state. However, there is still much to be done to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people living in Victoria.

Recommendations

The Victorian Government should work with the Council of Australian Governments to:

- Deliver on their commitment to working in genuine partnership with Aboriginal and Torres Strait Islander communities in refreshing the Closing the Gap agenda.
- Commit to new Closing the Gap targets that focus on improving social and emotional wellbeing and reducing suicide.
- Provide long-term funding certainty to Aboriginal Community Controlled Health Organisations (ACCHOs) to develop, deliver and evaluate 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.
- Establish a cross-government strategy to address the social determinants that underpin poor social and emotional wellbeing for Aboriginal and Torres Strait Islander peoples: poverty, housing and employment.

The case for action

1. There is a social and emotional wellbeing crisis in many Aboriginal and Torres Strait Islander communities.

Social and emotional wellbeing (SEWB) 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.[84] The impact of colonisation in Australia has led to widespread disruption and disconnection across these dimensions. The social and emotional wellbeing of Australia's Indigenous communities has been harmed where people have experienced intergenerational trauma, are separated from family and friends, 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.[85] In 2017, suicide was the fifth leading cause of death among Aboriginal and Torres Strait Islander peoples.[86]

2. Mental health is the number one health services gap.

- Mental health/social and emotional wellbeing services constitutes the top health services gap, reported by over 60 per cent of ACCHOs.[87] This leaves many Aboriginal and Torres Strait Islander people without the support they need to stay well, or to recover.
- The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 still has no implementation plan, service gaps have not been fully quantified, funding has not been allocated or reforms operationalised.

3. Social and emotional wellbeing are crucial to all Closing the Gap targets.

- Action on mental health and suicide prevention is critical in its own right and 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 severe mental health conditions live between 10-25 years less than average.
- Action towards Closing the Gap will give Indigenous people the opportunity to live the lives they have reason to value, producing more positive social and emotional wellbeing.

4. Genuine partnership with Aboriginal and Torres Strait Islander people can deliver success for Closing the Gap.

- Australia's history has repeatedly demonstrated that unilateral action by governments results in sub-optimal and, at times, catastrophic outcomes for Aboriginal and Torres Strait Islander peoples. Collaborative actions can deliver more effective solutions, while also facilitating the development of local Indigenous leadership.
- Research supports the notion that strong cultural identity is a central element of social and emotional wellbeing.[88] Practising culture can involve a living relationship with ancestors, the spiritual dimension of existence, and connection to country and language.[89] 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.

Prioritising housing as foundational for good mental health

Recommendations

Targeted housing with wrap-around mental health support

The Victorian Government should:

- Scale up proven models of integrated housing and support, such as Housing First, for people with mental health issues to meet the level of need. Build in annual unmet need reviews that shape future capacity planning and budgeting processes.
- Ensure adequate supply of permanent supportive housing is available to people with enduring psychosocial disability who are at risk of homelessness. This may include, but should not be limited to, housing provision associated with the National Disability Insurance Scheme (NDIS).

Governments should increase the capacity of specialist mental health services to actively partner and, where possible, co-locate with homelessness services to improve housing interventions for people who present with mental health problems. The Victorian Government should:

- Develop and resource partnerships between homelessness, housing and mental health services.
- Build mental health capability and links into assertive outreach programs for rough sleepers.

Better aftercare – no exits into homelessness

Governments should invest in more proactive, aftercare follow up for people with mental health issues who have been discharged from hospitals and psychiatric inpatient units. This should include:

- Developing a discharge policy that defines, resources and holds institutions accountable for "no exits into homelessness".
- Resourcing assertive follow up at 3, 6 and 12 months after discharge to check on housing status and provide pro-active assistance where housing is at risk.

The case for action

Australia's housing affordability crisis has been locking a generation out of home ownership,[90] increasing rental stress and contributing to growing rates of homelessness.[91] While the impact of skyrocketing housing costs has been felt to some degree by most Australians, it is much worse among those with the lowest incomes who spend proportionally more on rent, move house more often and far too often live in substandard conditions.[92] None of this is good for mental health.

