Mental Health Australia

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2017-18 pre-Budget submission

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Contents

Mental Health Australia is the peak independent, national representative body of the mental health sector in Australia.

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1. Overview

Recommended actions

This submission calls for a bi-partisan systematic approach to:

- **Restoring then increasing funding levels** to keep pace with demand for mental health services over the medium term
- **Urgently addressing the gaps** that are opening up in the mental health service system
- Urgent action to address the **unprecedented levels of funding uncertainty**, which is holding back co-investment and undermining mental health workforce retention and development
- Supporting **consumer and carer engagement** in order to build the consumer-centred mental health system of the future

The current situation is very poor

- **Mental illness places a huge burden and cost to the community**

  Responsible for 24 per cent of the non-fatal burden of disease, the highest of all diseases

- **Funding for mental health has never matched that burden**

  In 2014-15 spending on mental health was only 5.3 per cent of total health spending. That percentage has been stagnant since 2010-11

- **Current funding is not being directed where it is most needed**

  State and Territory per capita spending on community mental health services has actually declined from $83.61 in 2010-11 to $82.49 in 2014-15

  Rollout of the NDIS has shifted psychosocial support to a much smaller cohort of people - 64,000 of the 230,000 requiring psychosocial support

- **Unprecedented funding uncertainty is interfering with investment and workforce development**

  The rollout of Primary Health Networks and the NDIS has inadvertently exacerbated the effects of years of short-term and last minute funding contracts for non-government organisations, undermining the capacity of service providers to plan and deliver quality frontline services

Seven key reforms

This submission recommends seven key reforms:

- **Urgently fill the gaps** that have opened up as psychosocial support programs are transitioned to the NDIS
- **Develop a long term, bi-partisan plan** to increase future investment in mental health services and programs
- **Adopt national targets and indicators** to guide planning and investment
- **Strengthen the role of the National Mental Health Commission** in order to improve accountability and transparency
- **Improve the capacity of Primary Health Networks** to commission high quality stepped care and psychosocial support
- Focus **future investment on early intervention and prevention**
- **Support consumer and carer engagement**, and other system enablers, in order build the consumer centred system of the future

The costs of inaction are high

Australia cannot afford to delay action;

- Poor mental health costs the Australian economy $60 billion annually
- Mental health issues cost Australian businesses between $11 billion and $12 billion annually
- Suicide has increased by 43 per cent over the last 10 years and is more than double the road toll

The investments and actions recommended in this submission will immediately begin to address these costs.

The reform context

Mental and substance use disorders represent 12 per cent of the total national disease burden, ranked third after cancer (19 per cent) and cardiovascular diseases (15 per cent).[i] Mental and substance use disorders are the leading cause of years lived with disability worldwide.[ii] It is estimated that mental health conditions, such as depression and anxiety, are costing Australian businesses between $11 and $12 billion dollars each year through absenteeism, reduced work performance, increased turnover rates and compensation claims.[iii]

Yet in 2014-15, total spending on mental health was $8.5 billion[iv] – only 5.3 per cent of total health spending, as it was in 2010-11. More than 75 per cent of total spending on mental health is for clinical services[v], despite the well-recognised need to invest more in community based mental health services. The reforms announced by the Australian Government reflect only a very small proportion of the National Mental Health Commission Review's overall vision for change, and are being implemented within the existing funding 'envelope'.

Implementation has always been the challenge in our complex, federated system of services for mental health consumers and carers, and this is already proving to be the case in mental health reform.

Rollout of the NDIS has shifted resources from programs that were originally designed to address a broad spectrum of need to the much narrower cohort of people with psychosocial disability. There are no plans to ensure access to services for those who will be not be eligible for the Scheme, meaning the 'envelope' will actually shrink for the (much larger) population of mental health consumers and carers.

Mental Health Australia acknowledges the current budget constraints and the need to allocate resources efficiently. However, the capacity of the non-government mental health system is actually going backwards, even as demand increases with a growing population. Years of short-term and last minute funding contracts for non-government organisations have further undermined the capacity of service providers to deliver quality frontline services, and this situation has deteriorated significantly over the last three years.

