SVA Perspectives: Mental Health

May 2019

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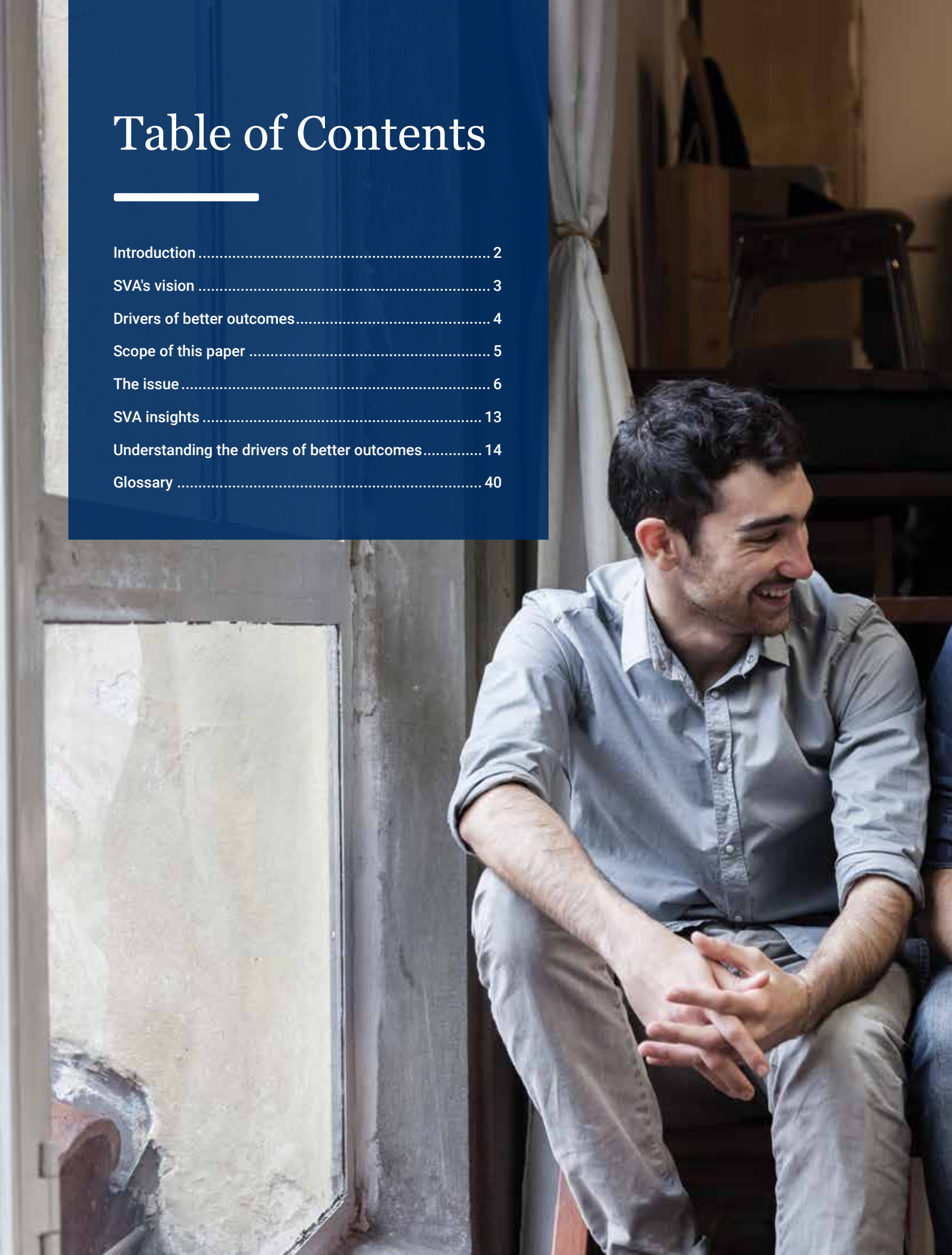
Introduction

Social Ventures Australia (SVA) is working towards an Australia where all people and communities thrive.

While there have been positive efforts and investment from governments and the social sector over recent decades, one in four people in Australia experience disadvantage.

SVA is committed to understanding the structural causes behind persistent disadvantage, then finding and supporting the innovative approaches that can create systemic change. Since 2002, we have taken an evidence-based approach to supporting community service organisations, philanthropists, governments and businesses to make decisions that lead to improved outcomes for people experiencing vulnerability and exclusion. Through our work, we have developed a practical understanding of what it takes to tackle disadvantage.

In 2016 SVA released a series of Perspective Papers in the areas of education, employment, housing and the drivers of better outcomes for First Australian peoples.

We have now expanded this set of insights to include papers on two new focus areas: disability and mental health. In addition, we have expanded on our education Perspective Paper to take a look at three specific cohorts at particular risk of experiencing entrenched disadvantage; children in out-of-home care, Aboriginal and Torres Strait Islander children, and children and young people disengaged from formal schooling.

We hope that these papers spark debate, innovation and collaboration among practitioners, community members, funders and policy makers – towards an Australia where everyone is able to thrive.

Suzie Riddell
CEO
Social Ventures Australia

SVA's vision

SVA has a vision for Australia where all people and communities thrive.

We recognise that mental health and wellbeing is an essential component of thriving communities, and that it is inextricably linked to good outcomes in education, employment and housing.

We believe that everyone in Australia should experience the best possible mental health and wellbeing, and that everyone, regardless of experiences of mental ill-health,[1] is able to live a happy, healthy, productive and meaningful life of their choosing.[2] We believe that experiencing good mental health should not be determined by someone's cultural background, sexual identity, age, gender, employment status, place they live; or by experiences of compounding disadvantage. This includes people living with an intellectual disability, experiences of childhood trauma or experiences of drug and alcohol addiction.[3]

We recognise that any true transformation of the mental health system in Australia must start with the empowerment, voice and participation of people with a lived experience of mental ill-health, and their carers, in all elements of program, service and policy design and delivery.

We have developed an evidence-informed perspective on what we believe is required to reduce the incidence, prevalence and impact of mental ill-health that includes:

- Public awareness and **prevention** approaches that reduce the incidence, prevalence and impact of mental ill-health
- **Early intervention** and integrated supports and services that are available when and where people need them
- Appropriate service systems that empower and support personal, clinical, social and functional **recovery**.

> *"I just want to emphasise that people with mental health issues are a part of the community and that our lives matter. Not only that, but by denying people like me the chance to have a stable life, with stable housing and a reduction in poverty-related stress, you are also denying our kids and loved ones relief from those stresses."*
>
> Person with lived experience, Victoria[4]

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1. The term mental ill-health is used here as an umbrella term to describe both mental illness and mental health problems, as adopted by Everymind Australia.
2. We believe that for an individual good mental health is characterised by experiences of:
   – happiness, or life satisfaction;
   – health, as "there is no health without mental health", Prince, Martin et al. 2007. "No Health without Mental Health." The Lancet 370(9590): 859–77.
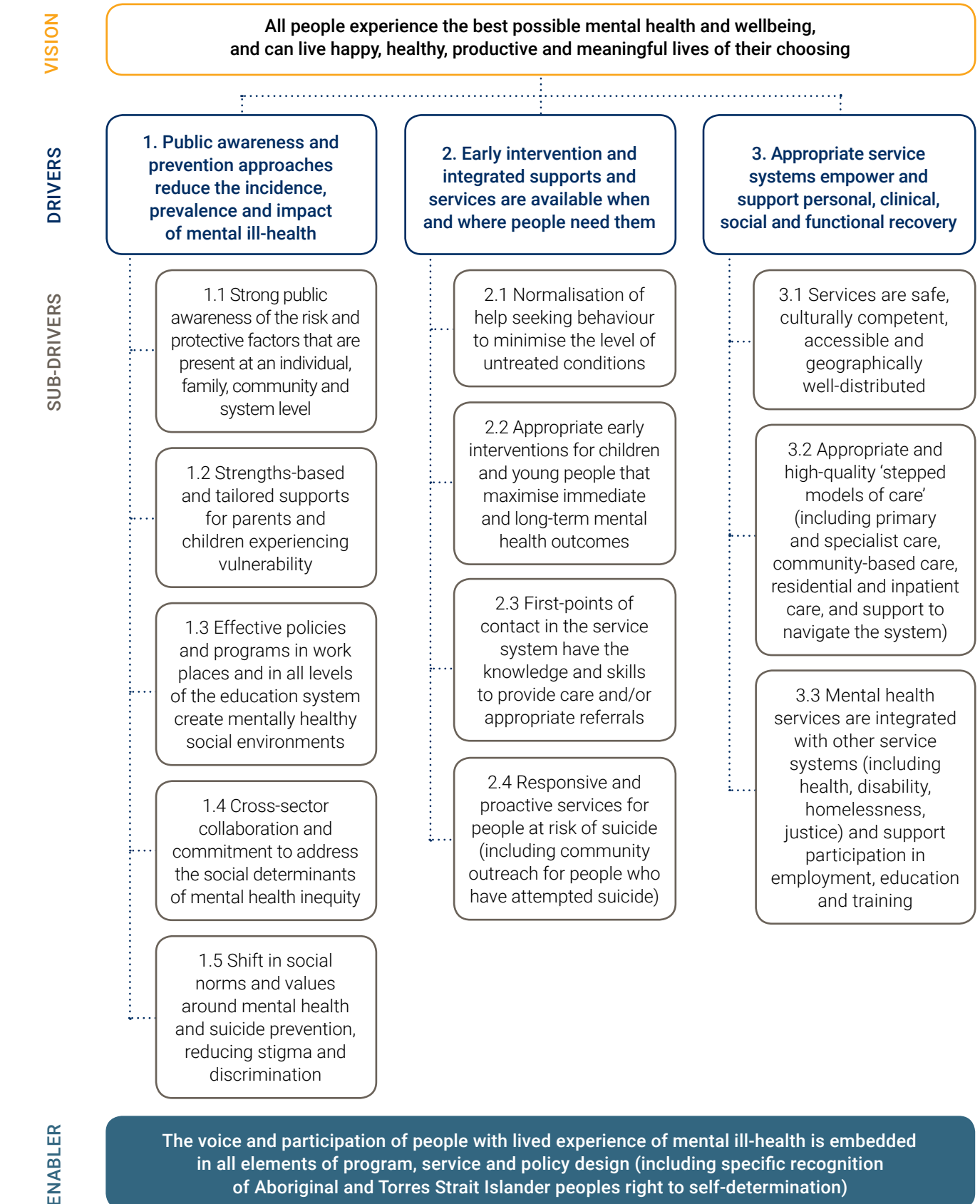   – productivity, as demonstrated through successful levels of functioning that support the achievement of potential;
   – and choice, acknowledging the centrality of the empowerment and self-determination of individuals.
3. National Mental Health Commission, *The National Review of Mental Health Programmes and Services*, NMHC: Sydney, 2014.
4. National Mental Health Commission, 2014.

Drivers of better outcomes

VISION

All people experience the best possible mental health and wellbeing, and can live happy, healthy, productive and meaningful lives of their choosing

DRIVERS

1. Public awareness and prevention approaches reduce the incidence, prevalence and impact of mental ill-health	2. Early intervention and integrated supports and services are available when and where people need them	3. Appropriate service systems empower and support personal, clinical, social and functional recovery

SUB-DRIVERS

1.1 Strong public awareness of the risk and protective factors that are present at an individual, family, community and system level

1.2 Strengths-based and tailored supports for parents and children experiencing vulnerability

1.3 Effective policies and programs in work places and in all levels of the education system create mentally healthy social environments

1.4 Cross-sector collaboration and commitment to address the social determinants of mental health inequity

1.5 Shift in social norms and values around mental health and suicide prevention, reducing stigma and discrimination

2.1 Normalisation of help seeking behaviour to minimise the level of untreated conditions

2.2 Appropriate early interventions for children and young people that maximise immediate and long-term mental health outcomes

2.3 First-points of contact in the service system have the knowledge and skills to provide care and/or appropriate referrals

2.4 Responsive and proactive services for people at risk of suicide (including community outreach for people who have attempted suicide)

3.1 Services are safe, culturally competent, accessible and geographically well-distributed

3.2 Appropriate and high-quality 'stepped models of care' (including primary and specialist care, community-based care, residential and inpatient care, and support to navigate the system)

3.3 Mental health services are integrated with other service systems (including health, disability, homelessness, justice) and support participation in employment, education and training

ENABLER

The voice and participation of people with lived experience of mental ill-health is embedded in all elements of program, service and policy design (including specific recognition of Aboriginal and Torres Strait Islander peoples right to self-determination)

Scope of this paper

This paper aims to take a systems lens to mental health and wellbeing in Australia. In doing so our perspective recognises that enormous diversity exists in experiences of mental health and wellbeing, and conversely mental ill-health.

It is not within the scope of this paper to capture the full diversity of experiences of mental ill-health, particularly noting that this paper is not able to adequately capture the nuance and complexity of: the role of culture in defining an individual and a community's experiences of mental health and wellbeing; the full spectrum of interventions relevant to suicide prevention and response; and the full spectrum of interactions between related systems, sectors and micro systems that intersect and inform the success (or failure) of mental health interventions.

Key terms used in this paper

(full glossary available on page 40)

Mental health and wellbeing: Good mental health, also referred to as positive mental health, complete mental health, social wellbeing and emotional wellbeing[5] is a state of wellbeing where all people can live happy, healthy, productive and meaningful lives of their choosing.

Social and emotional wellbeing: A broader concept than mental health and wellbeing which emphasises the social, emotional, spiritual and cultural wellbeing of an individual.

Mental ill-health: Diminished mental health from either a mental illness/disorder ("a health problem that significantly affects how a person feels, thinks, behaves and interacts with other people"[6] that is diagnosed by standardised criteria) or a mental health problem (a "combination of diminished cognitive, emotional, behavioural and social abilities"[7] that doesn't meet the criteria of a mental illness/disorder).

Psychosocial disability: Experiences of mental ill-health that impair and restrict an individual's capability to fully participate in their life.

