Policy Document

Mental Health Support Structures (2023)

Position Statement

AMSA believes that:

1. The current rates of mental illness and suicide within the Australian community are unacceptable and are in part attributable to the lack of an organised and efficiently laid out mental health support system structure.
2. Immediate action should be taken to further the development of Australia's mental health support network.
3. The current mental health system is crisis-driven and does not adequately facilitate prevention and appropriate care. Mental health initiatives that reduce social stigma and discrimination whilst encouraging mental health promotion and early intervention should continue to be promoted.
4. The Australian mental health system is deprived of sufficient funding and access to necessary resources, causing a lack of capacity and intolerable delays in care, increased wait times, and a deficiency in healthcare workers.
5. It is the duty of the medical profession to play an active advocacy role in the prevention, education, and amelioration of mental illnesses, proactive research into mental health, and in fostering an effective and inclusive mental health system.
6. Current legislation regarding treatment and community treatment authorities do not appropriately consider patient autonomy and represent human rights breaches and must be reviewed and repealed.
7. Multifaceted and innovative strategies should be put in place by health regulation authorities. These should result in improved service delivery, funding, and mental health infrastructure.
8. University students and representative bodies, such as AMSA, should be engaged as key stakeholders during the consultation, planning, implementation, and monitoring stages of any mental health system structure changes relevant to student communities.

Head Office
A Level 1,
39 Brisbane Avenue,
Barton, ACT 2600

Postal Address
PO Box 6099,
Kingston, ACT 2604

ABN:
67079 544 513

Email:
info@amsa.org.au

Website:
www.amsa.org.au

Policy Points

AMSA calls upon:

1. Federal, State and Territory Governments to:
    a. Uphold the patient's right to autonomy and use capacity-based criteria for the determination of treatment authorities by:
        i. Eliminating the discriminatory use of diagnosis of mental illness as a selection criteria; and
        ii. Implementing and promoting the use of shared-decision making and patient-centred healthcare models;
    b. Ensure a clear description and division of roles and responsibilities between levels of government and between mental health-related services to provide a more robust and transparent mental health system;
    c. Ensure clear description and appointment on how health and non-health sectors should collaborate in achieving whole-of-government mental health reform;
    d. Ensure that National Mental Health Strategies, Disability Strategies, and Suicide Prevention Plans are linked with measurable and accountable funding commitments;
    e. Revert the number of claimable sessions in the Mental Health Treatment Plan from 10 back to 20 per calendar year;
    f. Consistently monitor existing mental health services via tracking of performance indicators according to the National Mental Health Framework for quality improvement;
    g. Implement effective school-based prevention programs for students, parents and school staff to identify emerging mental health problems in children and adolescents and encourage early help seeking behaviour;
    h. Ensure that transitional youth-friendly mental health services for adolescents that reach the age boundary between Child and Adolescent Mental Health Services and Adult Mental Health Services are available;
    i. Ensure existing strategies in mental health promotion, prevention, and early intervention work in tandem with other endeavours to address:
        i. The underlying social determinants of mental health;
        ii. The social causes of mental distress; and
        iii. The accessibility of service for at-risk groups.
    j. Ensure that general mental health services are implemented and provided with a baseline level of cultural safety towards underserved

populations such as Aboriginal and Torres Strait Islander peoples, people with a disability, and LGBTQIASB+ people;

k. Ensure legislation appropriately reflects the needs and gaps of service expressed by underserved communities by direct consultation of those communities, including Aboriginal and Torres Strait Islander peoples, individuals living with disability, the "Missing Middle", LGBTQIASB+ Australians, and those living with mental illness or distress; and

l. Increase funding and workforce capacity for:
    i. Psychiatric training positions and rural psychiatric training positions;
    ii. Preventative and early-intervention services;
    iii. Services catered to at-risk populations;
    iv. Collaborative and multidisciplinary programs for long-term complex care;
    v. Mental health-related services including increased funding for MBS and PBS subsidies;
    vi. Community-led and lived-experience mental health support services, and peer support programs;
    vii. Services in rural and remote areas;
    viii. Crisis intervention services that are accessible at all hours and geographical locations; and
    ix. Mental health research to expand knowledge base for promotion, prevention and early intervention.