This situation is again playing out as responsibility for commissioning mental health services is transferred to PHNs. With PHNs having secure funding for only two years, they can in turn fund providers for an even shorter period. For organisations providing services on the ground, funding arrangements have never been so short-term.

The progress of reform is too slow and is not yet making a real difference for the community. Too many Australians are being left without services, the suicide rate is at 10-year high, and too many people are caring for loved ones without adequate support.

Failure to act now will almost guarantee that people will get sicker, with less opportunity to get the help they need, ultimately increasing costs to various parts of government.

As this submission argues, the following priority actions would be a strong first step:

- Adopt targets and indicators to bring accountability today, and drive the right investments for the future.
- Support people in the community by funding psychosocial support programs in the community, based on the success of programs like Partners in Recovery, Personal Helpers and Mentors, Mental Health Nurses, and other forms of community support.
- Publish a 10 year plan for expanding investment, scaling up our efforts at prevention and early intervention so every that Australian has access to age appropriate and culturally safe community based support services and online interventions.

2. Priority initiatives

Psychosocial services

Issue

There is good evidence that, when clinical treatment and community support co-exist, they complement each other and promote better outcomes for consumers, their families and carers.[vi]

Yet the introduction of the National Disability Insurance Scheme (NDIS) and implementation of the Australian Government's mental health reforms have left a substantial policy failure in the mental health system that is likely to result in a significant reduction in access to psychosocial support services.

The Australian Government estimated that 230,000 Australians with severe mental illness have a need for some form of psychosocial support, ranging from low intensity or group-based activities delivered through mainstream social services to extensive and individualised disability support.[vii] These psychosocial services aid recovery and support people with severe mental illness to live contributing lives. The NDIS is projected to cater for only 64,000 people who need psychosocial support.

Solution

- *Urgently extend existing psychosocial programs like Personal Helpers and Mentors, Partners in Recovery, Mental Health Nurses, Mental Health Carer Respite and Day to Day Living to provide psychosocial support to people where they need it most – in the community.*
- *Work urgently with the National Disability Insurance Agency to clarify who will be in and who will be out of the Scheme, in order to better understand the population who will require ongoing psychosocial support outside the NDIS.*
- *Use the current parliamentary inquiry and the Productivity Commission review to better plan the interplay between the NDIS and the broader mental health system.*

Background

The Australian Government's mental health reforms will mean that many people who previously received community-based psychosocial services no longer receive them. This is because:

- The NDIS access criteria requires participants to have an impairment that is permanent or likely to be permanent. This is a very high barrier to accessing psychosocial services and is antithetical to a focus on recovery for people with mental illness.
- Commonwealth-funded services under Partners in Recovery and Day to Day Living (Department of Health) and Personal Helpers and Mentors and Mental Health Respite: Carer Support (Department of Social Services) are being transferred in large part to the NDIS. Gaining entry to these programs has been much simpler than becoming an NDIS participant, with criteria focussing on functional need (rather than diagnosis and permanency).
- In many jurisdictions, State and Territory Government programs for psychosocial services are being wound back as funds are transferred to the NDIS.

The Commonwealth maintains that all recipients of the closed programs will be eligible for the NDIS and that there will therefore be no adverse consequences. Nevertheless, there is a glaring mis-match between the projections for the NDIS (64,000) and the Government's own estimate of 230,000 people whose have a need for some form of social support.[viii]

The eligibility criteria for the NDIS for people with psychosocial disability are proving difficult to apply to people with mental health issues, and the actual number of people with psychosocial disability who will be NDIS participants when the Scheme matures is highly uncertain and likely to remain so for some time.

Current Commonwealth policy will see funding withdrawn for community services that provide the critical psychosocial supports that people with severe and persistent mental illness (who are ineligible for the NDIS) need to recover and lead contributing lives. This is despite the NDIS only catering for the psychosocial needs of a small proportion of the community with severe mental illness.