5. Welsh, Jenny, Laura Ford, Lyndall Strazdins, and Sharon Friel. *Evidence Review: Addressing the Social Determinants of Inequities in Mental Wellbeing of Children and Adolescents*, National Centre for Epidemiology and Population Health and the Regulatory Institutions Network: Canberra, 2015.
6. Productivity Commission, *The Social and Economic Benefits of Improving Mental Health Productivity Commission Issues Paper*, Commonwealth Government: Canberra, 2019.
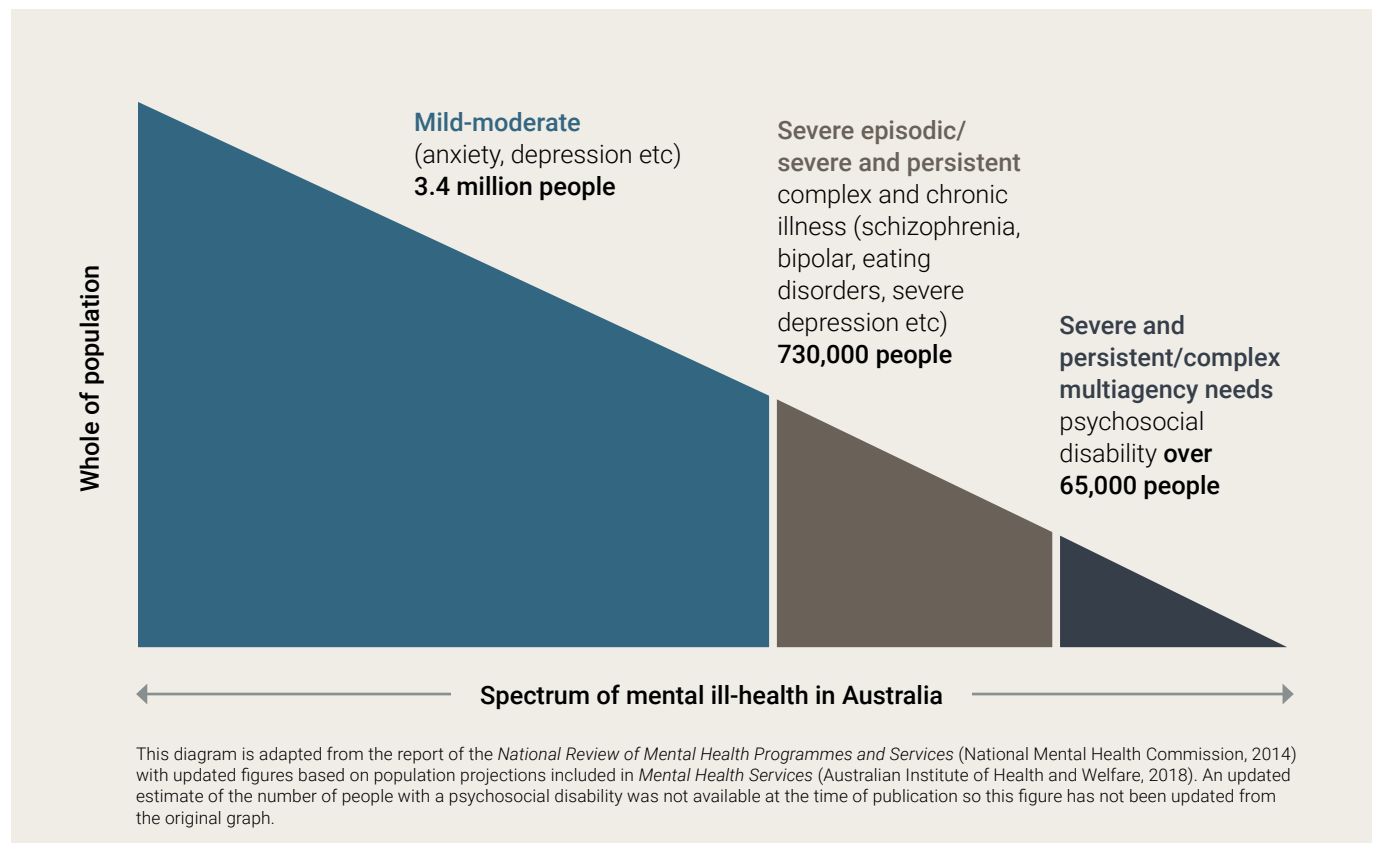7. Productivity Commission, 2019.

The issue

How many people are impacted by mental ill-health in Australia?

Experiences of mental ill-health will affect almost half of the population in Australia within their lifetime, with an estimated 20% of the population (over 4 million people) experiencing mental ill-health in any given year. Experiences of mental ill-health vary dramatically in severity and duration, with experiences of severe mental ill-health occurring in 2–3% of the population in any given year,[8] as shown in Figure 1 below.

Figure 1: Spectrum of mental ill-health in Australia. Source: National Mental Health Commission, 2014 and Australian Institute of Health and Welfare, 2018

Mild-moderate (anxiety, depression etc) **3.4 million people**

Severe episodic/ severe and persistent complex and chronic illness (schizophrenia, bipolar, eating disorders, severe depression etc) **730,000 people**

Severe and persistent/complex multiagency needs psychosocial disability **over 65,000 people**

Whole of population

Spectrum of mental ill-health in Australia

This diagram is adapted from the report of the *National Review of Mental Health Programmes and Services* (National Mental Health Commission, 2014) with updated figures based on population projections included in *Mental Health Services* (Australian Institute of Health and Welfare, 2018). An updated estimate of the number of people with a psychosocial disability was not available at the time of publication so this figure has not been updated from the original graph.

8. Australian Institute of Health and Welfare, *Mental Health Services—in Brief 2018. Cat. No. HSE 211*, AIHW: Canberra, 2018.
9. National Mental Health Commission, *The National Review of Mental Health Programmes and Services, NMHC: Sydney, 2014.*

What are the impacts of mental ill-health on individuals and on society as a whole?

Mental ill-health can contribute to experiences of isolation, discrimination and stigma and can lead to disability and the co-occurrence of other illnesses, or "co-morbidities". Severe mental ill-health can have significant negative impacts on individuals, but also on family members, friends and carers. It can also lead to flow on impacts for communities. For many people experiencing mental ill-health, there are connected and overlapping experiences of poverty, social exclusion, unemployment, physical ill-health, family violence and homelessness.

For carers of adults with mental ill-health, the impact can be significant, particularly where service responses are inadequate or incomplete. Recent studies have found that carers of adults with mental ill-health are significantly less

likely to be employed than non-carers, but are not adequately recognised as part of the health care workforce.[10] Carers of adults with mental ill-health provide an estimated 208 million hours of informal care in Australia each year, which has been estimated to amount to the equivalent of $14.3 billion of primary mental health care in 2015.[11]

Mental ill-health (including substance use disorders) represent the third largest group of diseases that have a burden on the Australian population (12.1%), after cancer (18.5%) and cardiovascular diseases (14.6%).[12] In Figure 2 below we can see the distribution of the burden of disease[13] across the life course, with mental ill-health presenting as the most significant disease group for children and young people.

Figure 2: Burden of disease, by disease group and age, 2011. Source: AIHW 2016

Source: Australian Burden of Disease Study 2011; Table S3.1.3.
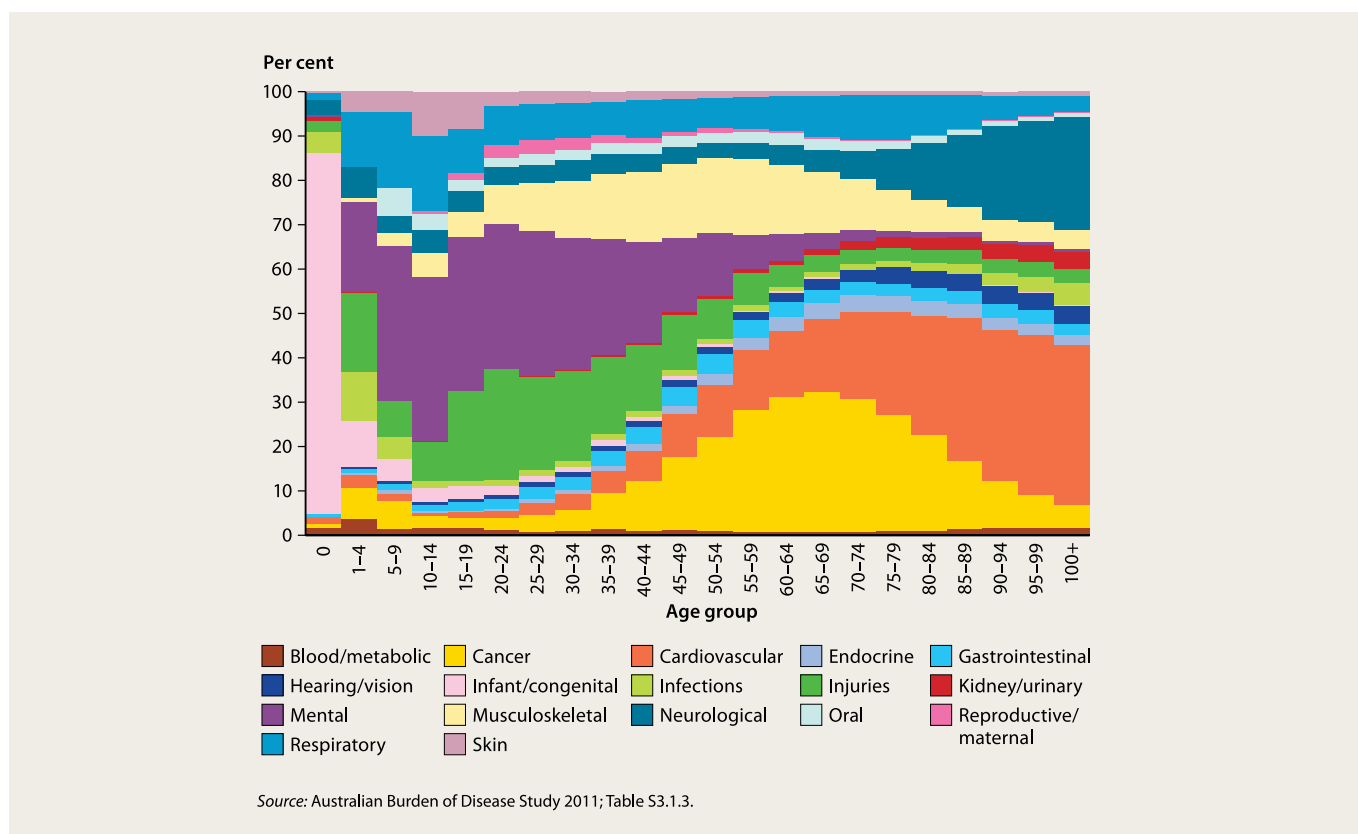
Some estimates suggest that the cost of mental ill-health in Australia each year is approximately 4% of GDP, or about $4000 for every tax payer,[15] costing the nation more than $70 billion every year.[16] In comparison, there is clear evidence demonstrating investing in mental health reform can drive significant outcomes in Australia's future prosperity and living standards.[17]

10. Diminic, Sandra, Emily Hielscher, and Meredith Harris. *Understanding Factors Associated with Australian Mental Health Carers' Employment*, University of Queensland: Brisbane, 2018.
11. Diminic, Sandra, Emily Hielscher, Yong Yi Lee, Meredith Harris, Jaclyn Schess, Jan Kealton and Harvey Whiteford. T*he Economic Value of Informal Mental Health Caring in Australia: technical report*, University of Queensland: Brisbane, 2017.
12. Australian Institute of Health and Welfare, *Australia's Health 2016*, AIHW: Canberra, 2016.
13. Burden of disease measures the impact of living with illness and injury and dying prematurely. The summary measure 'disability-adjusted life years' (or DALY) measures the years of healthy life lost from death and illness (AIHW).
14. Australian Institute of Health and Welfare, 2016.
15. National Mental Health Commission, *The Impact of Poor Mental Health – An Economic Issue*, NHMC: Sydney, 2016.
16. National Mental Health Commission, *Monitoring Mental Health and Suicide Prevention Reform: National Report 2018*, NHMC: Sydney, 2018.
17. KMPG and Mental Health Australia. *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, 2018.

What do responses to mental ill-health in Australia currently look like?

Policy and program responses to mental ill-health in Australia are best understood through examining the interaction between two interconnected systems – the population mental health system and the mental health care system. The population mental health system is targeted at families, communities and institutional environments, and is the key point of contact for the majority of the population. It is is focused on public awareness, prevention, reduction in stigma and suicide prevention. In comparison the mental health care system is focused on clinical and social service delivery for individuals and their carers, incorporating both early intervention services (particularly for children and young people) and treatment and recovery services (particularly for people with severe and persistent mental ill-health).

Service types within the mental health care system are diverse and occur in multiple settings: from short term clinical interactions in the community or in hospital; to longer term hospital and residential interventions. For some people this may include an experience of involuntary commitment and treatment under the provisions of mental health legislation.

Services can be public, private or delivered by a non-government organisation, and are funded by governments, private health insurers and individuals.[18] The workforce is also extremely diverse and includes General Practitioners (GPs), psychologists, psychiatrists, nurses, occupational therapists, social workers, and peer workers.[19]

Australia's current public expenditure on mental health services is significant – with over $9 billion invested in 2015–16 alone.[20] However, despite the investment equating to 7.7% of Australia's total health expenditure,[21] investment is heavily weighted towards acute care and crisis responses that are costly and limited in their scope and reach. This results in many people, particularly those experiencing severe mental ill-health, enduring: unmet care needs; poor levels of care; gaps in care and support; perpetuation and relapse of mental ill-health; and compounding levels of disadvantage that can lead to experiences of unemployment, homelessness, chronic ill-health and premature death.

Reforms to the system have been significant over the past few decades, most notably the transition from institutionalisation to community-based models of care. Despite ongoing investment and attempts to reform the mental health and suicide prevention service systems, the current state of care is fragmented, uneven, costly, compromising to individuals' human rights and not leading to significant changes in national health outcomes.[22] As described by former National Mental Health Commissioner, the late Jackie Crow:

> *"To describe Australia's mental health care sector as a 'system' would be incorrect. We have a whole set of silos in health and mental health that barely connect."[23]*

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18. Cook, Lauren, *Mental Health in Australia: A Quick Guide – Parliament of Australia*, Parliament of Australia: Canberra, 2019.
19. National Mental Health Commission, *The National Review of Mental Health Programmes and Services*, NMHC: Sydney, 2014.
20. Australian Institute of Health and Welfare, *Mental Health Services—in Brief 2018*. Cat. No. HSE 211, AIHW: Canberra, 2018.
21. Australian Institute of Health and Welfare, 2018.
22. National Mental Health Commission, 2014.
23. Crow, Jackie. 2017. "Reform, Revolution and Disruption in Mental Health Care: A Consumer's Perspective," *Public Health Research & Practice*, 27(2):e272.

The transformation and improvement of mental health outcomes in Australia is a complex social policy challenge that governments have been grappling with for decades.

For consumers engaging with the mental health care system there is significant diversity in pathways to access care and journeys through the system. One divide can be seen between people with mild and moderate conditions who predominantly access services funded by the Commonwealth Medicare Benefits Scheme; and people with moderate and severe conditions that access services funded by state or territory governments, including hospitals. The complexity of these interacting systems, government policy frameworks and funding arrangements; coupled with the diversity of circumstances and experiences facing people with mental ill-health (including the financial barriers to accessing services for people experiencing unemployment or on low incomes) are significant barriers to reducing the prevalence, incidence and impact of mental ill-health.

The recent introduction of the NDIS has challenges for people experiencing severe mental ill-health, with eligibility requirements creating barriers to accessing NDIS supports for some people experiencing a psychosocial disability.[24] In addition, the principles of care provided under the NDIS, particularly the permanence of disability, are at odds with the therapeutic approach of the psychosocial support sector which is heavily oriented to recovery from illness.[25]
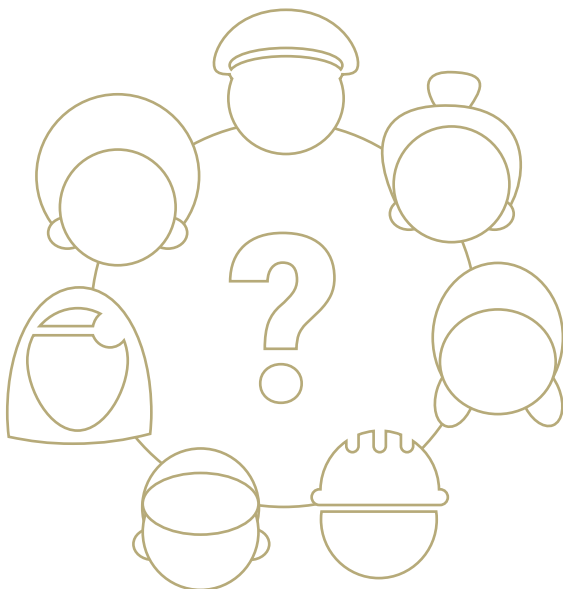
Who is affected by mental ill-health in Australia?