2. Mental Health Non-Governmental Organisations to:
    a. Improve and implement mental health support services catered to at-risk populations;
    b. Continue to work with medical health professionals and societies to ensure that evidence-based practices and mental health support programs are being implemented across all organisations, including areas such as social prescribing and peer support programs; and
    c. Continue to research, develop, and implement new programs focused on the promotion, prevention, and early intervention of mental illness.
3. The Federal Australian Medical Association (AMA), State-Based AMA's, and the Australian Medical Council to:
    a. Advocate for good mental health support systems that promote early prevention, intervention and treatment;
    b. Advocate for a model of collaborative care, that incorporates other allied health professionals, that will allow patients to seek integrated mental and physical health care form primary health providers;

c. Work with care-providing facilities including hospitals and medical centres to ensure that evidence-based care is implemented at all levels of the mental health support system;
d. Ensure that care models are accessible to all people in Australia, including at-risk populations and underserved populations; and
e. Provide clear avenues to receive feedback from medical students and student societies regarding Australian mental health support structures.

4. Royal Australian and New Zealand College of Psychiatrists (RANZCP) to:
    a. Increase the number of psychiatrist training positions, particularly in regional and remote areas;
    b. Urge current medical students and junior doctors to pursue psychiatry specialty training through by promoting the unique contributions of psychiatry and mental health care on holistic healthcare; and
    c. Cease sole usage of the DSM-V as the standard of diagnostic criteria for mental health disorders by;
        i. Transitioning towards a biopsychosocial model approach; and
        ii. Investing and promoting intersectional research towards a holistic diagnostic model, such as a collaboration of the HiTOP and RDoC diagnostic tools.
5. Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) to:
    a. Facilitate continuous, interconnected care by supporting ongoing relationships between patients and general practitioners;
    b. Provide adequate training in the delivery of mental health services to support general practitioners as the first point of contact for mental health related issues;
    c. Provide adequate training in the identification of risk factors and social determinants of health that lead to mental illness in order to promote prevention, early intervention, and trauma-informed practice; and
    d. Further develop emphasis in training curriculum to the intersectionality of overlapping forms of discrimination and marginalisation that contribute to mental health related presentations in general practice.
6. Medical specialty training colleges to:
    a. To ensure that all specialty colleges take the necessary steps to ensure that their trainees and the organisation receives adequate and

culturally responsive training in identifying and managing mental illness and suicide by;

i. Fostering working environments that do not tolerate bullying and other practices detrimental to mental health;
ii. Incorporating modules on unconscious bias training; and

b. To work collaboratively with other specialty training colleges to improve service delivery and encourage a multidisciplinary collaborative healthcare approach amongst the specialties.

7. Medical schools to:
    a. Acknowledge their role in improving mental health care and support structures across Australia by:
        i. Providing mental health education and mental health first aid to all students which equips them with the skills necessary to contribute effectively to Australia's mental health support structures;
        ii. Providing mental health education with a focus on prevention and early intervention that enables students to recognise the risk factors and social determinants of health which lead to mental illness;
        iii. Ensuring that education and support is catered to all student populations, particularly at-risk populations; and
        iv. Integrating a patient-centred and shared-decision making model as a core component of the healthcare curriculum;
    b. Provide mental health care education to students that:
        i. Incorporates a biopsychosocial and holistic approach; and
        ii. Includes modules on Trauma-Informed Care, Social Prescribing, Collaborative and Integrated Crisis Care, After Care, and Patient Autonomy.
8. Medical students to:
    a. Continue to advocate for adequate mental health support services at their university; and
    b. Provide feedback to medical associations and other relevant stakeholders when deficiencies in the Australian mental health support structures are noted.
9. Health care professionals to:
    a. Engage with ongoing training and education to ensure competency in providing safe, effective, and culturally appropriate mental health care;
    b. Foster collaboration and a multidisciplinary approach between general practitioners, mental health specialists and allied health

professionals to provide collaborative care that integrates mental and physical health into primary care services;

c. Incorporate a shared-decision making model and patient-centred approach to providing healthcare that respects the patient's autonomy and uses a holistic approach to wellbeing;
d. Incorporate a trauma-informed care and strengths-based framework in their approach to providing healthcare to;
    i. Create a safe environment that prevents retraumatization; and
    ii. Acknowledge the effect of trauma on the individual's physical and mental wellbeing;
e. Work with individuals experiencing mental illness to ensure an ongoing model of care taking into account both acute and long-term biopsychosocial needs;
f. Provide culturally responsive mental health care services catered to all populations; and
g. Prioritise their own mental health by advocating for;
    i. A zero-tolerance policy for bullying in the workplace,
    ii. Sustainable working conditions that include features such as a positive work culture, reasonable working hours, appropriate remuneration, and manageable shift frequency; and
    iii. Implementation of peer support groups.