Primary Health Networks (PHNs) are currently not permitted to commission psychosocial support services[ix] even though their regional Needs Assessments have concluded that successful treatment outcomes for those with mental illness require a high degree of integration between specialised clinical services and generalist support and recovery services.[x] PHNs being unable to respond to locally identified needs is antithetical to the policy intent behind the PHN initiative.

Mental health investment

Issue

Mental and substance use disorders represent 12 per cent of the total national disease burden, ranked third after cancer (19 per cent) and cardiovascular diseases (15 per cent).[xi] Mental and substance use disorders are the leading cause of years lived with disability worldwide.[xii] It is estimated that mental health conditions, such as depression and anxiety, are costing Australian businesses between $11 and $12 billion dollars each year through absenteeism, reduced work performance, increased turnover rates and compensation claims.[xiii]

Yet in 2014-15, total spending on mental health was $8.5 billion[xiv] – only 5.3 per cent of total health spending, as it was in 2010-11. More than 75 per cent of total spending on mental health is for clinical services[xv].

Solution

- *Publish a 10 year investment plan to provide mental health services with funding commensurate to need and, consistent with the finding of the National Mental Health Commission's Review, prioritise investment in early intervention, prevention, online and community based services.*
- *Empower the National Mental Health Commission to monitor and publicly report progress of the investment plan.*

Background

The Australian Government's mental health reforms, announced on 26 November 2015, are being delivered "within the existing funding envelope"[xvi] with an expectation that changes to funding arrangements will be more effective in their targeting of services to needs. While increases in efficiency will continue to be made, the Government has no policy or investment plan to increase the capacity of the mental health sector to meet increased demand and better target services.

Targets and indicators

Issue

In the absence of targets and performance indicators, there will be no way of assessing if mental health reforms have had the intended effect, or to make adjustments when and where the system is not meeting the needs of consumers and carers.

Solution

- *Implement the targets and indicators recommended by the National Mental Health Commission and task the National Mental Health Commission with monitoring and reporting on outcomes on a consistent basis.*

Background

In December 2012 the Council of Australian Governments (COAG) asked the National Mental Health Commission to chair an Expert Reference Group (ERG) to assist the COAG Working Group on National Mental Health Reform to develop targets and indicators for mental health[xvii] by providing advice on a set of ambitious and achievable national, whole of life, outcome based indicators and targets for mental health that will be understood by the community and drive systemic change.[xviii] The ERG provided its advice to COAG on 25 September 2013.

The National Mental Health Commission's Review recommended eight mental health and suicide prevention targets as the key priorities to pursue over the next decade, and for the Commonwealth to lead a process to develop and/or confirm appropriate indicator measures to support the eight targets.[xix]

Mental Health Australia and its members support the recommendations of both the ERG and the National Mental Health Commission in relation to targets and indicators.

The draft Fifth National Mental Health Plan offers indicators, but without targets. Further, it is unclear how many of these whole of life indicators can be influenced by the narrow range of health specific actions proposed in the draft Fifth Plan.

Transparency and accountability

Issue

The current environment allows substantial cost shifting between Commonwealth departments, the National Disability Insurance Scheme (NDIS), Primary Health Networks (PHNs) and between governments, with a risk that there will be a decline in aggregate spending on community-based mental health services.

In the midst of reform, the roles and responsibilities of governments remain highly unclear and there is no accountability or transparency regarding spending across departments or between governments. Further, there are no mechanisms to ensure that spending on frontline services is maintained as we transition from one set of complex financial arrangements to another. This situation will impede PHNs in "promoting links and easy to navigate referral pathways between clinical services and broader support services for people with mental illness".[xx]