Experiences of mental ill-health impact people from all walks of life, however the impact, incidence and prevalence of mental ill-health does not impact every group equally. Young people are significantly over represented in the prevalence of mental ill-health for an age group,[26] and between 2016 and 2018 the proportion of young people who considered mental health as an important national issue doubled from 20.6% to 43%.[27] Experiences of mental ill-health are also variable according to gender, with women much more likely than men to experience depression and anxiety, but much less likely to die by suicide than men.

Exposure to discrimination is identified as the key causal factor behind the high incidence of mental ill-health in the LGBTI community, where lesbian, gay and bisexual Australians experiencing high to very high levels of psychological distress at twice the rate of heterosexual people; and almost half of trans people have attempted suicide.[28] The National LGBTI Health Alliance identifies that "the elevated risk of mental ill-health and suicidality among LGBTI people is not due to sexuality, sex or gender identity in and of themselves but rather due to discrimination and exclusion as key determinants of health…this is sometimes referred to as minority stress."[29]

For Aboriginal and Torres Strait Islander peoples the impact of colonisation, intergenerational trauma and ongoing social, cultural and political marginalisation in Australia has driven high rates of mental ill-health. Aboriginal and Torres Strait Islander peoples are 2.6 times more likely to experience high to very high levels of psychological distress and almost twice as likely as non-Indigenous people to die by suicide.[30] A study that interviewed 755 Aboriginal people in Victoria found that people who had experienced higher rates of racism were more likely to experience higher rates of psychological distress.[31]

24. Smith-Merry, Jennifer, Nicola Hancock, John Gilroy, Gwynnyth Llewellyn, Ivy Yen and Amanda Bresnan, *Mind the Gap: The National Disability Insurance Scheme and Psychosocial Disability Final Report: Stakeholder Identified Gaps and Solutions Contributing Stakeholder Organisations and Programs*, University of Sydney: Sydney, 2018.
25. Mental Health Australia, *Optimising Psychosocial Supports*, MHA: Canberra, 2018.
26. Black Dog Institute, *Keeping Health in Mind*, Black Dog Institute: Sydney, 2019.
27. Mission Australia, *Youth Survey 2018*, Mission Australia: Sydney, 2018.
28. Rosenstreich, Gabi, *LGBTI People Mental Health & Suicide*, National LGBTI Health Alliance: Sydney, 2013.
29. Rosenstreich, Gabi, 2013.
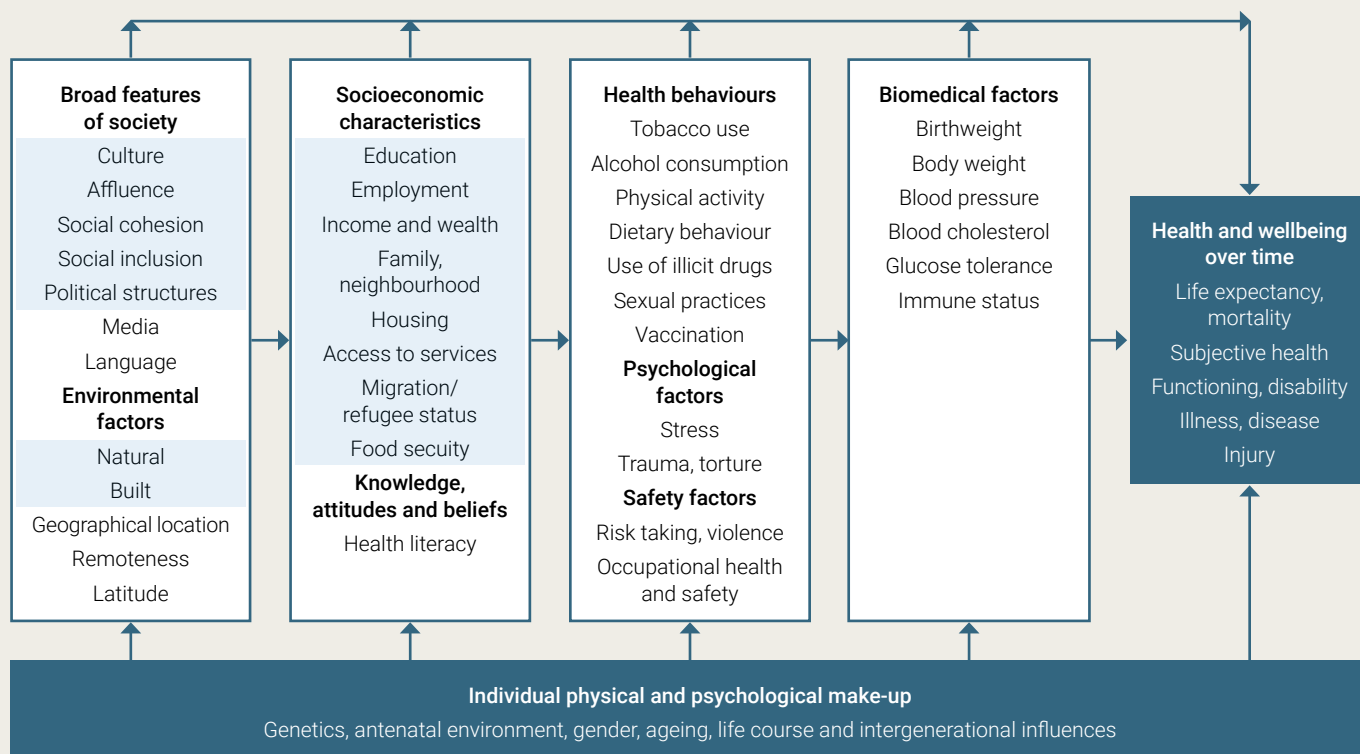30. Australian Bureau of Statistics, *Causes of Death*, Australia, 2017 Cat. No. 3303.0., ABS: Canberra, 2018.
31. Ferdinand, Angeline, Yin Paradies and Margaret Kelaher, *Mental Health Impacts of Racial Discrimination in Victorian Aboriginal Communities: The Localities Embracing and Accepting Diversity (LEAD) Experiences of Racism Survey*, Lowitja Institute: Melbourne, 2013.

What are the risk and protective factors that influence mental health and wellbeing?

Good mental health is in part driven by a set of behavioural and biological risk and protective factors, including genetics, diet, physical activity and drug use. But beyond factors specific to an individual, good mental health and wellbeing is inextricably linked to our social, cultural, political and economic environments. The social determinants of health, endorsed by the World Health Organisation (WHO), provide a framework for understanding the complex intersection of mental health and other experiences of social, cultural, political and economic disadvantage, marginalisation and exclusion. In Figure 3 below we can see that health is driven by: individual factors; social and community networks, and the broader socio-economic, cultural and political conditions within society. Yet the impact of social conditions has been identified by the WHO as the single most important determinant of whether an individual will experience good or ill health in their lifetime.[32] A series of meta-analyses have identified that income inequality is a significant driver of illness and mental ill-health, with societies that experience higher levels of income inequality experiencing higher levels of mental ill-health.[33]

Figure 3: Framework for determinants of health. Source: AIHW 2018

Broad features of society	Socioeconomic characteristics	Health behaviours	Biomedical factors	Health and wellbeing over time
Culture	Education	Tobacco use	Birthweight	Life expectancy, mortality
Affluence	Employment	Alcohol consumption	Body weight	Subjective health
Social cohesion	Income and wealth	Physical activity	Blood pressure	Functioning, disability
Social inclusion	Family, neighbourhood	Dietary behaviour	Blood cholesterol	Illness, disease
Political structures	Housing	Use of illicit drugs	Glucose tolerance	Injury
Media	Access to services	Sexual practices	Immune status	
Language	Migration/ refugee status	Vaccination		
Environmental factors	Food secuity	**Psychological factors**		
Natural	**Knowledge, attitudes and beliefs**	Stress		
Built	Health literacy	Trauma, torture		
Geographical location		**Safety factors**		
Remoteness		Risk taking, violence		
Latitude		Occupational health and safety		

Individual physical and psychological make-up
Genetics, antenatal environment, gender, ageing, life course and intergenerational influences

Note: Blue shading highlights selected social determinants of health.

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32. Australian Institute of Health and Welfare, *Australia's Health 2016,* AIHW: Canberra, 2016.
33. Wilkinson, Richard and Kate Pickett, *The Spirit Level: Why Greater Equality Makes Societies Stronger,* Allen Lane: London, 2009.

Case study – Culture is Life

Culture is Life supports and promotes Aboriginal and Torres Strait Islander led solutions to prevent youth suicide, with a deep emphasis on strengthening connection to culture and country. This approach recognises that experiences of racism and intergenerational trauma are significant risk factors for the social and emotional wellbeing of Aboriginal and Torres Strait Islander young people. Drawing on a growing body of international evidence demonstrating the role of cultural strengthening as a key protective factor for Aboriginal and Torres Strait Islander young people, Culture is Life builds awareness and influences public debate to strengthen support and funding for culturally safe initiatives in regional and remote Australia.

SVA supported Culture is Life to develop theories of change for their organisation and programs, and a practical data collection and reporting framework. The work also identified an opportunity for Culture is Life to take a more active 'evidence intermediary' role – to aggregate and mobilise evidence around cultural resilience – a role Culture is Life is adopting.

SVA insights

Through a range of partnerships with organisations working in mental health, we have developed a set of insights for enabling system change in the sector. This is not intended to be an exhaustive list, it represents our perspective based on our experience on some of the essential systemic changes required to improve outcomes.

1. Governments and service delivery organisations embed the role of people with a **lived experience** of mental ill-health in decision-making structures and service delivery approaches to ensure that service models situate the needs of consumers at the centre.

2. The mental health sector fosters a **stronger outcomes management culture,** capability and systems, both within governments and service delivery organisations, to ensure investment in mental health services is achieving the desired outcomes. This includes being able to:

   a. Identify outcomes that are good indicators of improvements in wellbeing;

   b. Commission work and measure its efficacy through proper data analysis; and

   c. Change practice based on the results.

3. Mental health and wellbeing policy and program frameworks support and enable service delivery providers to invest in the **capability building and workforce development** required to deliver high quality, appropriate, integrated, culturally competent, accessible and evidence-based stepped models of care. This includes business development, data analysis, evidence implementation, partnership development, outcomes management and financial management.

4. Social policy and program frameworks enable and incentivise **integration, collaboration and cooperation** with the mental health sector (notably housing, employment, education, health and justice) to ensure more holistic care and support and reduce the risk of people missing out on service or receiving services with conflicting or contradictory approaches.

5. Governments invest in the next generation of research evidence and improving the **translation of existing evidence** into practice across the spectrum of mental health interventions to increase the speed at which more effective practices are adopted.

6. Governments adopt an 'investment approach'[34] to **refocus and reshape the size and direction of funding** for mental health and wellbeing with an aim to shift public expenditure from a focus on crisis response services to an investment in quality and evidence-informed recovery, early intervention and prevention services.

7. The mental health sector and the private sector partner to **unlock new channels of investment** that can support the demonstration and scaling of innovative programs and approaches (for example social impact bonds).

8. The mental health sector increases the **use of technology in service delivery approaches** to reduce barriers to access; increase the availability and quality of services; enable individuals to tailor services to their own needs and preferences; and manage the rising costs of service delivery, particularly for universal access points such as crisis phone counselling.

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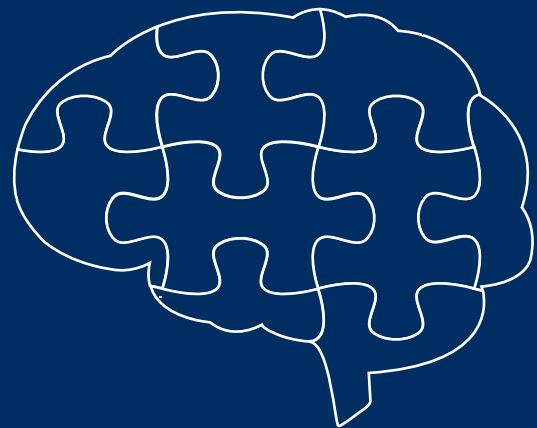
34. An investment approaches considers how to better utilise the projected lifetime costs of welfare payments through investing in policies and programs that improve the lifetime wellbeing of people and communities in Australia, including increasing people's capacity to work and live independently of welfare.

Understanding the drivers of better outcomes

The voice and participation of people with lived experience of mental ill-health is embedded in all elements of program, service and policy design

The starting point for any transformation of Australia's mental health system is the inclusion of people with a lived experience of mental ill-health in all elements of mental health policy, program and service design.[35]

Experiences of mental ill-health in Australia have historically been characterised by a loss of personal autonomy and power that includes involuntary incarceration, unnecessary hospitalisation, the use of restraints and seclusion.[36] Additionally, there has been a history of marginalisation and disempowerment of consumers within the mental health system, with ongoing government inquiries concluding that the current system is predominantly weighted towards clinical support, rather than oriented towards addressing the holistic needs of an individual to support their recovery. The National Mental Health Commission concluded that we need to "redesign the system to focus on the needs of users rather than providers".[37]

It has been broadly acknowledged by governments that people experiencing mental ill-health are extremely vulnerable to human rights' violations, stemming from stigma and discrimination, and enabled through the provisions of mental health legislation.[38] A complete recognition of rights requires the voice of consumers in policy decision making, enabled by the public participation of individuals.[39] Enabling the voice and participation of people with lived experience of mental ill-health has multiple components, as described in a National Mental Health Policy adopted in 2009:

> *"People with mental health problems and mental illness have rights and responsibilities to be informed about and involved in decisions about their own individual treatment. They also have the right to contribute to the formulation of mental health legislation and policy, and to the design, implementation and evaluation of mental health services at national, state/ territory and local levels to ensure that services comprehensively meet their needs, including from a cultural perspective. Mental health legislation should include recognition of these rights and the conditions that apply when decision-making is delegated."[40]*

Beyond ensuring that the human rights of people experiencing mental ill-health are recognised, there is strong evidence to support that better outcomes are achieved through consumer oriented and directed care.[41] The most common mechanisms for shifting towards a consumer oriented and directed care model are the employment of peer workers and the establishment of advisory mechanisms.

35. National Mental Health Commission, *The National Review of Mental Health Programmes and Services*, NMHC: Sydney, 2014.
36. National Mental Health Commission, 2014.
37. National Mental Health Commission, 2014.
38. Australian Health Ministers, *National Mental Health Policy 2008*, Commonwealth of Australia: Canberra, 2008.
39. Mental Health Standing Committee of the Standing Council on Health, *Mental Health Statement of Rights and Responsibilities*, Standing Council on Health: Canberra, 2012.
40. Australian Health Ministers, 2008.
41. Bywood, Petra, Lynsey Brown and Melissa Raven, *Improving the Integration of Mental Health Services in Primary Health Care at the Macro Level*, Primary Health Care Research and Information Service: Adelaide, 2015.