Unsurprisingly, mental health issues have been shown to be more prevalent among people experiencing homelessness, but research has also shown the majority developed these issues *after* becoming homeless.[93]

> *"One of the biggest obstacles in the lives of people with a mental illness is the absence of adequate, affordable and secure accommodation. Living with a mental illness – or recovering from it – is difficult even in the best circumstances. Without a decent place to live, it is virtually impossible."*
>
> Brian Burdekin, Human Rights & Equal Opportunity Commission

If we are going to fix Australia's mental health issues, we need to pay substantial attention to our housing problems.

1. All other mental health interventions are compromised when housing is missing.

Having a place to call home is fundamental to the health and wellbeing of individuals and families. Housing that is safe, secure and affordable can provide refuge and certainty in the midst of life's challenges.

Correspondingly, in the absence of reliable housing, every other crisis becomes much more difficult to overcome.

Research has also shown that **the quality of housing directly affects people's mental health**.[94] Good housing improves mental health and bad housing has a detrimental effect. Decades of under-investment in public housing, once a safety net offering secure tenure that was affordable for all tenants, have resulted in interminable waiting lists that leave people without hope. *While decent, affordable housing remains inaccessible to people on low incomes, Victoria's mental health will be unfairly stratified.* The most efficient solution is to invest in housing and support models, such as Housing First and permanent supportive housing, that help people with mental health issues to gain and keep their housing.

2. Too many people are still discharged from clinical services without a place to go.

In Victoria, **more than 500 people leaving psychiatric inpatient services had to seek help from a homelessness service in just one year**.[95] The consistent failure of discharge planning and implementation, which is seen through readmissions and presentations to homelessness services, must be addressed through independent monitoring and reporting.[96] Despite the current lack of appropriate and affordable housing options, improvements can be made to discharge planning and coordination processes to ensure that people exiting clinical mental health facilities have continuity of care and are not placed at risk of homelessness and subsequent deterioration of their mental health. In Canada, one community-based health partnership developed a model of discharge planning and care which resulted in a *40 per cent lower readmission rate*.[97]

By increasing the capacity of housing and mental health services to work together, we can decrease the number of people who find themselves continually moving between institutions and homelessness.

3. Stable housing has economic and social benefits.

Positive interventions that help people to sustain their housing when it is at risk have been consistently shown to be much more cost effective than allowing people to become homeless and having to re-establish their homes.[98] KPMG reported that Housing First models, which combine stable housing with tailored supports, have a return on investment of $3 for each $1 invested in the short term and $6.70 in the longer term.[99] More importantly, avoiding the disruption and trauma of homelessness is far better for the person, with immediate and long-term benefits for their physical health, their mental health and wellbeing.

The formal integration of mental health with housing and homelessness services is one approach that has proven to be successful. An evaluation of the Housing and Accommodation Support Initiative (HASI) in NSW showed that when housing is linked to appropriate clinical and rehabilitative support, people are better able to overcome the impacts of mental health issues and live more independent lives.[100] Programs like this exist across the country but are not scaled sufficiently to meet demand and would benefit from greater funding stability and shared learnings.[101]

> *"The evidence shows that existing programs that integrate housing and mental health supports are effective in generating government cost savings (especially in health) and reduce hospital admissions and length of hospital stay. They also contribute to tenancy stability, improve consumer mental health and wellbeing, social connectedness and lead to modest improvements in involvement in education and work."*[102]

Seeking a fair go inside and outside the justice system

Recommendations

- All Australian governments, including the Victorian Government, should actively explore justice reinvestment approaches that prioritise support and treatment for mental health issues, instead of criminalising people who have adverse health conditions.
- The Victorian Government should expand the Assessment and Referral Court (ARC), so that people with mental health issues get the help they need, rather than dealing with their symptoms through the prison system.
- All Australian governments, including the Victorian Government, should invest in post-release mental health supports that connect people to the clinical and non-clinical services they need to reintegrate back into the community and reduce recidivism.