Solution

- *Immediately task the National Mental Health Commission to report:*
  - » *How much governments spend on what services in mental health, including at regional levels, and whether expenditure matches budget allocations in practice.*
  - » *Whether ongoing reforms inadvertently result in a concentration of service availability for some groups at the cost of gaps in services for others.*
  - » *Previous spending, funding allocation, re-allocation and subsequent spending by governments, via line agencies, the NDIS and PHNs from the 15-16 financial year through to July 2019.*

This period coincides with the transition to full roll-out of the NDIS and the end of the $1.030 billion flexible primary mental health care funding pool.[xxi]

- **In addition, COAG should urgently sign a new Intergovernmental Agreement to resolve ongoing confusion about governments' roles and responsibilities.**[xxii]

This could be incorporated into the Fifth National Mental Health Plan, which is currently in draft but includes no clear delineations of responsibilities across governments.

Background

When it was established in 2012, the National Mental Health Commission was given responsibility for increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.[xxiii] While the National Mental Health Commission's 2014 Review was a major contribution, its role in tracking funding and expenditure in mental health should be expanded.

Acknowledging that the Federation reform process has been abandoned, it remains unfinished business for the Council of Australian Governments (COAG) to clearly define roles and responsibilities in mental health. This is the only way that stakeholders – government and non-government – can confidently plan and implement coordinated action in the interests of consumers and carers.

Primary Health Network commissioning and stepped care

Issue

There is a risk of gaps or delays in service delivery for people while Primary Health Networks (PHNs) establish their commissioning arrangements and sort out the interface between their roles and responsibilities and those of state and territory governments and the National Disability Insurance Scheme, and the respective funding streams.

The success of these reforms will rest on three key factors:

- PHNs will need to develop a deep understanding of the kinds of evidence-based services and programs that could be offered by the mental health sector
- Community-based mental health service providers will need to be ready to respond as PHNs commission services in response to local need
- PHNs will need to have deep engagement with well-resourced and supported consumers and carers in order to develop service offering that are truly co-designed.

In addition, PHNs currently have secure funding for only two years, meaning they can in turn fund providers for an even shorter period. This is seriously undermining the ability of PHNs and providers to plan over the longer term and build a capable workforce.

Solution

The Australian Government should invest in capacity building activities that link the activities of PHNs and the broader expertise of the mental health sector;

- *Build PHN knowledge of evidence-based programs and services that could be offered by a broad range of mental health providers*
- *Support PHNs in building and translating evidence when there are gaps in knowledge or insufficient evaluation*
- *Support structures that strengthen the capacity and embed the voices of people with lived experience in service co-design*
- *Support evidence based commissioning practices that have the greatest chance of achieving improved outcomes*
- *Build knowledge and understanding amongst mental health service providers of the respective roles of PHNs, Local Hospital Networks and the National Disability Insurance Agency.*

The Government should provide stronger guidance for PHNs on commissioning and stepped care that allow for flexibility in local implementation and which can be relaxed over time, e.g. the guidance on suicide prevention.[xxiv]

At the same time, the Government must relax the current restriction on PHNs commissioning psychosocial services if a local need for such services is identified.

Alternatively, funding for existing psychosocial programs should be maintained to ensure ongoing access to support, particularly for people with severe and complex mental illness who will not be eligible for the NDIS. In any case, investment in community-based psychosocial services should not come at the expense of clinical services, but be recognised as an ongoing need in its own right.

- *Finally, the Australian Government should extend contracts with PHNs for an additional two years, to allow PHNs and providers to plan over the longer term.*

Background

PHNs have been charged with a significant challenge that successive governments have been unable to achieve: "lead mental health and suicide prevention planning, commissioning and integration of services … in partnership with state and territory governments, general practitioners, non-government organisations, National Disability Insurance Scheme providers and other related services, organisations and providers."[xxv] The complexity of this task should not be underestimated, with most state/territory governments having their own mental health plans and policies developed without reference to PHNs or Commonwealth-funded services.