"A Peer Worker is an occupational title for a person in recovery from a mental disorder or mental health problem, who is working to assist other people with a mental disorder. Because of their life experience, such persons have expertise that professional training cannot replicate; they are important sources of information, a potential source of motivation, and may serve as mentors to others".[42]

Advisory mechanisms at all levels of the system recognise that people with a lived experience of mental ill-health (and the people who care for them) are experts in their own life. However, the success of these measures is highly dependent on adequate resourcing to build the capability of peer workers to drive service transformation of service delivery models and to adequately participate in decision making through advisory bodies.

Driving better outcomes for Aboriginal and Torres Strait Islander peoples requires recognising the right to self-determination through acknowledging the critical role of peak bodies and community-controlled service delivery organisations. The National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) launched the Gayaa Dhuwi (Proud Spirit) Declaration in 2015 (an adaptation of the international Wharerata Declaration developed by Indigenous mental health leaders from Canada, the United States, Australia, Samoa and New Zealand), which identified that:

"Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes."[43]

Australian governments endorsed the implementation of the Gayaa Dhuwi (Proud Spirit) Declaration in the Fifth National Mental Health and Suicide Prevention Plan.

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 outlines a pathway for transforming the experiences of Aboriginal and Torres Strait Islander peoples in accessing adequate mental health care and treatment, which at the core necessitates:

"Aboriginal and Torres Strait Islander leadership, engagement and partnership in the planning, delivery, evaluation, and measurement of services and programs is critical in fostering greater trust, connectivity, culturally appropriate care and effective outcomes." [44]

42. Beattie, Valli, Janet Meagher and Peter Farrugia, *Embracing Inclusion - Employment of People with Lived Experience*, RichmondPRA: Sydney, 2013.
43. National Aboriginal and Torres Strait Islander Leadership in Mental Health, *Gayaa Dhuwi (Proud Spirit) Declaration*, NATSILMH, 2015.
44. Department of the Prime Minister and Cabinet, National strategic framework for *Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing 2017-2023*, Commonwealth of Australia: Canberra, 2017.

Case study – Resolve Social Benefit Bond

SVA is working with Flourish Australia on the Resolve Social Benefit Bond (SBB), Australia's first social impact investment aimed at improving mental health outcomes. The Resolve Program is an innovative, peer-led and delivered community support program that brings together short-term accommodation, individual outreach and a warm line of support to people, with the aim to avoid hospitals unless that course of action is absolutely necessary.

Essential to the success of the Resolve Program is a peer workforce. Flourish are a national leader in the employment of mental health peer workers, which is supported by academic and practice evidence demonstrating that people with mental health issues are far more likely to trust, relate to and respond to someone who has their own experience of a mental health issue – a peer worker – than staff without mental health histories.

The Resolve SBB is an innovative approach to building the evidence base in support of early intervention approaches, as well as demonstrating the cost savings to government through a reduction in participants' utilisation of health and other services, in particular by reducing the number of days spent in hospital.

1. Public awareness and prevention approaches reduce the incidence, prevalence and impact of mental ill-health

Reducing the incidence and prevalence of mental ill-health requires targeted, joined up efforts to raise public awareness, shift social norms, transform service models and increase political investment in mental health.

Prevention can be broadly classified into three stages: primary, which is aimed at reducing the prevalence of mental ill-health in the population; secondary, which is aimed at reducing both the prevalence of relapse and the impact of mental ill-health; and tertiary, which is aimed at reducing the impact of mental ill-health through preventing psychosocial disability.

As primary prevention is predominantly concerned with whole of population health promotion activities, there is a further delineation between universal, selective and indicated prevention.

Universal prevention refers to whole of population approaches, most notably seen in Australia through the work of Beyond Blue. Selective prevention refers to targeted approaches for cohorts who do not currently have mental ill-health, but have been identified at high-risk of developing mental ill-health in the future, like targeted awareness raising for children and young people in education environments. Indicated prevention refers to approaches targeted to individuals who do not currently have mental ill-health, but who display some indication (such as exposure to risk factors and absence of protective factors) of developing mental ill-health in the future (although the distinction between indicated prevention and early intervention can often be blurry).

In Figure 4 below these prevention components are situated alongside the continuum of health promotion, treatment and maintenance; illustrating the distinct role of prevention in reducing the impact and prevalence of mental ill-health, well before an individual experiences it (identified in this figure as commencing at the case identification phase).[45]

Figure 4: Mental health intervention spectrum.
Source: Adapted from Institute of Medicine, 1994, in National Academy of Sciences Engineering and Medicine, 2016
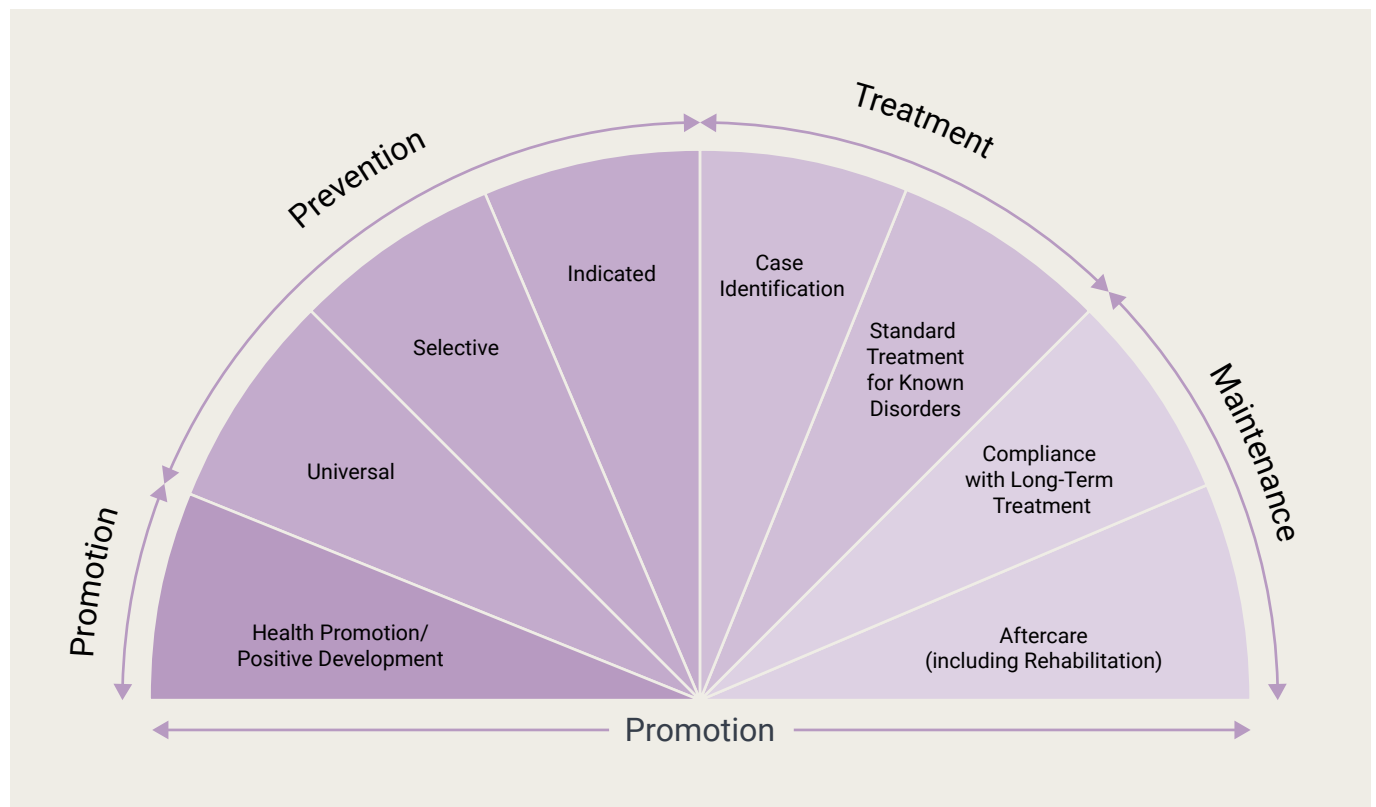
45. National Academy of Sciences, Engineering and Medicine, *Preventing Bullying Through Science, Policy, and Practice*, ed. Frederick Rivara and Suzanne Le Menestrel, National Academies Press: Washington, DC, 2016.
46. Adapted from Institute of Medicine, 1994, in National Academy of Sciences Engineering and Medicine, 2016.

In considering selective and indicated approaches to prevention it is also important to consider key life stages.

Because the majority of mental ill-health develops in adolescence, prioritising interventions focused on children and young people is critical. Despite the growing evidence behind effective programs, prevention efforts require investment to scale across population groups (including whole of population universal approaches). In 2014 the National Mental Health Commission found that of the $3.63 billion invested by the Commonwealth in direct clinical and psychosocial services, only $22.4 million was invested programs focused on prevention.[47]

Current mental health practices vary significantly in their reliance on evidence, with existing research often failing to be translated into modalities of prevention, intervention, treatment and care. In addition, there are significant gaps in the evidence, particularly in the Australian context, which create barriers to transition current care models to best practice approaches. Without prioritising building the evidence base and translating existing evidence into practice, there are significant risks that the limited pool of funding is supporting interventions with no proven success. There is an additional gap in monitoring and evaluation evidence gathered through service delivery.

Academics and researchers are sitting on a significant number of successful interventions, particularly in the area of prevention, that are not currently utilised within our mental health practice, which if scaled could have significant impact on the prevalence, incidence and impact of mental ill-health in Australia.[48]

Professor Patrick McGorry from Orygen, the National Centre of Excellence in Youth Mental Health describes:

"Innovation is essential if we are to dispel the low expectations and largely palliative mindset of traditional mental health care. Innovation includes new thinking, new models, and new treatments, all of which are desperately needed. Innovators and early adopters must be nurtured as we seek progress in mental health care. Late adopters are more conservative and should be respected, listened to, persuaded, and convinced on the basis of logic and scientific evidence wherever possible. They do have a legitimate role in the process. Even if no new treatment advances were made in the next 20 years, we could still substantially reduce… the avertable burden of disease by increasing the scale, coverage, and value of mental health care and changing the timing and culture of the provision of services."[49]

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47. Prevention United, *The Case for a Focus on Prevention*, Prevention United, 2018.
48. Prevention United, *A Submission to Create The Australian Centre for the Promotion of Mental Wellbeing and Prevention of Mental Health Conditions*, Prevention United, 2018.
49. McGorry, Patrick, Sherilyn Goldstone, Alexandra Parker, Debra Rickwood and Ian Hickie, 2014, "Cultures for Mental Health Care of Young People: An Australian Blueprint for Reform." *The Lancet Psychiatry 1*(7): 559–68.

1.1 Strong public awareness of the risk and protective factors that are present at an individual, family, community and systems level
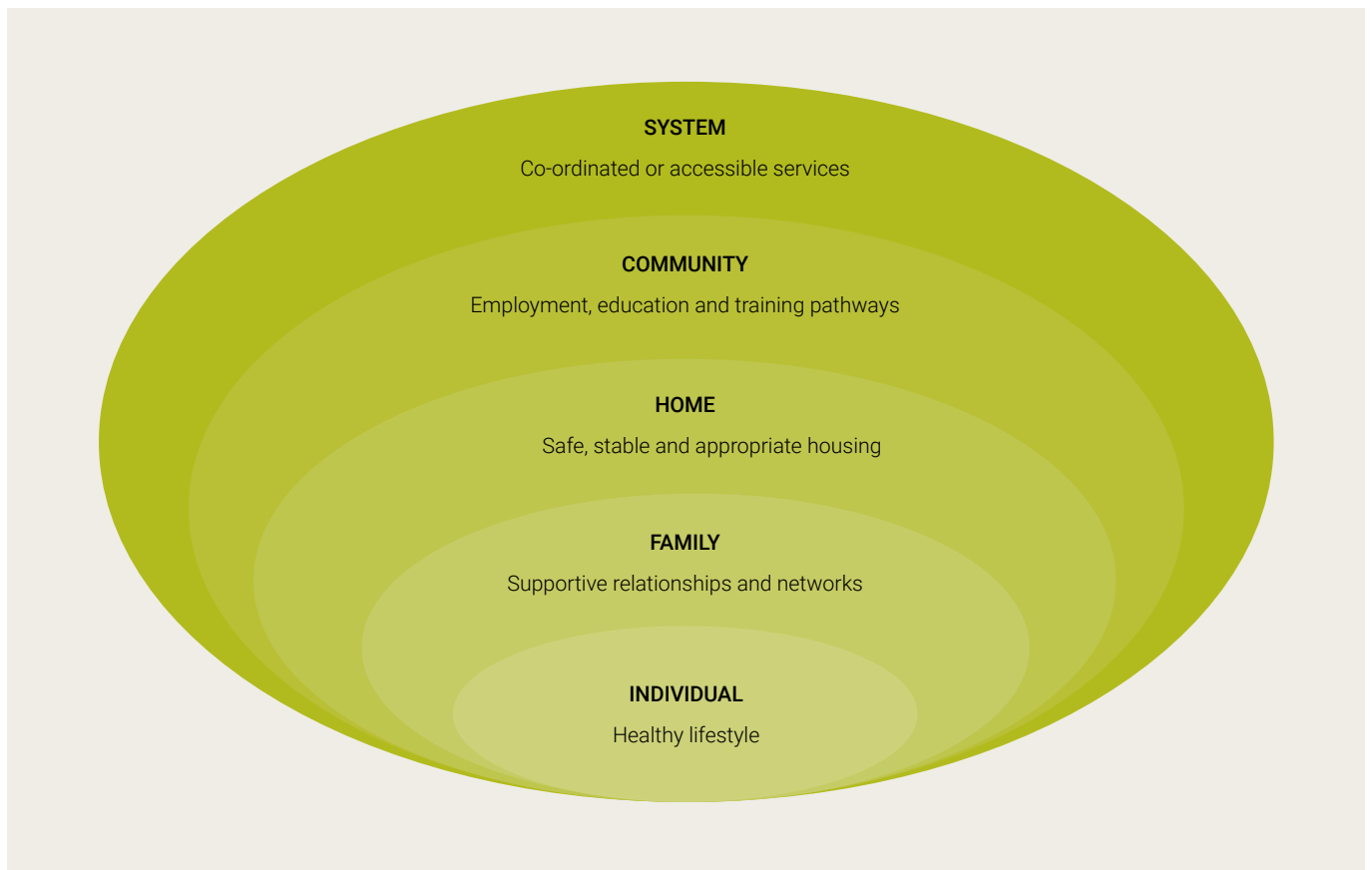
Knowledge of the risks and protective factors of mental health and wellbeing is a critical component of reducing the incidence, prevalence and impact of mental health.

Prevention requires literacy of what drives mental ill-health, which requires understanding the full spectrum of health determinants that drive mental ill-health, as described above. These include individual physical and psychological makeup; environmental factors; societal factors; socioeconomic characteristics; knowledge attitudes and beliefs; health behaviours; psychological factors; safety factors; and biomedical factors.

In considering this broad set of drivers, prevention efforts commonly delineate between influencing individual behavioural change, which can include (for example) promoting a healthy lifestyle or identifying the impact of substance abuse; and social and environmental change, which can include shifting perceptions and norms around mental health and wellbeing or increasing awareness of the impact of racial discrimination on mental ill-health. In Figures 5 and 6 examples of risks and protective factors are mapped against an ecological model to illustrate the complex set of drivers influencing an individual's experience of mental health and wellbeing.

Figure 5: Examples of mental health protective factors.