The case for action

1. Prison numbers are growing and people with mental health issues are disproportionately represented.

People in prison are more than twice as likely as the rest of the population to be experiencing mental health issues, with almost 50 per cent having been previously told they have a mental health disorder.[103] The following table illustrates the high prevalence of mental health issues among people who become caught up in the justice system:

> *"There is currently no overarching strategy or leadership for mental health and the justice system that focuses on improving outcomes for people with a mental illness. Where plans do exist, they are limited to agencies' own areas of responsibility, or only address parts of the justice system. While there is evidence of agencies working together, this is neither uniform nor sufficiently coordinated across the justice system to address mental illness effectively."*[104]
>
> Victorian Auditor General,
> *Mental Health Strategies for the Justice System*

Mental health indicators on entering prison[105]

Indicator	Proportion
Prison entrants with high or very high level of psychological distress as measured by the Kessler 10 (K10) scale	31%
Prison entrants who are currently taking medication for a mental health disorder	27%
Proportion of prison entrants, who, at reception, were referred to mental health services for observation and further assessment	22%

2. Prisons are failing in their rehabilitative role, as many people leave without the support they need to stabilise their lives and reintegrate back into the community.

One in five prisoners does not expect to continue their medication regime upon release.[106] While half of prisoners have a referral or appointment to see a health professional on release, one in four does not even have a valid Medicare card.[107] Almost a third leave prison expecting to be homeless, an increase on the rate of those who entered prison from homelessness (1 in 4).[108] Suicide rates are also higher among prisoners, including those who have been recently released.[109]

The failure of Australia's prison systems to effectively deal with the known problem of disproportionate mental health conditions is in direct contrast to the growth of prisons, prisoner numbers and the cost of imprisonment, which currently stands at over $110,000 per prisoner, per annum.[110]

3. Focus on reducing the causes of crime rather than only dealing with its consequences.

Justice reinvestment approaches, which divert funds from incarceration to early intervention, have been shown to be highly effective and cost far less than correctional alternatives.[111] [112] The National Mental Health Commission noted that justice reinvestment initiatives could reduce imprisonment rates in overrepresented groups, including people with mental health issues.[113]

The Commission specifically recommended that governments "scale up court diversion and justice reinvestment schemes to ensure that people whose criminal behaviour is prompted by a struggle with mental illness and/or addiction are diverted to therapeutic rather than custodial interventions."[114]

A current example is the Victorian Assessment and Referral Court (ARC), which has shown that supporting people with mental health issues within the justice system helps to address the underlying causes of offending, diverts people with mental illness from the justice system and contributes to the prevention of recidivism.[115]

4. Increase support for exiting prisoners to reduce recidivism.

The prevalence of mental health issues among prison entrants highlights the importance of post-release supports to sustain good mental health and reduce recidivism. The National Mental Health Commission notes an unfair and avoidable concern: "imprisonment can be a consequence of trying to deal with a mental illness with insufficient or inappropriate support."[116] Yet there are programs that show that it doesn't have to be this way.

In Queensland, one example is the Community Mental Health Transition to Recovery Program. An evaluation showed that people who engaged in this program demonstrated improvements in mental health, physical health, social connectedness, employment status and housing[117] - all of which act as protective factors against recidivism.

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. 380,000 unique website visitors in 2017/18 with 80% reporting greater involvement in their child's life. • **Heads Up**: facilitating the adoption of workplace mental health strategies in organisations across Australia; lifting resilience, recovery and productivity. 430,000 website visits in 2017/18. • **Be You:** Australia's national education initiative, supporting educators to change the mental health trajectory of children and young people. In five months since launch, 52,000+ individual learning accounts created; 2,200+ early learning services and 4,100+ schools signed up.
2. New service innovation to support reform of the mental health system	• **NewAccess:** coaching people with mild-to-moderate depression and anxiety from 22 sites; 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, practical support in the community. 8 sites, 3,000+ referrals to date, expanding to 25 sites nationally. • **BeyondNow:** An app for people to develop a suicide safety plan they work through when experiencing suicidal thoughts. Since 2016 25,500 plans have been completed.
3. Changing the conversation - mental health literacy, stigma & discrimination	• **Campaigns**: e.g. 'Know When Anxiety is Talking' to help people to recognise and take action on anxiety conditions and 'The Invisible Discriminator' highlighting the impact of racism on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. • **Traditional and social media:** Beyond Blue reaches millions of Australians daily through our newsroom contacts, media releases and opinion pieces. Over 760,000 followers on social media.
4. Supporting people in need	• **Beyond Blue Support Service**: in 2017/18 helping nearly 170,000 people with free advice, immediate counselling and referral by mental health professionals. 95% per cent of people are first time users. 2018 independent evaluation looked at the immediate and short-term (one month) impacts of a single session of psychological support and referral and found: users reported reduced distress and increased coping ability, acted on the advice provided by counsellors and were satisfied with the service. There were statistically significant reductions in distress (decrease of 42% from pre- to post-contact) and improvements in ability