The PHNs have to do this while simultaneously developing and introducing a new 'stepped care' approach to mental health service provision.[xxvi]

PHNs also have a complementary role in "planning and coordination of the clinical service needs of people with severe and complex mental illness who are managed in primary care."[xxvii]

While some PHNs (and their Medicare Local predecessors) have previously been involved in the delivery of some mental health programs and services, not all have yet acquired sufficient capability or links with existing services to implement these reforms in a way that meets the needs of the local population and optimises the use of available funding. The three year budget (July 2016 to June 2019) for the PHN Primary Mental Health Care Flexible Funding Pool is relatively small to meet the needs of up to 8.94 million Australians affected by mental illness[xxviii] at $1.030 billion,[xxix] or $115 per person.

Promotion and prevention

Issue

Apart from suicide prevention and a school-based programme, both the Australian Government's response to the Review of Mental Health Programmes and Services and the draft Fifth National Mental Health Plan are silent on specific Government actions on promotion and prevention. Instead, the draft Fifth Plan vaguely mentions promotion and prevention in the discussion on 'integration at the regional level.'[xxx] The Department's guidelines for Primary Health Networks (PHNs) do not include promotion and prevention in the objectives for the primary mental health care flexible funding pool[xxxi] nor in its guidance on Stepped Care arrangements.[xxxii]

Solution

- *Australian governments must invest in specific promotion and prevention programs and strategies that will meet Global target 3.1 in the World Health Organisation Mental Health Action Plan 2013-2020.*

Background

The World Health Organisation (WHO) recognises that integrated and responsive mental health care includes promotion and prevention, and has set a global target that by 2020, 80 per cent of countries will have at least two functioning national, multi-sectoral promotion and prevention programmes in mental health.[xxxiii]

The WHO describes 'functional' promotion and prevention programs as having at least two of the following three characteristics: a) dedicated financial and human resources; b) a defined plan of implementation; and c) evidence of progress and/or impact, and that they not be related to treatment or care.[xxxiv]

PHNs cannot be expected to develop and implement promotion and prevention programs in the absence of specific actions and investment by governments for promotion and prevention, as defined by the WHO. Consequently, Australia is not on track to meet the WHO global target.

System enablers

There are several elements of the mental health system that can be strengthened, during the reform phase and beyond, to 'enable' an enduring and efficient mental health system. While work is underway in many of the areas listed below, it is not sufficient to guarantee successful implementation of the Government's vision for change.

Governance of reforms

There is no common forum in which government, departments and sector come together to consider the progress of mental health reform. Without proper engagement with the sector to implement the reforms, poor communication and confusion create a risk that responses will be ad hoc, and the mental health system will continue to be poorly planned and badly integrated.

- *The Ministers for Health and Social Services should convene quarterly meetings of key stakeholders to consider the progress of reform and oversee and advise on the integration of services for consumers and carers in the new funding and commissioning arrangements.*
- *Departmental stakeholder advisory groups should be convened in a way that genuinely seeks the advice of the sector, rather than being used as a forum for one-way updates.*
- *During reform implementation, senior departmental representatives should speak with members of the National Mental Health Consumer & Carer Forum (NMHCCF) at their regular meetings.*

Consumer and carer participation

Consumers and carers are the experts in what services and programs work for them. Consumers and carers must be involved in decisions that affect them from services available locally to the development of national policy. This is especially the case for vulnerable groups such as Aboriginal and Torres Strait Islander peoples, CaLD, LGBTIQ and people with intellectual disability. Meaningful involvement of people with lived experience should be at the heart of both policy development, implementation and evaluation, as well as service design, delivery and evaluation.

- *Government should complete the development of the national consumer and carer participation framework.*
- *Government should continue to fund existing national mental health consumer and carer leadership and representation structures, including the NMHCCF and the National Register of Mental Health Consumer and Carer Representatives.*
- *Following the consumer and carer participation framework activity, governments should fund enhanced and further structures that enable consumer and carer leadership and representation, and which strengthen the capacity and embed the voices of people with lived experience, contributing to the work of all levels of government.*

Digital gateway

There is consistent feedback from the e-mental health sector that the Digital Mental Health Gateway (DMHG) will duplicate and compete with existing services with high brand awareness and trust in the community.