SYSTEM
Co-ordinated or accessible services

COMMUNITY
Employment, education and training pathways

HOME
Safe, stable and appropriate housing

FAMILY
Supportive relationships and networks

INDIVIDUAL
Healthy lifestyle

The risk and protective factors listed here are indicative examples only and not exhaustive.

Figure 6: Examples of mental health risk factors.
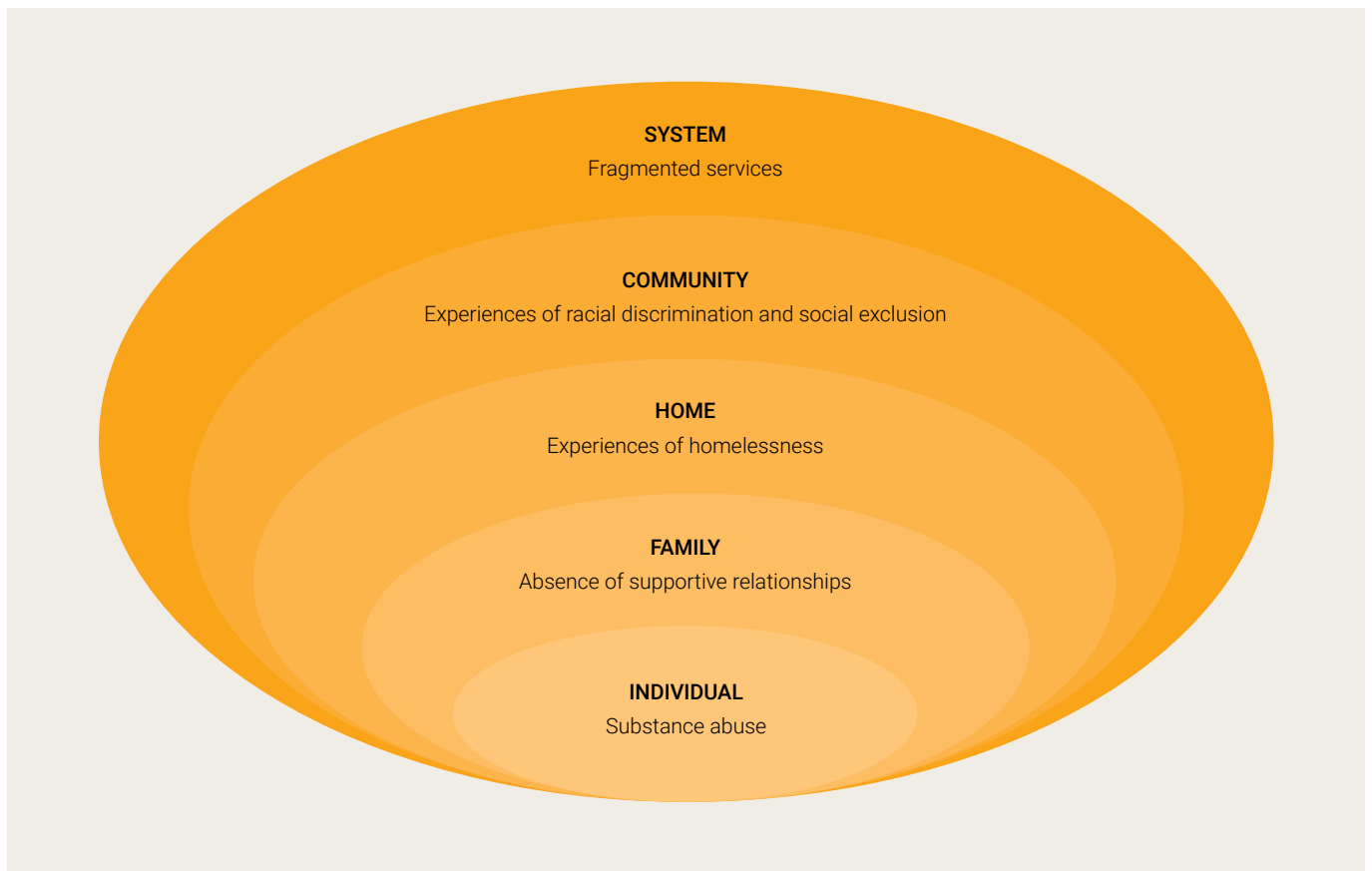
SYSTEM
Fragmented services

COMMUNITY
Experiences of racial discrimination and social exclusion

HOME
Experiences of homelessness

FAMILY
Absence of supportive relationships

INDIVIDUAL
Substance abuse

The risk and protective factors listed here are indicative examples only and not exhaustive.

The complexity of mental health risk and protective factors is recognised as a barrier to implementing prevention as it feeds scepticism that it's even possible.[50] However there are a range of evidence-based interventions that have proven impact in reducing the prevalence, incidence and impact of mental ill-health.

The Black Dog Institute estimates that up to 22% of adult cases of depression can be prevented, significantly reducing the burden of mental ill-health on the population, through the implementation of evidence-based prevention programs early in the life stage. An example of this approach is Sparx, an interactive "game" for high school students that delivers cognitive behaviour therapy approaches. The piloting of this game in New South Wales resulted in estimates of 61,000 young Australians being prevented from developing depression and anxiety each year if the implementation was universal.[51]
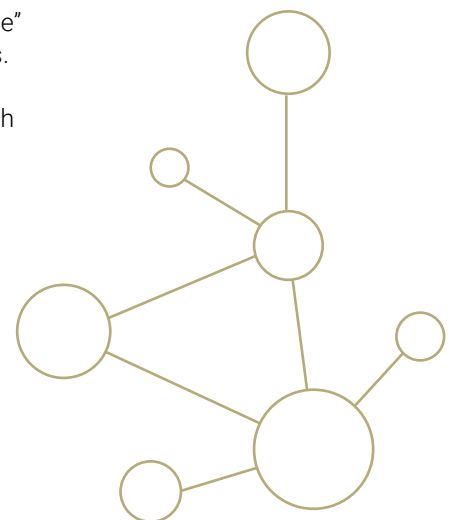
50. Prevention United, *The Case for a Focus on Prevention*, Prevention United, 2018.
51. Black Dog Institute, *Submission in Response to the Draft 5th National Mental Health Plan*, Black Dog Institute: Sydney, 2016.

1.2 Strengths-based and tailored supports for parents and children experiencing vulnerability

Prevention requires recognising the critical importance of early life in a child's development. This is acknowledged internationally and in Australia through the First 1000 Days movement:

> *"Experiences in early childhood have a lasting impact on an individual's future; what happens during the first 1000 days – the period from conception to the end of a child's second year – has the greatest potential to affect health and wellbeing throughout the life course... Many challenges in adult life, including major public health concerns such as obesity, heart disease, and mental health problems, once regarded solely as products of adult behaviour and lifestyles, are now known to be linked to processes and experiences that take place during the first 1000 days."[52]*
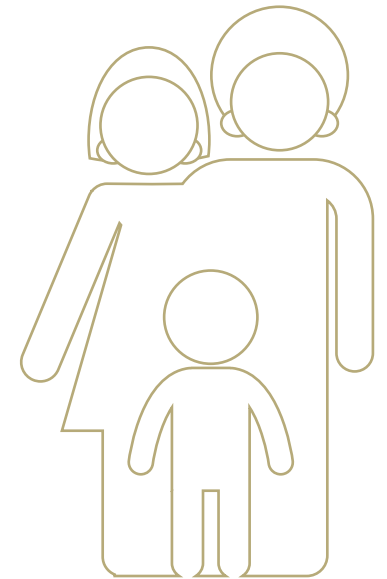
It is not currently well recognised in the design of social policy frameworks, programs and services that preventative interventions in childhood and adolescence can mitigate the incidence, prevalence and impact of mental ill-health. The set of risk and protective factors for children's mental health are outlined below in Figure 7:

Figure 7: Risk and protective factors for children's mental health. Source: KidsMatter, 2019

Risk factors	Protective factors
• Family history of mental health difficulties	• Warm, trusting and supportive relationships with significant adults
• Lack of warm, trusting and supportive relationships with significant adults	• Positive social interactions
• Limited experiences of social interaction	• High-quality child care
• Unstable home environment (for example, family violence, parental conflict)	• Stable home environment
• Inconsistent care giving	• Access to positive social support networks
• Limited family social support networks	• Good social and emotional skills
• Parent mental health difficulties	• Good physical health
• Physical health problems	• Higher education level and financial security of parents
• Exposure to major or many stressful life events	• Access to health care
• Lower levels of parental education, income and employment	• Community connectedness
• Difficult temperament	• Easy temperament
• Impaired brain development	• Well-developed cognitive skills (for example, learning, attention, motor skills)
• Bullying	• Supportive relatives (for example, grandparent, aunt)
• Early separation from primary caregivers.	

52. Centre for Community Child Health, *The First Thousand Days: Our Greatest Opportunity*, Murdoch Children's Research Institute/The Royal Children's Hospital: Melbourne, 2017.

Strengths based programs for families that build protective factors and mitigate risk factors are critical in supporting children's mental health and wellbeing. This is especially true where there have been experiences of childhood trauma, a significant risk factor for mental ill-health. Recent research has found that one of the biggest, if not the biggest, risk factor is exposure to adverse childhood experiences – which includes family violence, neglect, poverty, serious physical illness and exposure to parental mental ill-health, substance misuse and criminal behaviour.[53] A recent study found that adverse childhood experiences accounted for a significant proportion of the burden of mental ill-health in Australia (in males 16% of the burden of depressive disorders, 21% for anxiety disorders and 24% for self-harm; and in females 23% for depressive disorders, 31% for anxiety disorders and 33% for self-harm).[54]

53. Jorm, Anthony and Roger Mulder, "Prevention of Mental Disorders Requires Action on Adverse Childhood Experiences", *Australian & New Zealand Journal of Psychiatry 1*,no. 4, 2018.
54. Moore et al in, Jorm and Mulder, 2018.

Case study – Restacking the Odds

Restacking the Odds is a ground breaking research collaboration between Murdoch Children's Research Institute, SVA and Bain & Company that is aimed at measuring the impact of 'stacking' a set of five carefully selected, evidence-based interventions in early childhood that target both children and parents: antenatal care; sustained nurse home visiting; early childhood education and care; parenting programs; and early intervention in schools.

Inequities emerging in early childhood often continue into adulthood, contributing to unequal rates of low educational attainment, poor mental and physical health and low income. In some cases, this experience is part of a persistent cycle of intergenerational disadvantage. Inequities constitute a significant and ongoing social problem and – along with the substantial economic costs – have major implications for public policy. To redress inequities, research tells us that efforts should be delivered during early childhood (pregnancy to eight years of age) to deliver the greatest benefits.

Restacking the Odds focuses on five key evidence-based interventions/platforms in early childhood: antenatal care; sustained nurse home visiting; early childhood education and care; parenting programs; and the early years of school. These five strategies are only a subset of the possible interventions, but they have been selected carefully. They are notably longitudinal (across early childhood), ecological (targeting child and parent), evidence-based, already available in almost all communities and able to be targeted to benefit the 'bottom 25 per cent'. Our premise is that by 'stacking' these fundamental interventions (i.e., ensuring they are all applied for a given individual) there will be a cumulative effect – amplifying the impact and sustaining the benefit.

Our intent is to use a combination of data-driven, evidence-based and expert informed approaches to develop measurable best practice indicators of quality, quantity and participation for each of the five strategies. These indicators will help identify gaps and priorities in Australian communities. We will test preliminary indicators in ten communities over the next three years to determine which are pragmatic to collect, resonate with communities, and provide robust measures to stimulate community and government action.

1.3 Effective policies and programs in work places and in all levels of the education system create mentally healthy social environments

Building mental health literacy and safety into education and work place environments is essential to transition to a culture of prevention. Educational settings are a critical space for delivering mental health awareness programmes to promote literacy of the risk and protective factors of mental ill-health.[55] A leading workforce capability building initiative in Australia is Be You, which combines the existing efforts of a range of school based mental health education initiatives. Be You recognises that educators play a key role in promoting the resilience and wellbeing of children and young people:

"Early learning services and schools play a significant role in supporting children and young people with emotional and behavioural problems and these environments are often where symptoms of mental health issues are first identified."[56]

The evidence supporting Be You highlights the common characteristics of effective interventions as:

"...explicit teaching of mental health or social and emotional learning skills and competencies; focusing on positive mental health not problems; balancing universal and targeted approaches; starting with the youngest children and building throughout their education; using a multimodal, whole school approach with links to academic learning, school ethos, professional learning, and involvement of parents and community."[57]

The evidence demonstrates that school-based programs that involve multiple components (trauma informed teaching approaches; integration of prevention into the curriculum; engagement with parents; recognition of mental health and wellbeing in school values and mission; and integration with external services) deliver significant outcomes in preventing the prevalence of depression, anxiety and behavioural disorders.[58]

Beyond educational settings, there is growing evidence to support the success of workplace programs in preventing the incidence of depression and post-traumatic stress disorder, as well as reducing the work-related risk factors facing individuals that including job stress.[59]

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55. McGorry, Patrick, Sherilyn Goldstone, Alexandra Parker, Debra Rickwood and Ian Hickie, 2014, "Cultures for Mental Health Care of Young People: An Australian Blueprint for Reform." *The Lancet Psychiatry* 1(7): 559–68.
56. Beyond Blue, *Beyond Blue Launches Be You – a New Mental Health Initiative for Schools and Early Learning Services*, Beyond Blue: Melbourne, 2018.
57. Beyond Blue, 2018.
58. Prevention United, The Case for a Focus on Prevention, Prevention United, 2018.
59. Prevention United, 2018.