Impact area	Major initiatives
	to cope (increase of 32% from pre- to post-contact). Improvements were maintained at one month after receiving the service. Most took action to improve their mental health, with 76% acting within 3 days of contacting the service and 85% within 1 month of contact. • **Online peer-to-peer forums**: helping over 1.2 million people a year seek advice and support from others with similar experiences with measurable positive outcomes on symptoms and behaviours. One in four users visiting the forums are actively seeking help for suicidal thoughts or self-harm. A 2017 review found that 54% of users said that they felt less depressed, 56% said that they felt less anxious, after interacting with the forums. • **Beyond Blue website**: helping almost 12 million people a 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 policy thinking and advice 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 and/or suicidality	• **blueVoices:** an online reference group of more than 8,300 people who provide expert insights that inform all aspects of Beyond Blue's work. • **Speakers and Ambassadors:** 30 high profile Ambassadors and 240 Speakers undertake 900 national engagements a year, lifting mental health literacy and helping to eliminate stigma.

Endnotes

[1] Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing: Summary of Results*, 2007, cat. No 4326.0.
[2] Productivity Commission (2019), *The Social and Economic Benefits of Improving Mental Health*, p.6.
[3] National Mental Health Commission. *(2016). The Impact of Poor Mental Health: An Economic Issue: Media Release*.
[4] https://www.mhvic.org.au/images/documents/Mental_Health_reform_2013-14/2015_August_-_MHCSS_AOD_Recommissioning_Report.pdf
[5] https://sydney.edu.au/health-sciences/cdrp/publications/technical-reports/NDIS-and-Psychosocial-Disability_TheVICTORIANStory_March2018.docx
[6] See for instance the analysis of mental health service use and disadvantage at https://theconversation.com/three-charts-on-why-rates-of-mental-illness-arent-going-down-despite-higher-spending-97534
[7] See for instance, the Centre for Community Child Health Policy Brief (2018) *Child Mental Health: A Time for Innovation* https://www.rch.org.au/uploadedFiles/Main/Content/ccchdev/1805-CCCH-PolicyBrief-29.pdf
[8] Murdoch Children's Research Institute (2018). *The First Thousand Days – Our Greatest Opportunity: Policy brief.* Accessed online 14 November 2018: https://www.rch.org.au/uploadedFiles/Main/Content/ccchdev/1803-CCCH-Policy-Brief-28.pdf
[9] Kessler, RD et al. (2005). *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62*: p. 593-602.
[10] Kessler, RD et al. (2005). *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62*: p. 593-602.
[11] Moore, S.E., et al. (2015). Burden attributable to child maltreatment in Australia. *Child Abuse and Neglect, 48: p.* 208 – 220.
[12] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J & Zubrick S.R. (2015). *The mental health of children and adolescents. Report on the second Australian child and adolescent survey of mental health and wellbeing.* Department of Health: Canberra.
[13] National Mental Health Commission (2014). *Report of the National Review of Mental Health Programmes and Services.* NMHC: Canberra.
[14] The Centre for Adolescent Health, Murdoch Children's Research Institute (2018). *Student wellbeing, engagement and learning across the middle years.* Australian Government Department of Education and Training: Canberra.
[15] Rhodes, A. (2017). *Child mental health problems: can parents spot the signs? Poll report.* The Royal Children's Hospital, Parkville.
[16] Rhodes, A. (2017). *Child mental health problems: can parents spot the signs? Poll report.* The Royal Children's Hospital, Parkville.
[17] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J & Zubrick S.R. (2015). *The mental health of children and adolescents. Report on the second Australian child and adolescent survey of mental health and wellbeing.* Department of Health: Canberra.
[18] Patel, V., et al. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet Commissions,* 9 October 2018.
[19] Toumbourou, J., Jorm, T. & Reavley, N. (2018). *Depression and anxiety programs for children and young people: an Evidence Check rapid review brokered by the Sax Institute for Beyond Blue.*
[20] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J & Zubrick S.R. (2015). *The mental health of children and adolescents. Report on the second Australian child and adolescent survey of mental health and wellbeing.* Department of Health: Canberra.
[21] Lawrence, D., Johnson, S., Hafekost, J., Boterhoven De Haan, K., Sawyer, M., Ainley, J & Zubrick S.R. (2015). *The mental health of children and adolescents. Report on the second Australian child and adolescent survey of mental health and wellbeing.* Department of Health: Canberra.
[22] Lancet Commission on Global Mental Health & Sustainable Development: 2018 Report.
[23] National Mental Health Commission (2014). *Report of the National Review of Mental Health Programmes and Services.* NMHC: Canberra.
[24] Australian Council for Educational Research (July 2016). Evaluation of the redeveloped model of MindMatters: Final Report. Slee PT, Lawson MJ, Russell A, Askell-Williams H, Dix KL, Owens L, Skrzypiec G, Spears B (2009). KidsMatter Primary Evaluation Final Report. Centre for Analysis of Educational Futures, Flinders University of South Australia.
[25] https://www.greghunt.com.au/record-investment-advances-long-term-national-health-plan/
[26] https://mentallyhealthyworkplacealliance.org.au/