- *The Government should suspend the current DMHG development process and work with existing gateway-like services and consumers to enhance those services' ability to support the community to navigate to mental health services.*
- *New planning and governance processes should be established to develop a DMHG that integrates with existing gateway-like services to complement (and not compete with) them.*

Service Planning and Workforce Development

National Mental Health Service Planning Framework

The National Mental Health Service Planning Framework (the NMHSPF) is an intergovernmental initiative which provides a population based planning model for mental health, to identify the demand and mix of services at regional, state and national levels across inpatient and community settings. It is the first of its kind in the world, and draws on contributions from hundreds of experts in a wide range of areas. The NMHSPF could be used by Primary Health Networks (PHNs), Local Hospital Networks and the National Disability Insurance Agency to plan for and coordinate services within and across systems.

- *The Government should fund the ongoing development, application and refinement of the NMHSPF to support a more appropriate and efficient mix of mental health services nationally.*

Develop the peer workforce

Investing in the development of the mental health peer workforce will make a major contribution to the quality and recovery orientation of service provision. This could involve, for example, initiating a mental health peer workforce development framework and providing incentives to integrate peer workers into all relevant services.

- *The Government should fund the development and implementation of a national mental health and psychosocial support peer workforce strategy, as recommended by Health Workforce Australia and the National Mental Health Commission.*

Workforce planning

Health Workforce Australia identified a need to undertake a study of the mental health workforce to support future workforce planning. In particular, there is currently a lack of data on the workforce in the non-government mental health sector.

- *To support the role of the PHNs and the National Disability Insurance Agency in commissioning mental health services, the Department of Health should commission a study of the mental health workforce to identify the detailed nature of support work being performed and map this against mental health sector roles, skills and qualification requirements.*

The community mental health sector

The supply and sustainability of community mental health services is particularly vulnerable during the transition of block funded Commonwealth programs to fee for service arrangements through the National Disability Insurance Scheme (NDIS). Many providers are struggling to adapt their service models to the new pricing structures mandated by the National Disability Insurance Agency, which have not yet recognised the skills and qualifications required for staff delivering psychosocial support services. At the same time, providers are losing revenue streams for clients who under previous arrangements accessed services flexibly and as needed, consistent with best practice in recovery-oriented service provision. These developments are having a major impact on the capacity and financial sustainability of the community mental health sector.

- *The Government should urgently commission a study to understand the impact of current reforms on sector capacity and implications for ongoing access to quality psychosocial support for people with severe and complex mental illness.*

Data harmonisation and collection

Co-design of services must be informed by consistent and robust indicators underpinned by consistent data collection and reporting at regional and national levels. Without harmonised data collection, we cannot hope to have a complete picture of service provision and consumer outcomes across Australia. With the right efforts to coordinate data collection, aggregated data can be used for national policy development as well as local planning and evaluation.

- *The Government should fund a project to:*
  - » *Unify, rationalise and harmonise data collection across PHNs, including mental health, drug and alcohol and other PHN-commissioned services*
  - » *Develop IT capacity and systems to enable data sharing within and across government and non-government organisations in the mental health sector*
  - » *Fund and support service providers to collect and submit new data sets electronically.*

A National Mental Health Plan

According to the WHO, a national mental health plan should detail the strategies and activities that will be implemented to realise the vision and achieve the objectives of a mental health policy. It also should specify a budget and timeframe for each strategy and activity, as well as delineating the expected outputs, targets and indicators that can be used to assess whether the implementation of the plan has been successful.[xxxv]

The draft *Fifth National Mental Health Plan* does not appear to build on the work done by governments, service providers, consumers, carers and advocacy organisations over the past few years, nor is it consistent with the WHO's definition of a national plan. It was expected that the *Fifth Plan* would honour previous commitments by the Council of Australian Governments (COAG) on mental health and that it would be aligned with the National Mental Health Commission's vision for reform.