1.4 Cross-sector collaboration and commitment to address the social determinants of mental health inequity

As identified above, experiences of mental ill-health are intimately linked to experiences of disadvantage, social exclusion and marginalisation. Extensive international research demonstrates that reducing mental health inequity can only be achieved through interventions that impact on the social determinants of health, notably housing, education, employment, poverty, racism, homophobia and family violence.[60]

These interventions necessarily involve cross-sector collaboration and cooperation to build commitment and resources behind efforts that address social, and therefore health, inequity.[61]

An integrated and cross-sector approach to suicide prevention is outlined in Figure 8 below. Called the LifeSpan framework, it incorporates a comprehensive set of evidence-based strategies and interventions aimed at connecting people at risk of suicide with existing interventions and programs to ensure adequate care is provided.[62]

Figure 8: LifeSpan approach to suicide prevention. Source: Black Dog Institute, 2017
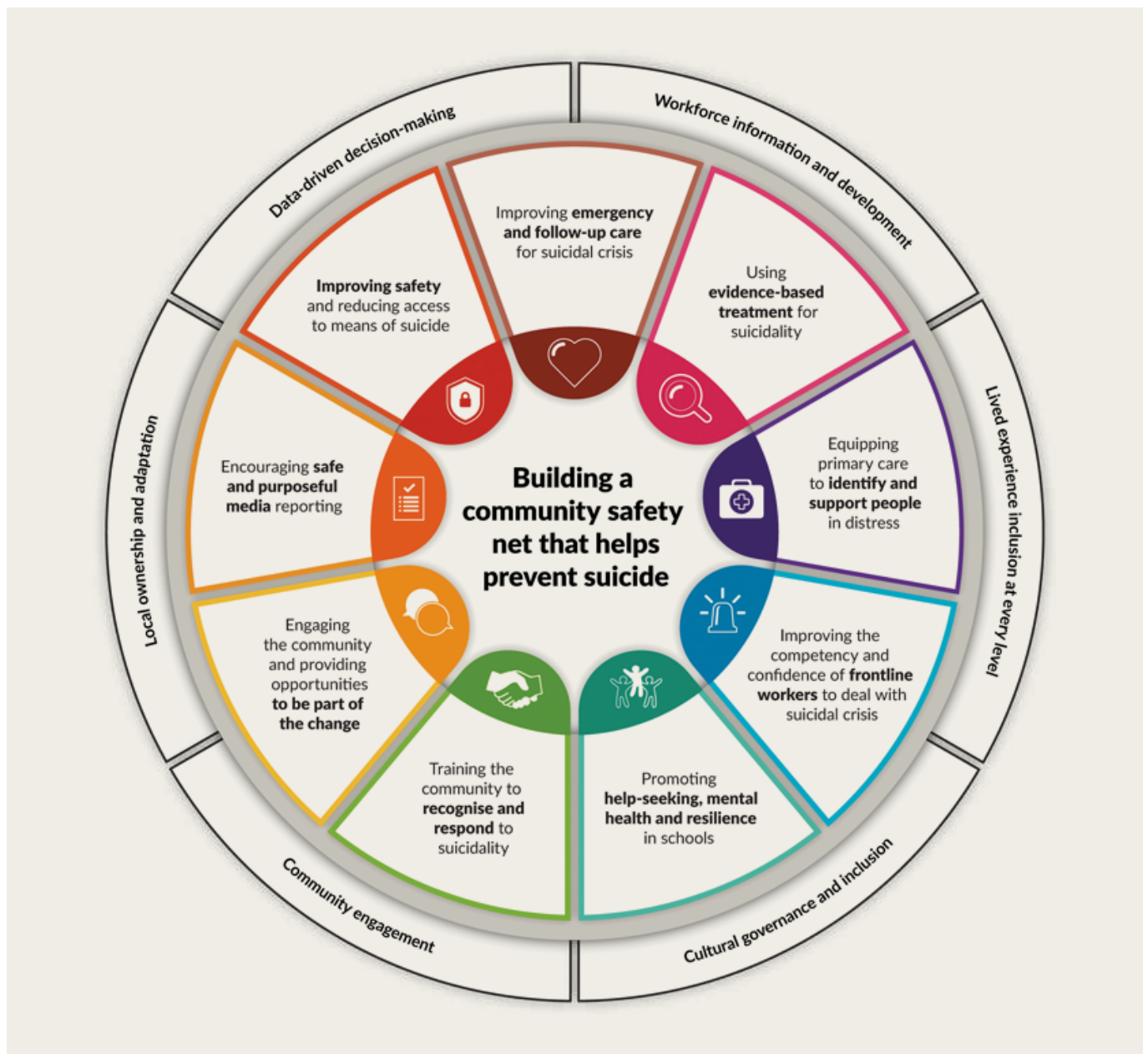
60. Marmot, Michael. 2007. "Achieving Health Equity: From Root Causes to Fair Outcomes." *The Lancet* 370(9593): 1153–63.
61. Welsh, Jenny, Laura Ford, Lyndall Strazdins, and Sharon Friel, *Evidence Review : Addressing the Social Determinants of Inequities in Mental Wellbeing of Children and Adolescents*, National Centre for Epidemiology and Population Health and the Regulatory Institutions Network: Canberra, 2015.
62. Hill, Nicole, Lyndal Halliday and Nicola Reavley, *Guidelines for Integrated Suicide-Related Crisis and Follow-up Care in Emergency Departments and Other Acute Settings*, Black Dog Institute: Sydney, 2017.
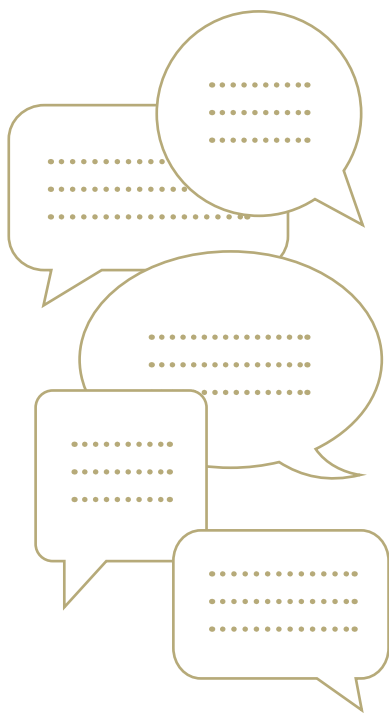
1.5 Shift in social norms and values around mental ill-health and suicide prevention, reducing stigma and discrimination

Addressing the stigma and discrimination that exists around experiences of mental ill-health has been a priority of governments for decades. The Fifth National Mental Health and Suicide Prevention plan identifies that:

> *"While there have been some improvements in knowledge about mental illness, there is still widespread misunderstanding, and people living with mental health illness still experience significant stigma. It will take a sustained and collective effort to dispel the myths associated with mental illness, change ingrained negative attitudes and behaviours and, ultimately, support social inclusion and recovery."[63]*

The social and cultural stigma that exists around mental ill-health and suicide has been identified as the primary reason people experiencing mental ill-health do not seek help or access services.[64] Experiences of stigma can include fears about accessing support, misconceptions about mental ill-health, lack of awareness of support services and fears of experiencing compounding discrimination (including racial and sexual discrimination).

Mindframe is a national initiative aimed at reducing social and cultural stigma around mental ill-health through improving the way mental ill-health is covered in Australian media (including both news coverage and fictional portrayal in television and film). Mindframe's approach is based on evidence and research that has identified "reporting that is inaccurate or sensationalised can reinforce common myths and impact significantly on people diagnosed with a mental ill-health, making them less likely to seek help when they need it".[65] Whole of population and targeted public awareness campaigns are required to shift social norms and understandings of mental health and wellbeing, including campaigns that are nuanced to the specific needs of different cohorts.[66]

63. Council of Australian Governments Health Council, *The Fifth National Mental Health and Suicide Prevention Plan*, Commonwealth of Australia: Canberra, 2018.
64. Black Dog Institute, Submission in Response to the *Draft 5th National Mental Health Plan*, Black Dog Institute: Sydney, 2016.
65. Mindframe, *Mindframe Guidelines for Communicating about Mental Ill-Health*, Mindframe: Newcastle, 2019.
66. Orygen The National Centre of Excellence in Youth Mental, *A Better Fit Improving the Access and Acceptability of Youth Mental Health Services*, Orygen The National Centre of Excellence in Youth Mental Health: Melbourne, 2018.

2. Early intervention and integrated supports and services are available when and where people experiencing mental ill-health need them

The current state of mental health service delivery in Australia is significantly skewed towards:

- Funding activity rather than outcomes
- Crisis responses rather than early intervention and prevention
- Ongoing investment in services that indicate system failure [67]
- Lack of integrated and coordinated models of care, particularly for people experiencing severe mental ill-health
- Limited investment in recovery-based models that support "people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia's wealth." [67]

Critical to driving better outcomes is transforming the style, location and nature of services, with a significant emphasis on intervening as early as possible to reduce the impact and severity of mental ill-health.

Beyond the benefits to individual's mental health and wellbeing, the cost savings from investing in early intervention are clear. KPMG and Mental Health Australia estimate that:

"Preventative or early intervention activity for 50,000 children and young people experiencing an initial onset of depression or anxiety (or at risk for depression due to having one parent with a depressive disorder) would cover its costs in the short term and deliver $200 million in long-term benefits (with a return on investment of $7.90 for every $1 spent)."[68]

In addition:

"Early interventions for individuals experiencing initial onset of psychosis would save $90 million in the short term (with a return on investment of $2.30 for every $1 spent) and $270 million in long-term benefits (with a return on investment of $10.50 for every $1 spent)."[69]

A critical enabler of systemic change in the nature and scale of mental health interventions is the effective use of technology to: reduce barriers to access; increase the availability and quality of services; and manage the rising costs of service delivery, particularly for universal access points such as crisis phone counselling.

A recent international meta-analysis found that self-guided online psychological therapy, where programs are evidence-based, is a safe modality and an effective and viable approach for the majority of people experiencing depression, irrespective of severity or background.[70] Black Dog Institute researchers, participants in the meta-analysis, identify that,

"We know that a significant number of Australians with depression won't, or can't, access formal mental health treatment due to factors such as stigma, cost, availability of services and time limitations. Self-guided, internet-based cognitive behavioural therapy enables users to engage with good quality mental health programs by simply accessing their computer, tablet or Smartphone. They can undertake treatment where and when they feel most comfortable, and programs can be easily supported by a local GP as well as mental health practitioners."[71]

Evidence-based online programs can provide significant cost-saving measures for governments, which enable limited pools of funding to be diverted towards intensive and therapeutic supports for people experiencing severe and persistent mental ill-health.

New technologies (including messaging services, apps, social media, gamification and wearables) also offer mental health practitioners and organisations the opportunity to reach new service users, offer better services, and increase service frequency when needed. Finally, chatbots, artificial intelligence and machine learning technologies also offer the mental health sector significant potential, albeit with a range of ethical, privacy and quality risks and challenges that need to be overcome.

67. National Mental Health Commission, *The National Review of Mental Health Programmes and Services*, NMHC: Sydney, 2014.
68. KMPG and Mental Health Australia. *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, 2018.
69. KPMG and Mental Health Australia, 2018.
70. Karyotaki, Eirini et al., "Efficacy of Self-Guided Internet-Based Cognitive Behavioral Therapy in the Treatment of Depressive Symptoms." *JAMA Psychiatry* 74(4): 351–59, 2017.
71. Black Dog Institute, *Online Psychological Therapy Effective in Reducing Depression*, Black Dog Institute: Sydney, 2017.

2.1 Normalisation of help-seeking behaviour to minimise the level of untreated conditions

Many people with experiences of mental ill-health do not seek support for their condition, with rates of help-seeking and treatment at much lower levels than the prevalence of mental ill-health in the community.[72] The primary reason identified as a barrier to seeking help is the stigma surrounding mental ill-health and suicide.[73]

Normalising help seeking behaviour can occur through public awareness campaigns that aim to reframe attitudes and understandings of mental health and mental health treatment.[74]

2.2 Appropriate early interventions for children and young people that maximise immediate and long-term mental health outcomes

Interventions that occur early in the life stage will have the most likelihood of long-term impacts and outcomes. As children and young people spend significant amounts of time in education and training settings, these environments offer an opportunity to increase the early identification of children who are at risk of mental ill-health and increase the entry points between schools and the mental healthcare system.[75]

Beyond the school environment, specialist services are required to mitigate the barriers to access that children and young people face. This requires the involvement of young people in the design of services. Key principles to support appropriate and tailored service interventions for children and young people include: youth participation at all levels of service design to support stigma-free environments; optimistic approaches that are holistic and preventative; and integrated and wrap-around supports for young people who may be experiencing complex needs.[76]

Headspace is a unique model of service delivery to young people aged from 12–25 years of age. It prioritises early intervention and offers four streams of service delivery – mental health, drug and alcohol services, primary health care, and vocational and educational assistance – to minimise the stigma young people face in accessing mental health services, particularly for the first time. Headspace also runs local community awareness campaigns, provides national telephone assessment and counselling, and specialist suicide prevention and response services.[77]

Case study – Aftercare

Aftercare operates an early intervention service known as The Poppy Centre which provides clinical and related mental health early intervention and support services to hundreds of children aged 0–11 and their families in Ipswich, Queensland. The service aims to improve the mental health and social and emotional wellbeing of children who have mild to moderate experience of mental ill-health.

SVA has partnered with Aftercare in the development of its organisational strategic direction, including reviewing the evidence base and clarifying the cohorts and needs it should focus on, the services it will provide, and how its operations can be funded.

Case study – Orygen

Orygen, The National Centre of Excellence in Youth Mental Health is the world's leading research and knowledge translation organisation focusing on mental ill-health in young people. Through the work of eOrygen, they are seeking to revolutionalise youth mental health care using digital technology. SVA has been a proud partner in this work.

Specifically, eOrygen is working to integrate face-to-face and 24/7 online support for young people including: safe online social networking, peer and expert support, evidence-based interventions, personalised treatment and real-time interventions powered by wearable technology, AI and Virtual Reality.

72. National Mental Health Commission, *The National Review of Mental Health Programmes and Services*, NMHC: Sydney, 2014.
73. Black Dog Institute, *Submission in Response to the Draft 5th National Mental Health Plan*, Black Dog Institute: Sydney, 2016.
74. Rickwood, Debra, Kerry Thomas and Sally Bradford, *Review of help-seeking measures in mental health: an Evidence Check rapid review brokered by the Sax Institute, Sax Institute: Sydney*, 2012.
75. McGorry, Patrick, Sherilyn Goldstone, Alexandra Parker, Debra Rickwood and Ian Hickie, "Cultures for Mental Health Care of Young People: An Australian Blueprint for Reform." *The Lancet Psychiatry* 1(7): 559–68, 2014.
76. McGorry et al, 2014.
77. McGorry et al, 2014

2.3 First-points of contact in the service system have the knowledge and skills to provide care and/or appropriate referrals

Education environments and workplaces can be a first point of contact for people who may not have any interaction with the mental health care system. Equipping these environments with knowledge on early warning signs, appropriate referral pathways and the support required to enable recovery is critical to support the early identification and intervention of experiences of mental ill-health.[78]

Be You, a national school based mental health education initiative described above, recognises that the evidence around help-seeking behaviour for children and young people identifies educators as a key first-point of contact in seeking support and services for experiences of mental ill-health.

For many people experiencing mental ill-health their first point of contact may be a general practitioner, however the quality of care and referral pathways provided can vary significantly. Initiatives such as the General Practice Mental Health Standards Collaboration (GPMHSC) are critical to mitigating experiences of stigma, discrimination or inadequate care.[79] While it is critical to strengthen the role of general practitioners as first points of contact in the system, transformation is required to shift towards a multi-disciplinary model that alleviates the current over reliance on primary care practitioners.

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78. Beyond Blue, *Beyond Blue Launches Be You – a New Mental Health Initiative for Schools and Early Learning Services*, Beyond Blue: Melbourne, 2018.
79. The Royal Australian College of General Practitioners, *RACGP – Mental Health (GPMHSC)*, RACGP: Melbourne, 2019

2.4 Responsive and proactive services for people at risk of suicide (including community outreach for people who have attempted suicide)

In 2017 3,128 people died from suicide (intentional self-harm), with suicide ranking as the 13th leading cause of death in Australia.[80] For people at risk of suicide there are significant gaps in care and support, most notably seen through care experiences in hospital emergency department's where:

"Patients and carers reported that their emotional distress was not attended to; many believed they were discharged too rapidly and were left to seek their own options for ongoing care."[81]

The National Mental Health Commission identified that suicide risk is particularly high for people following discharge from a hospital, or an emergency department, immediately after a suicide attempt.[82]

The evidence in Australia and internationally shows that multidisciplinary and coordinated approaches are required to provide effective early interventions and responses for people at risk of suicide.[83] Despite this the Black Dog Institute has critiqued the Fifth National Mental Health and Suicide Prevention Plan for only prioritising suicide awareness campaigns, arguing that the evidence demonstrates that awareness raising alone will not be effective in reducing the prevalence of suicide in Australia.[84]

Case study – Lifeline Australia

Lifeline is one of the more important and well-known services in Australia's crisis support and suicide prevention system. With funding from the Department of Health, Lifeline Australia engaged SVA to support the design and development of a pilot crisis support service that utilises text messaging.