[27] KPMG, and MHA, *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform (May 2018).* The marginal impact of mild depression on labour productivity is estimated to be 3.9%, rising to 9.2% for severe depression.
[28] McTernan, Dollard and LaMontagne (2013), 'Depression in the workplace: An economic cost analysis of depression-related productivity loss attributable to job strain and bullying' in Work and Stress 27:4.
[29] SuperFriend, 2015, *Work in Progress – A National Snapshot of Workplace Mental Health and Wellbeing.* http://www.superfriend.com.au/resources/work-in-progress-wip/, accessed 30 October 2016.
[30] Nous Group and Medibank Private, *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design*, 2013.

[32] Ipsos. (2017). *Workplaces that are Implementing the National Standard of Canada for Psychological Health and Safety in the Workplace Described by Employees as Psychologically-Safer Environments: Press Release.*
[33] https://www.beyondblue.org.au/about-us/about-our-work/workplace-mental-health/pes-program/national-mental-health-and-wellbeing-study-of-police-and-emergency-services
[34] *Answering the call national survey Beyond Blue's National Mental Health and Wellbeing Study of Police and Emergency Services – Final report* (2018) http://resources.beyondblue.org.au/prism/file?token=BL/1898
[35] Productivity Commission (2019), *The Social and Economic Benefits of Improving Mental Health*, p.6.
[36] PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance – Stepped Care
[37] PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance – Stepped Care
[38] National Mental Health Commission (2014). *Report of the National Review of Mental Health Programmes and Services.* NMHC: Canberra.
[39] Report of the PHN Advisory Panel on Mental Health (September 2018), 9-10.
[40] Report of the PHN Advisory Panel on Mental Health (September 2018), 7.
[41] Report of the PHN Advisory Panel on Mental Health (September 2018), 6,8.
[42] University of Queensland sold the rights to CCBT Ltd (an international group) who continue to cover the cost of this program in Australia.
[43] https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0353_beyondblue-newaccess-demonstration-independent-evaluation.pdf?sfvrsn=7e1050ea_0
[44] Johnson, et al. (2018) 'Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial' in *The Lancet*, 392:10145
[45] http://rosesintheocean.com.au/
[46] https://www.beyondblue.org.au/get-support/beyondblue-connect
[47] https://www.beyondblue.org.au/docs/default-source/research-project-files/bw0353_beyondblue-newaccess-demonstration-independent-evaluation.pdf?sfvrsn=7e1050ea_0
[48] Australian Bureau of Statistics (2017). *Causes of death*, Australia, 333.0.
[49] Bureau of Infrastructure, Transport and Regional Economies (2018). Road Safety Statistics. Retrieved 23 September 2018: https://bitre.gov.au/statistics/safety/index.aspx.
[50] Australian Bureau of Statistics (2017). *Causes of death*, Australia, 333.0.
[51] Black Dog Institute, *Facts about suicide in Australia*. Available at: https://www.blackdoginstitute.org.au/clinical-resources/suicide-self-harm/facts-about-suicide-in-australia. Retrieved on 25 March 2019.
[52] Suicide Prevention Australia and University of New England (2016). *The Ripple Effect: Understanding the exposure and impact of suicide in Australia.*
[53] Suicide Prevention Australia and University of New England (2018). *The Ripple Effect: Understanding the exposure and impact of suicide in Australia.*
[54] Australian Bureau of Statistics (2017). *Causes of death*, Australia, 333.0.
[55] National Mental Health Commission (2018). National report card 2018. Available at http://www.mentalhealthcommission.gov.au/media/245211/Monitoring%20Mental%20Health%20and%20Suicide%20Prevention%20Reform%20National%20Report%202018.pdf. Retrieved 27 February 2019.
[56] National Mental Health Commission (2018). National report card 2018. Available at http://www.mentalhealthcommission.gov.au/media/245211/Monitoring%20Mental%20Health%20and%20Suicide%20Prevention%20Reform%20National%20Report%202018.pdf. Retrieved 27 February 2019.
[57] Turning Point (2019). *Beyond the Emergency: A national study of ambulance responses to men's mental health.* Richmond, Victoria.
[58] Lizardi, D and Stanley, B (2010). *Treatment Engagement: A Neglected Aspect in Psychiatric care of suicidal patients:* Psychiatric Services 61:12 pp 1183-1991