- *The draft Fifth Plan must be reworked to:*
  - » *Clarify in detail the respective responsibilities of different levels and parts of government for mental health.*
  - » *Identify which levels and parts of government will be responsible for planning, coordinating, funding and/or delivering psychosocial support services for people with severe and complex mental illness who will not be eligible for the NDIS.*
  - » *Address the broader determinants of mental health, and ensure that there are defined mechanisms to influence KPIs that lie outside of the clinical domain.*
  - » *Honour previous COAG commitments by adopting national, whole-of-life, long-term, outcome-based targets.*
  - » *Explain how Activity Based Funding and other financial arrangements between governments will be used to provide the right incentives across various parts of the mental health system.*
  - » *Describe how consumers and carers will be empowered to become genuine partners in co-design and co-production.*
  - » *Specify how the Fifth Plan will help meet Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities.*
  - » *Outline a growth strategy for the community mental health sector, and embed the role of the community and private mental health sectors in the Fifth Plan as genuine partners.*
  - » *Describe how the work of Aboriginal Community-Controlled Organisations and a range of NDIS-funded services will be integrated at a regional level.*
  - » *Explain how provider organisations will be supported to maximise the benefits of ICT in their respective business practices.*

- *Explain how e-mental health will be integrated into the set of services and supports for consumers and carers.*
- *Explain how governments will ensure routine and objective reporting on whole-of-life mental health outcomes and expenditure at national and regional levels.*
- *Describe how the National Mental Health Commission will contribute to the implementation and monitoring of actions under the Fifth Plan.*

[i] Australian Institute of Health and Welfare 2016. *Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011—summary report*. Australian Burden of Disease Study series no. 4. BOD 5. Canberra: AIHW.

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[viii] ibid

[ix] Department of Health. PHN Primary mental Health Care Flexible Funding Pool Implementation Guidance. Primary Mental Health Care Services for People with Severe Mental Illness.

[x] For example, see Murrumbidgee Local Health District and Murrumbidgee PHN. Murrumbidgee Mental Health, Suicide Prevention and Alcohol and Other Drugs Needs Assessment 2015-16. Section 10. Primary Care and Mental Health – Building Capacity

[xi] Australian Institute of Health and Welfare 2016. *Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011—summary report*. Australian Burden of Disease Study series no. 4. BOD 5. Canberra: AIHW.

[xii] Whiteford HA, Degenhardt L, Rehm J, et al. *Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010*. Lancet 2013; 382: 1575–86.

[xiii] Harvey SB, Joyce S, Tan L, et al. *Developing a mentally healthy workplace: A review of the literature. A report for the National Mental Health Commission and the Mentally Healthy Workplace Alliance*. November 2014.

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[xvii] Response of the Council of Australian Governments to “A Contributing Life: the 2012 National Report Card on Mental Health and Suicide Prevention” – a report by the National Mental Health Commission.

[xviii] Expert Reference Group on Mental Health Reform. Governance Arrangements and Terms of Reference. 16 April 2013.

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[xxi] Department of Health. *Primary Health Networks. Grant Programme Guidelines. Annexure A1 – Primary Mental Health Care*. February 2016 – Version 1.2

[xxii] National Mental Health Commission *Contributing Lives, thriving communities. Report of the National Review of Mental Health Programmes and Services.* November 2014.

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[xxiv] Ridani, R., Torok, M., Shand, F., Holland, C., Murray, S., Borrowdale, K., Sheedy, M., Crowe, J., Cockayne, N., Christensen, H. (2016). *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning, and monitoring*. Document for Primary Health Networks. Sydney: Black Dog Institute.

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[xxvi] Department of Health *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance. Stepped Care*.

[xxvii] ibid.

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[xxix] Department of Health. *Primary Health Networks. Grant Programme Guidelines. Annexure A1 – Primary Mental Health Care*. February 2016 – Version 1.2

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[xxxiv] World Health Organisation. *Mental Health Atlas 2014*.

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