With the trial of the Lifeline Text service currently underway, Lifeline is adapting to changes in behaviour and advances in technology to better meet the persistent issue of suicide in Australia.

80. Australian Bureau of Statistics, *Causes of Death, Australia, 2017* Cat. No. 3303.0, ABS: Canberra, 2018.
81. Hill, Nicole, Lyndal Halliday and Nicola Reavley, *Guidelines for Integrated Suicide-Related Crisis and Follow-up Care in Emergency Departments and Other Acute Settings*, Black Dog Institute: Sydney, 2017.
82. National Mental Health Commission, *The National Review of Mental Health Programmes and Services, NMHC: Sydney*, 2014.
83. National Mental Health Commission, *A Contributing Life: The 2013 National Report Card on Mental Health and Suicide Prevention*, NHMC: Sydney, 2013.
84. Black Dog Institute, *Submission by the Black Dog Institute Inquiry into the Accessibility and Quality of Mental Health Services in Rural and Remote Australia*, Black Dog Institute: Sydney, 2018.

3. Appropriate service systems empower and support personal, clinical, social and functional recovery for people experiencing mental ill-health

For people with experiences of mental ill-health, the journey to recovery is dependent on the availability, quality, intensity, and appropriateness of care.

In the transition away from institutionalisation and towards community-based care, it is widely recognised that adequate investment was not made to support the new service system. This created an environment, that still persists today, where many people find themselves unable to seek treatment or care appropriate to their needs – framed by many in the mental health sector as the "missing middle".

> *"It is widely accepted that on closing the asylums, Australia failed to invest in an alternative model of community mental health care. This means that for people seeking mental health assistance, there are few alternatives between the GP's surgery and the hospital emergency department."*[85]

In the Australian context, service systems have had a tendency "to be structured in ways that inhibit effective coordinated and connected care".[86] The investment in expensive crisis supports, such as hospital emergency departments, rather than community-based models of care are representative of system failure, leaving a large proportion of people with significant gaps in their care, no continuity of care and a high level of impact through compounding experiences of complexity. It also leads to situations where individuals receive significantly uneven quality of care.

A mental health care system that lacks effective coordination makes it difficult for people experiencing complex mental ill-health to navigate all the support services they require. The lack of coordination and integration signals a deeper design flaw with services that are not oriented to the needs of the consumer or their recovery, resulting in high levels of readmission and relapse for people experiencing severe and persistent mental ill-health.

The National Mental Health Commission recommends that governments:

> *"repackage funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care"*[87]

Where the complexity of the policy, funding and governance mechanisms underpinning the current system are barriers to transformation, mechanisms such as outcomes management can enable the mental health sector to set clear roles and accountabilities, and prioritise outcomes, evidence and long-term system sustainability.

Building an outcomes management culture or an investment approach into program and service design enables people with a lived experience of mental ill-health, service providers and governments access to clear data and information on the outcomes of different programs and services. Understanding how to best utilise limited pools of funding supports a reorientation of systems towards driving improved mental health outcomes – rather than the continuation of funding for activity.

Outcomes management refers to a set of activities that help an organisation clearly define its goals, rigorously measure performance against those goals, and then continuously manage in line with those goals and measures. It means that organisations have the right information to respond and make better decisions to improve program design and delivery in a timely manner.

An **investment approach** considers how to better utilise the projected lifetime costs of welfare payments through investing in policies and programs that improve the lifetime wellbeing of people and communities in Australia, including increasing people's capacity to work and live independently of welfare.

85. Rosenberg, Sebastian, "From Asylums to GP Clinics: The Missing Middle in Mental Health Care," *The Conversation*, 2015.
86. Mental Health Coordinating Council, *Care Coordination Literature Review and Discussion Paper*, Mental Health Coordinating Council: Sydney, 2011.
87. National Mental Health Commission, *The National Review of Mental Health Programmes and Services, NMHC: Sydney, 2014.*

A critical component to driving better outcomes for people experiencing mental ill-health is the approach to delivering services and support. Reducing the incidence and impact of mental ill-health can be achieved through the adoption of recovery-oriented models of care that go beyond a narrow understanding of clinical recovery, and incorporate the personal, social and functional elements of mental health recovery, as described below:

> *"From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember that recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connection – and external conditions that facilitate recovery – implementation of human rights, a positive culture of healing, and recovery-oriented services."[88]*

Recovery-oriented care was formally endorsed by the Commonwealth in 2013 through the National Framework for Recovery-Oriented Mental Health Services, which outlines a "transformative conceptual framework for practice, culture and service delivery in mental health service provision"[89].

> *"The lived experience and insights of people with mental health issues and their families are at the heart of recovery-oriented culture. The concept of recovery was conceived by, and for, people living with mental health issues to describe their own experiences and journeys and to affirm personal identity beyond the constraints of their diagnoses. …. Recovery approaches challenge traditional notions of professional power and expertise by helping to break down the conventional demarcation between consumers and staff. Within recovery paradigms all people are respected for the experience, expertise and strengths they contribute. Recovery-oriented approaches focus on the needs of people who use services rather than on organisational priorities."[90]*

88. Jacobson and Greenley, 2001 p.482, in Mental Health Standing Committee, *National Standards for Mental Health Services 2010: Principles of Recovery Oriented Mental Health Practice*, Commonwealth of Australia: Canberra, 2010.
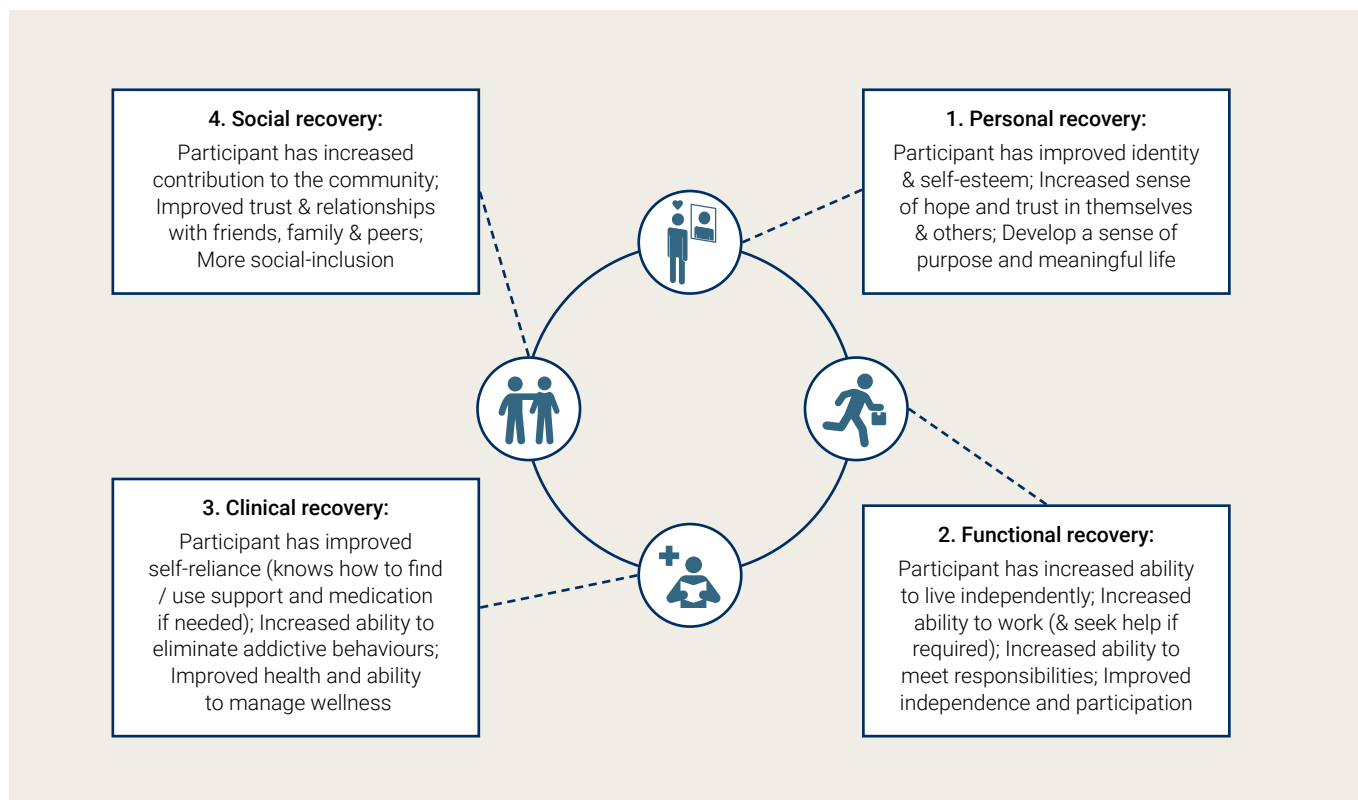89. Australian Health Ministers' Advisory Council, *A National Framework for Recovery-Oriented Mental Health Services: Policy and Theory*, Commonwealth Government: Canberra, 2013.
90. Australian Government, 2013

For people with experiences of severe mental ill-health, recovery is "a personal journey of discovery" that requires "becoming an expert in your own self-care; building a new sense of self and purpose in life; discovering your own resourcefulness and possibilities and using these, and the resources available to you, to pursue your aspirations and goals".[91]

Recovery oriented practice commonly identifies four key domains, as illustrated in Figure 9.

Figure 9: Four domains of recovery. Source: Adapted from Hancock et al, 2015

4. Social recovery:
Participant has increased contribution to the community; Improved trust & relationships with friends, family & peers; More social-inclusion

1. Personal recovery:
Participant has improved identity & self-esteem; Increased sense of hope and trust in themselves & others; Develop a sense of purpose and meaningful life

3. Clinical recovery:
Participant has improved self-reliance (knows how to find / use support and medication if needed); Increased ability to eliminate addictive behaviours; Improved health and ability to manage wellness

2. Functional recovery:
Participant has increased ability to live independently; Increased ability to work (& seek help if required); Increased ability to meet responsibilities; Improved independence and participation

As described by Mental Health Victoria:

"Critical supports are those that help people to live well in their family, relationships, and the broader community, to have a safe home, to live lives that are as healthy as possible with control and choices, and to support the recovery from grief and trauma. The evidence is clear that recovery in these domains leads to better mental health and supports mental health rehabilitation, recovery and self-management. Lack of support in these areas, which are largely provided by non-government community organisations, conversely can lead to ill-health and mean that more Victorians are being forced into crisis."[92]

91. RichmondPRA, *Recovery Action Framework*, RichmondPRA: Sydney, 2014.
92. Mental Health Victoria, *Saving Lives. Saving Money: The case for better investment in Victorian mental health*, Mental Health Victoria: Melbourne, 2018.

Case study – Flourish Australia

Flourish Australia is a large non-profit organisation dedicated to working in local communities to support people on their mental health recovery journey. They engaged SVA Consulting to help them understand the value created for stakeholders through their Peer Operated Service using the Social Return On Investment (SROI) methodology.

Flourish Australia continues to build a strong evidence-based for its Peer Operated Service, sharing the learnings with other mental health service providers and the sector more broadly. They have also drawn on insights from the SROI evaluation to inform the design of the Resolve Social Benefit Bond.

3.1 Services are safe, culturally competent, accessible and geographically well-distributed

Critical to the success of mental health recovery is the orientation of services to the diverse needs of consumers. For many people experiencing mental ill-health, effective treatment is impeded by experiences of unsafe service environments as a result of stigma and discrimination from health professionals.

> *"Stigma is a major barrier to recovery for people with mental health problems, their families and those working in the field of mental health. Stigma acts as a 'social disability' – often contributing to at least the same amount of, if not more, stress than the original mental health issue."[93]*

As identified in the Fifth National Mental Health and Suicide Prevention Plan, workforce capability building is required to build awareness and literacy amongst health professionals of the negative impact stigma and discrimination have on an individual's: likelihood of seeking help; severity of mental ill-health; and recovery outcomes.

Ensuring accessibility of services requires mitigating key barriers to access including stigma, cost and location (particularly for people living in regional and remote areas).

A Senate Inquiry into the *Accessibility and quality of mental health services in rural and remote Australia* highlighted the gap in access to adequate mental health care for people living in rural and remote communities, as evidenced by the over representation of people living outside of capital cities in deaths from suicide (equating to 47 per cent of suicides for only 32 per cent of Australia's total population).[94]

Successful service delivery approaches also require ensuring services are culturally safe and competent for Aboriginal and Torres Strait Islander peoples and people from a culturally and linguistically diverse (CALD) background. As identified in the Fifth National Mental Health and Suicide Prevention Plan "cultural competence should be considered a core clinical competence capability", recognising that there is a significant gap in workforce capability to effectively and safely engage with Aboriginal and Torres Strait Islander peoples, which can lead to: scenarios where conditions are misdiagnosed or remain undiagnosed; lower rates of access; and experiences of care that have limited efficacy (Council of Australian Governments Health Council, 2018). Critical to ensuring culturally safe and competent care is available and accessible for Aboriginal and Torres Strait Islander peoples are the unique and essential role of Aboriginal Medical Services (AMSs) and Aboriginal Community Controlled Health Organisations (ACCHOs).

Case study – Mind Australia

Mind Australia offers a range of services to provide timely, evidence-driven and individualised community-based support to people whose lives are significantly impacted by mental ill-health and/or psychosocial disability.

Mind Australia engaged SVA to support the establishment of a whole-of-organisation approach to outcomes management. This approach to outcomes management will support Mind Australia to build their evidence base around what works and does not work in their services and from this provide more effective support to those people experiencing mental ill-health and/or psychosocial disability.

93. Mental Health Council of Australia, *Consumer and Carer Experiences of Stigma from Mental Health and Other Health Professionals*, MHCA: Canberra, 2011.
94. Senate Community Affairs References Committee, *Accessibility and Quality of Mental Health Services in Rural and Remote Australia*, Commonwealth of Australia: Canberra, 2018.