[59] Inagaki et al (2015). *Interventions to prevent repeat suicidal behaviour in patients admitted to an emergency department for a suicide attempt: A meta-analysis.* Journal of Affective Disorders 175: 66-78
[60] Krysinska K, Batterham PJ, Tye M, Shand F, Calear AL, Cockayne N and Christensen H. (2016). Best strategies for reducing the suicide rate in Australia. *Australian and New Zealand Journal of Psychiatry*. 50(2):115-118.
[61] Wessex Academic Science Network and Happy Health at Home. (2017). *Independent Evaluation of the North East Hampshire and Farnham Vanguard Aldershot Safe Haven Service Evaluation*. Available at: https://wessexahsn.org.uk/img/projects/Safe%20Haven%20Evaluation_FINAL_October%202017.pdf Retrieved 18 February 2019.
[62] The Allen Consulting Group (2012). Police, Ambulance, and Clinical Early Response (PACER) Evaluation: A final report.
[63] Fitts M, Robertson J. Review of the Cairns mental health co-responder project. 2017.
[64] Mental Health Australia and KPMG (2018). *Investing to save: The mental health benefits for Australia in investing in mental health reform*. Available at: https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf. Retrieved 21 November 2018.
[65] Mental Health Australia and KPMG (2018). *Investing to save: The mental health benefits for Australia in investing in mental health reform*. Available at: https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-_kpmg_mental_health_australia.pdf. Retrieved 21 November 2018.
[66] The General Principles of Suicide Prevention Policy Toward the Creation of a Society Where No One Is Driven to Suicide (Cabinet Decision, 28th August 2012). Available at https://jssc.ncnp.go.jp/file/pdf/2015-1101_GeneralPlinciples.pdf. Retrieved 26 February 2019
[67] For the current Scottish Suicide Prevention Plan, see The Scottish Government (2018). *Every life matters: Scotland's Suicide Prevention Action Plan*. The Scottish Government: Edinburgh. Available at https://www.gov.scot/binaries/content/documents/govscot/publications/publication/2018/08/scotlands-suicide-prevention-action-plan-life-matters/documents/00539045-pdf/00539045-pdf/govscot%3Adocument. For details of the 'Choose Life' strategy that commenced in 2002, see https://www2.gov.scot/Publications/2002/12/15873/14473. Retrieved 26 February 2019.
[68] Wessex Academic Science Network and Happy Health at Home. (2017). *Independent Evaluation of the North East Hampshire and Farnham Vanguard Aldershot Safe Haven Service Evaluation*. Available at: https://wessexahsn.org.uk/img/projects/Safe%20Haven%20Evaluation_FINAL_October%202017.pdf Accessed on 18 February 2019. For a summary of the program see: https://www.england.nhs.uk/mental-health/case-studies/aldershot/ (Access 18 February 2019); Evaluation at: https://wessexahsn.org.uk/img/projects/Safe%20Haven%20Evaluation_FINAL_October%202017.pdf Accessed on 18 February 2019
[69] https://stvincentsmelbourne.blog/2018/05/17/st-vincents-safe-haven-cafe/
[70] http://www.maytree.org.uk/about-us.php
[71] Briggs, Stephen & Webb, Liz & Buhagiar, Jonathan & Braun, Gaby. (2007). Maytree: A Respite Center for the Suicidal. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. 28. 140-7. 10.1027/0227-5910.28.3.140. For a summary, see file:///C:/Users/csullivan/Downloads/Maytree.Summary%20(1).pdf Accessed on 26 February 2019.
[72] Covington, David (2018). Crisis Now Retreat Model 2018: What People Think What We Do –Suicide Prevention Australia Conference 2018 Pre-Conference Workshop. Delivered 23 July 2018; Notes retrieved on 23 September: https://www.slideshare.net/davidwcovington/spa-conference-2018-crisis-now-workshop
[73] Johnson, et al. (2018) 'Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial' in *The Lancet*, 392:10145
[74] Department of Health (2017). The Fifth National Mental Health and Suicide Prevention Plan. Department of Health: Canberra.
[75] Page A, Atkinson J, Heffernan M, McDonnell G, Hickie I. A decision-support tool to inform Australian strategies for preventing suicide and suicidal behaviour. Public Health Res Pract. 2017;27(2):e2721717. Accessed on 18 February 2018: http://www.phrp.com.au/issues/april-2017-volume-27-issue-2/a-decision-support-tool-to-inform-australian-strategies-for-preventing-suicide-and-suicidal-behaviour/
[76] The Allen Consulting Group (2012). Police, Ambulance, and Clinical Early Response (PACER) Evaluation: A final report. Available at file:///C:/Users/csullivan/Downloads/PACER_Eval_18April2012_FinalFinal%20-%20PDF.pdf. Accessed on 27 February 2019.
[77] WEBSITE BLOCKED – citation pending.
[78] Australian Council of Social Service (2016). Poverty. https://www.acoss.org.au/poverty/
[79] Australian Psychological Society (2018), *Australian Loneliness Report: A survey exploring the loneliness of Australians and the impact on their health and wellbeing.* Accessed 22 November 2018: https://psychweek.org.au/loneliness-study/
[80] Australian Psychological Society (2018). *Australian Loneliness Report: A survey exploring the loneliness of Australians and the impact on their health and wellbeing.* Accessed 22 November 2018: https://psychweek.org.au/loneliness-study/