3.2 Appropriate 'stepped models of care' (including primary and specialist care, community-based care, residential and inpatient care, and support to navigate the system)
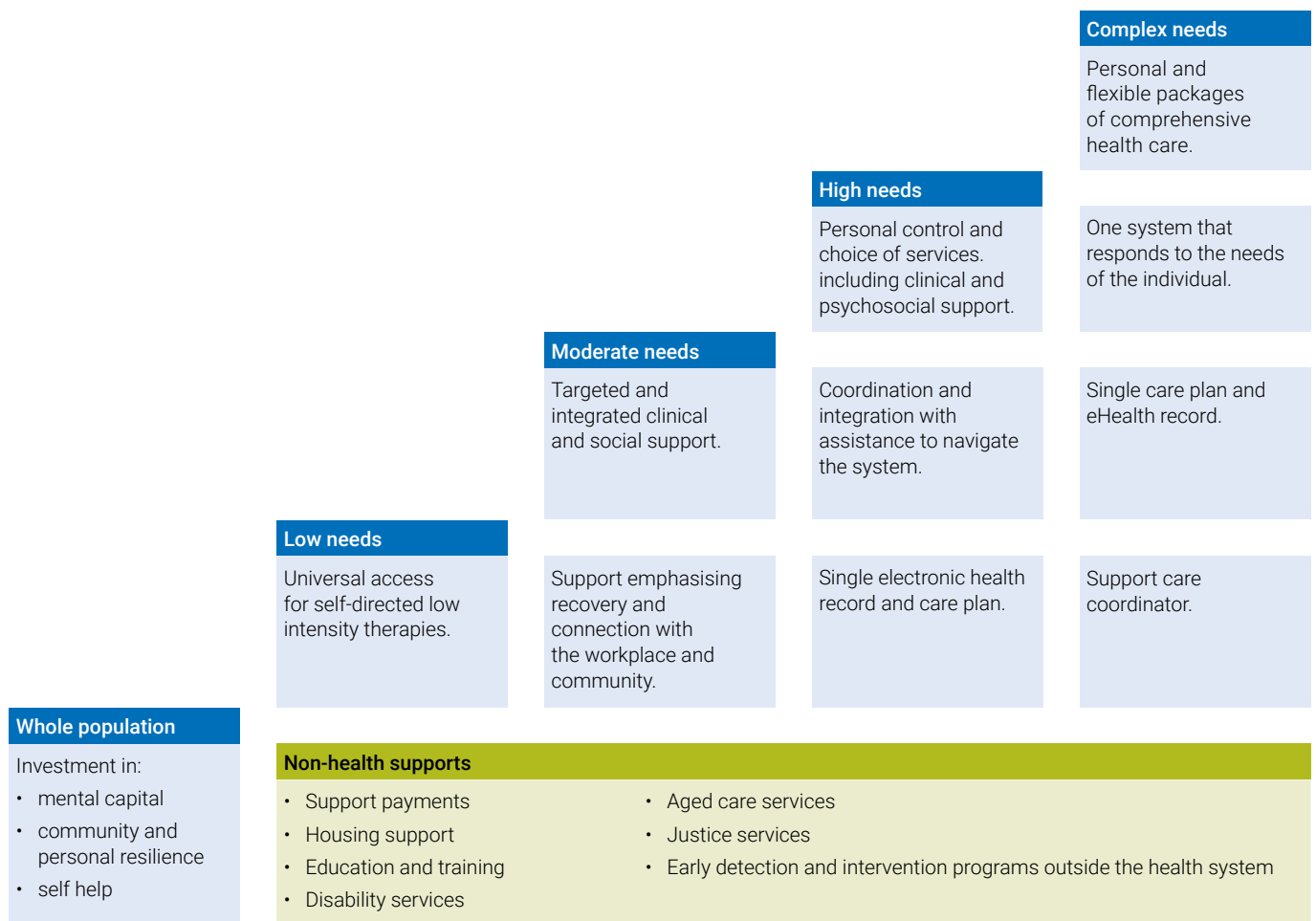
The current complexity of mental health care models in Australia result in many people experiencing inadequate care, with the gaps in care increasing with the complexity of need. The lack of integration between primary, secondary and tertiary environments, as well as the complexity of funding regimes between state and Commonwealth governments are drivers of system failure and service arrangements that can at times exacerbate the incidence and impact of mental ill-health. As described by Bywood, Brown and Raven:

"given the multifaceted nature of mental health conditions, support for individuals experiencing such diagnoses also needs to be multidisciplinary and collaborative".[95]

Stepped models of care enable services to orient the intensity of treatment to the needs of the consumer by delivering evidence based services in increasing (or decreasing) intensity that is responsive to need, including monitoring of progress to ensure the appropriate intensity of response is being provided.[96] The shift towards an integrated and stepped model of care has been recognised by governments for some time, but implementation across multiple levels of governments and portfolios has "remained elusive".[97]

Figure 10 below outlines a framework for a stepped model of care that is responsive to the needs of mental health consumers along the spectrum of need.

Figure 10: Stepped model of care. Source: Productivity Commission, 2019

Complex needs
Personal and flexible packages of comprehensive health care.

High needs
Personal control and choice of services. including clinical and psychosocial support.

One system that responds to the needs of the individual.

Moderate needs
Targeted and integrated clinical and social support.

Coordination and integration with assistance to navigate the system.

Single care plan and eHealth record.

Low needs
Universal access for self-directed low intensity therapies.

Support emphasising recovery and connection with the workplace and community.

Single electronic health record and care plan.

Support care coordinator.

Whole population
Investment in:
· mental capital
· community and personal resilience
· self help

Non-health supports
· Support payments
· Housing support
· Education and training
· Disability services
· Aged care services
· Justice services
· Early detection and intervention programs outside the health system

Source: Adapted from (NMHC 2014a).

95. Bywood, Petra, Lynsey Brown and Melissa Raven, *Improving the Integration of Mental Health Services in Primary Health Care at the Macro Level*, Primary Health Care Research and Information Service: Adelaide, 2015.
96. Reavley, Nicola, *Stepped Care Models in Mental Health: The Evidence Base*, University of Melbourne: Melbourne, 2016.
97. Reavley, Nicola, 2016.
98. Council of Australian Governments Health Council, *The Fifth National Mental Health and Suicide Prevention Plan*, Commonwealth of Australia: Canberra, 2018.

Integrating services is inherently complex, as described below:

> *"While definitions vary, integration typically refers to bringing together people and organisations that represent different sectors to align relevant practice and policy and to improve access and quality of health care. At the macro (systems) level, integration involves coherence across policies and legislation; development of cross-sectoral partnerships, collaborations and agreements; and joint administrative, planning and funding arrangements."*

Achieving this level of integration across a diverse range of service settings, service types, practitioners, policy settings and funding regimes requires considerable planning and coordination, as well as ongoing commitment from governments.[98]

Case Study – SANE Australia and Lifeline Australia

SANE Australia supports people in Australia with complex mental ill-health including schizophrenia, bipolar, borderline personality disorder, OCD, PTSD and severe depression and anxiety. SANE Australia and Lifeline Australia identified a need to engage in a collaborative model of care to increase the impact of their work, and engaged SVA to develop a strategy for implementing this partnership.

SVA worked closely with SANE and Lifeline to identify the objectives and terms of a collaboration, including the development of a detailed model of collaboration and implementation plans. The project enabled Lifeline and SANE to enter into a Memorandum of Understanding which enables Lifeline to refer frequent callers with severe and complex mental ill-health to the SANE helpline for more appropriate, ongoing support.

3.3 Mental health services are integrated with other service systems (including health, disability, homelessness, justice) and support participation in employment, education and training

Beyond the integration of mental health care models across the spectrum of mental ill-health, recovery-oriented approaches require the integration and coordination between other social service systems – most notably health, disability, homelessness, justice, employment and education. As described by Mental Health Victoria:

"Psychosocial rehabilitation involves essential services and programs that support people with mental health issues to succeed on their recovery journey, often through the strength and support of their peers. Critical supports are those that help people to live well in their family, relationships, and the broader community, to have a safe home, to live lives that are as healthy as possible with control and choices, and to support the recovery from grief and trauma."[99]

The impact of mental ill-health on physical health can be significant, with Mental Health Australia and KPMG estimating that:

"The economic cost of premature death of people with a mental illness in Australia amounts to $15 billion annually. Of this cost, 80 per cent is attributable to physical health comorbidities. Using the PHNs to roll out collaborative care models to 50,000 people with a severe or complex mental illness who may not otherwise be eligible for community mental health supports would generate savings of $315 million. Commonwealth and state policy directions unanimously reinforce the need for more integrated, coordinated, holistic care approaches with the consumer at the centre. This is strongly supported by the evidence base."[100]

For people experiencing severe and persistent mental ill-health, international evidence demonstrates that a housing first model can be a highly effective way to reduce the incidence and impact of mental ill-health, especially through the minimisation and/or management of psychosocial disability:

"the guiding principle of Housing First is that safe and secure housing should be quickly provided prior to, and not conditional upon, addressing other health and well-being issues. In contrast, other models make housing provision conditional, such as by requiring individuals to abstain from alcohol or drug use or comply with mental health programs to qualify for housing. Such approaches can make it hard for those experiencing homelessness to become well enough to qualify for housing or make it difficult to maintain tenancy if they do get into housing."[101]

The provision of safe and stable housing along with integrated with wrap around supports is particularly effective for people with psychosis who are experiencing chronic homelessness, leading to *"improved continuity of care and reduced psychiatric admissions"*.[102]

99. Mental Health Victoria, Saving Lives. *Saving Money: The case for better investment in Victorian mental health*, Mental Health Victoria: Melbourne, 2018.
100. KMPG and Mental Health Australia. *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*, 2018.
101. Australian Housing and Urban Research Institute, "What Is the Housing First Model and How Does It Help Those Experiencing Homelessness?", AHURI Brief, AHURI: Melbourne, 2018.
102. Holmes, Alex et al. 2016. "Housing First: Permanent Supported Accommodation for People with Psychosis Who Have Experienced Chronic Homelessness." *Australasian Psychiatry 1*(4).

Case study – SVA Venture Vanguard Laundry Services

Vanguard Laundry Services is a social enterprise commercial laundry creating employment opportunities for people previously excluded from the workforce, predominately due to mental ill-health. It is also an example of social procurement, as St Vincent's Health committed to a long-term contract to support the laundry. The laundry also has an in-house Career Development Centre to support jobseekers experiencing disadvantage into sustainable career opportunities.

James* had applied for numerous jobs, but nobody would hire him. At one point he spent an entire year trying to get hired. When he finally did get a job, it didn't work out because of the workplace's perceptions around mental ill-health.

Today James has steady employment with Vanguard. It has improved his sense of self. Working in an environment that feels safe has made life just that little bit easier. He's particularly pleased to be following in the footsteps of his father, who also used to work in a laundry.

'I'm proud of Dad for doing what he did, I'm very proud to be able to work in a laundry too,' he says.

Steady employment has made a real, positive impact on James life. He was able to save enough money to make a special trip to Sydney to see his daughter for the first time. While he was nervous, it turned out to be a great weekend and his daughter said it was everything she wanted.

'Working in the laundry suits me down to a tee!' he says.

*The name of the employee has been changed to respect their privacy.

Glossary

Experiences of mental health and wellbeing, and conversely mental ill-health, are diverse and influenced by a broad and complex range of intersecting factors. We recognise that a wide range of terms are used and that there is no universally accepted definition of mental health or mental ill-health. For clarity we have chosen to a set of key terms throughout this paper, as outlined below:

Mental health and wellbeing

Good mental health, also referred to as positive mental health, complete mental health, social and emotional wellbeing is defined by the WHO as

> "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."[104]

This definition, which is used broadly within Australian policy settings, incorporates a broad set of components and features of mental health and wellbeing that are multidimensional, indivisible from the concept of health and prioritise the happiness and satisfaction of an individual.[105]
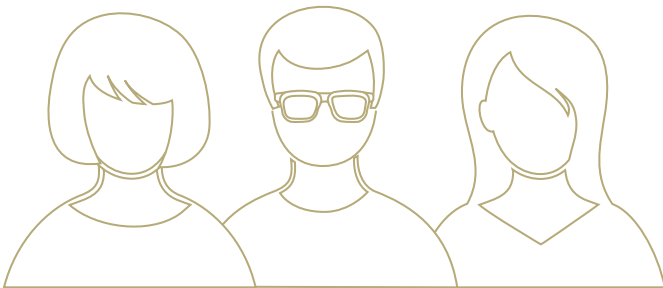
Social and emotional wellbeing

The term social and emotional wellbeing is commonly used to accommodate more complex cultural and spiritual knowledge systems, which emphasises the social, emotional, spiritual and cultural wellbeing of an individual:

> "The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment. The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination, and social disadvantage"[106]

Effective responses to the experiences of Aboriginal and Torres Strait Islander peoples requires first recognising that mental health and wellbeing is understood and conceptualised distinctly across different cultural groups. For many Aboriginal and Torres Strait Islander peoples the term mental health is not an adequate translation for perspectives and approaches to health and wellbeing that are underpinned by complex cultural and spiritual knowledge systems, therefore social and emotional wellbeing is more appropriate, as illustrated in Figure 11.

103. Welsh, Jenny, Laura Ford, Lyndall Strazdins, and Sharon Friel, *Evidence Review: Addressing the Social Determinants of Inequities in Mental Wellbeing of Children and Adolescents*, National Centre for Epidemiology and Population Health and the Regulatory Institutions Network: Canberra, 2015.
104. Australian Institute of Health and Welfare, Australia's Health 2016, AIHW: Canberra, 2016.

© Gee, Dudgeon, Schultz, Hart and Kelly, 2013

Mental ill-health

In this paper we have adopted the term mental ill-health as an umbrella term for a spectrum of experiences. Terms commonly used in policy and service settings, often interchangeably, include mental illness, mental disorder, mental health problem and mental health condition. These terms enable differentiation between experiences of mental ill-health by diagnosis, duration and severity. While some experiences of mental ill-health are commonly defined by detailed diagnostic criteria, other experiences don't meet specific criteria, including stress and substance abuse.[108] A detailed discussion on different types of mental ill-health is beyond the scope of this paper, but a summary of key terms is provided below:

Excerpt from Productivity Commission report 2019

Mental illness or mental disorder is a health problem that significantly affects how a person feels, thinks, behaves and interacts with other people. It is diagnosed according to standardised criteria.

Mental health problem refers to some combination of diminished cognitive, emotional, behavioural and social abilities, but not to the extent of meeting the criteria for a mental illness/disorder.

Mental ill-health refers to diminished mental health from either a mental illness/disorder or a mental health problem.[109]

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107. Department of the Prime Minister and Cabinet, *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing 2017-2023*, Commonwealth of Australia: Canberra, 2017.

108. Slade, Tim, Amy Johnston, Maree Teesson, Harvey Whiteford, Phillip Burgess, Jane Pirkis and Suzy Saw, *The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing: Canberra, 2009.

109. Productivity Commission, *The Social and Economic Benefits of Improving Mental Health Productivity Commission Issues Paper*, Commonwealth Government: Canberra, 2019.

Psychosocial disability

In considering the impact of severe and persistent mental ill-health, the internationally recognised term psychosocial disability, recognised in the United Nations Convention on the Rights of Persons with Disabilities, is used to describe experiences of mental ill-health that impair and restrict an individual's capability to fully participate in their life.

"Psychosocial disability relates to the 'social consequences of disability' – the effects on someone's ability to participate fully in life as result of mental ill-health. Those affected are prevented from engaging in opportunities such as education, training, cultural activities, and achieving their goals and aspirations"[110]
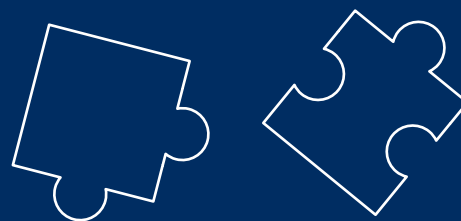
Psychosocial disability has been adopted by the Australian Government in the administration of the National Disability Insurance Scheme (NDIS), however the accessibility of the NDIS for people experiencing psychosocial disability has been widely criticised[111] *(discussed further in SVA's perspective paper on disability)*.

Thank you

110. Mental Health Australia, *Getting the NDIS Right for People with Psychosocial Disability*, MHA: Canberra, 2019.
111. Smith-Merry, Jennifer, Nicola Hancock, John Gilroy, Gwynnyth Llewellyn, Ivy Yen and Amanda Bresnan, *Mind the Gap: The National Disability Insurance Scheme and Psychosocial Disability Final Report: Stakeholder Identified Gaps and Solutions Contributing Stakeholder Organisations and Programs*, University of Sydney: Sydney, 2018.

SVA Social Ventures Australia