[81] Holt-Lunstad, J. (2015). Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. Perspectives on Psychological Science, *Perspectives on Psychological* Science, 10(2):227-237.

[82] The Australian Youth Homeless Experience: Evidence from a Longitudinal Survey of Homeless Youth: Paul Flatau University of Western Australia Centre for Social Impact, Monica Thielking and David MacKenzie, Swinburne University of Technology and Adam Steen, Charles Sturt University, https://www.beyondblue.org.au/media/statistics

[83] https://theconversation.com/three-charts-on-why-rates-of-mental-illness-arent-going-down-despite-higher-spending-97534

[84] See Garvey, D. (2008), A review of the social and emotional wellbeing of Indigenous Australian peoples – considerations, challenges and opportunities. Retrieved 13th January 2012 from http://www.healthinfonet.ecu.edu.au/sewb_review

[85] Australian Bureau of Statistics (2018). *Leading causes of death in Aboriginal and Torres Strait Islander people*, Cat. No. 3303.0 – Causes of Death, Australia, 2017. Canberra: ABS.

[86] Australian Bureau of Statistics (2018). *Leading causes of death in Aboriginal and Torres Strait Islander people*, Cat. No. 3303.0 – Causes of Death, Australia, 2017. Canberra: ABS.

[87] Australian Institute of Health and Welfare (2016). *Healthy Futures—Aboriginal Community Controlled Health Services: Report Card 2016.* Cat. no. IHW 171. Canberra: AIHW

[88] Bourke. S., Wright. A., Guthrie. J., Russell. L., Dunbar. T., Lovett, R., (2018). Evidence review of Indigenous culture for health and wellbeing. International Journal of Health, Wellness, and Society 8(4), 11-27. Cultural Determinants Paper

[89] Garvey, D. (2008). *A review of the social and emotional wellbeing of Indigenous Australian peoples – considerations, challenges and opportunities*. p.61.

[90] https://www.news.com.au/finance/real-estate/renting/locked-out-its-all-gone-horribly-wrong-for-generation-rent/news-story/5f8f620daa541c1d424b34018941bbcf

[91] https://www.abc.net.au/news/2018-03-14/homelessness-in-australia-jumps-14pc-over-five-year-period/9547786

[92] https://www.sbs.com.au/topics/life/culture/article/2016/06/21/why-housing-affordability-crisis-making-poor-even-poorer

[93] Chamberlain, Chris et al "Homelessness in Melbourne: Confronting the Challenge" Centre for Applied Social Research, 2007

[94] Brackertz, N., Wilkinson, A., and Davison, J. (2018) *Housing, homelessness and mental health: towards systems change*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne. p.?

[95] https://www.theage.com.au/national/victoria/more-go-straight-from-psychiatric-hospital-into-homelessness-20180419-p4zamr.html

[96] Mental Health Council of Australia, *Home Truths: Mental Health, Housing and Homelessness in Australia,* 2009, p.9

[97] Jensen, An Evaluation of Community Based Discharge Planning, 2009

[98] Brackertz, N., Wilkinson, A., and Davison, J. (2018) *Housing, homelessness and mental health: towards systems change*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne. p.4

[99] KPMG/MHA, Investing to Save, 2018, 43

[100] Bruce, McDermott, Ramia, Bullen & Fisher, Evaluation of the Housing and Accommodation Support Initiative, 2012

[101] Brackertz, N., Wilkinson, A., and Davison, J. (2018) *Housing, homelessness and mental health: towards systems change*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne. p.1-2

[102] Brackertz, N., Wilkinson, A., and Davison, J. (2018) *Housing, homelessness and mental health: towards systems change*, AHURI Research Paper, Australian Housing and Urban Research Institute Limited, Melbourne. p.1

[103] Australian Institute of Health and Welfare 2015. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra: AIHW. pp.xi-xii

[104] Victorian Auditor General (2014), *Mental Health Strategies for the Justice System,* p.x

[105] Australian Institute of Health and Welfare 2015. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra: AIHW. pp.xi-xii

[106] Australian Institute of Health and Welfare 2015. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra: AIHW. p.xvi

[107] Australian Institute of Health and Welfare 2015. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra: AIHW. p.xvi

[108] Australian Institute of Health and Welfare 2015. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra: AIHW. p.xi

[109] https://www.mja.com.au/journal/2007/187/7/suicide-risk-among-recently-released-prisoners-new-south-wales-australia

[110] https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/justice/corrective-services/rogs-2019-partc-chapter8.pdf

[111] Willis M & Kapira M. 2018. *Justice reinvestment in Australia: A review of the literature*. Research Reports No. 9. Canberra: Australian Institute of Criminology. https://aic.gov.au/publications/rr/rr09
[112] Ruth McCausland (2013). People with mental health disorders and cognitive impairment in the criminal justice system: cost-benefit analysis of early support and diversion. Retrieved from Analysis and Policy Observatory Website: https://apo.org.au/node/35188
[113] NMHC, *Contributing Lives, Thriving Communities (Vol 2)*, 2014, p.45
[114] NMHC, *Contributing Lives, Thriving Communities (Vol 1)*, 2014, p.108
[115] Victorian Legal Aid, The Assessment and Referral Court List is a triumph, 2013
[116] NMHC, *Contributing Lives, Thriving Communities (Vol 2)*, 2014, p.45
[117] Australian Healthcare Associates, Evaluation of the Community Mental Health Transition to Recovery Program, 2012.