Background

Prevalence

According to the World Health Organization (WHO), mental health is "a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community." The WHO also highlights mental health as an integral component of health and wellbeing. [1] Mental health conditions are becoming increasingly recognised as an important health issue in contemporary society, especially as relationships between mental and physical health are being identified, with those who have a mental illness being more likely to develop physical illness. [2] Mental illness can be described by two broad categories: any mental illness (AMI) and serious mental illness (SMI). AMI encompasses all mental illnesses, whereas SMI is a smaller, more severe subset of AMI. [3] Furthermore, AMI is defined by its encompassment of conditions with variable impact or no impact. SMI is then used to define mental illnesses resulting in serious functional impairment that impairs activities of daily life. To highlight a few examples, SMI includes major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, and post traumatic stress disorder.

The Australian Bureau of Statistics estimates that over 2 in 5 Australians aged between 16 and 85 have experienced a mental disorder at some point in their lives, with mental and substance use disorders being the second largest contributor to Australia's non-fatal burden of disease. [4, 5] Anxiety is the most common disorder affecting 1 in 6 Australians, which is then followed by affective disorders and substance use disorders. [5] Mental illness is not limited to adults either, with nearly 1 in 7 children and adolescents aged 4 to 17 estimated to have experienced a mental illness within the past 12 months. [5]

Due to structural violence, the impact of mental illness disproportionately affects certain populations, such as Aboriginal and Torres Strait Islander peoples, individuals with a disability, and LGBTQIASB+ people. In 2018 and 2019, an estimated 24% of Aboriginal and Torres Strait Islander peoples reported having a mental health or behavioural condition. [6] Aboriginal and Torres Strait Islander peoples rely heavily on primary care for mental health treatment, seeking general practitioner management at a greater rate than non-Indigenous Australians. [7] This highlights the central role of general practice in the provision of mental health care, particularly as a first point of contact for mental health support in Australia. This is especially the case for Aboriginal and Torres Strait Islander peoples, given that general practice clinics are commonly the only point of care in certain areas of Australia. [8]

Those living with disability have also been found to be affected differently by the prevalence of mental illness and mental distress. In 2018 and 2019, an estimated 38% of adults with a disability reported psychological distress in the previous week, compared to 8% of all adults living without disability. Individuals living with psychological disability were also increasingly likely to report high or very high psychological distress (76%), followed by people living with intellectual disability (60%). [9] *The Private Lives survey*, most recently undertaken in 2020, surveyed 6,800 LGBTQIASB+ participants. 61% reported being diagnosed with depression, 47% reported having anxiety disorder, and 57% of survey participants reported experiencing high or very high levels of psychological distress within the past four weeks. [10] This skewed distribution of burden of disease should command more attention and consideration with respect to how assistance is provided to those experiencing a mental illness.

Diagnosis and Misdiagnosis

Misdiagnosis is an ongoing challenge in healthcare that is met with the same difficulties in the space of mental health care. In 2021, it was found that nearly 40% of patients living with severe psychiatric disorders were misdiagnosed. [11] One major contribution is the current standard of diagnosis being used in Australia.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 is the current standard classification of mental disorders in the US and Australia. With that being said, it has undergone a number of revisions of historical terminology and definitions. Previous editions have been met with criticism for uninterpretable diagnostic criteria, and pathologising of the human experience. The progression of the DSM through the editions also parallels and reflects the growing social acceptance of mental illness and its definition. The current DSM 5 Text Revision (DSM-5-TR) is the most up to date version, and was the first update to the manual since 2013. [12] This revision has notable changes that reflect the shifts in the literature which consists of a stronger focus of inclusivity. It incorporates current scientific literature including Prevalence, Risk and Prognostic Factors, Culture-Related Diagnostic Issues, Sex- and Gender-Related Diagnostic Issues, Association with Suicidal Thoughts or Behaviour, and Comorbidity.

However, the DSM-5 and the DSM-5-TR are still not refined enough to be considered the bases of diagnostic criteria, with researchers pointing out that two people could receive the same diagnosis without any common symptoms. [13] The pragmatic criteria, although giving clinical flexibility, undermines the diagnostic model. This does not mean that there are no resources that can fill this gap in knowledge and refinement. Other diagnostic systems such as The Hierarchical Taxonomy of Psychopathology (HiTOP) and Research Domain Criteria (RDoC) take a more holistic approach to diagnosis of mental health conditions both being created due to the current and ongoing dissatisfaction with the current classification systems. [14] These approaches should be seen as complementary approaches that allow for more accurate diagnostic criteria and research. [14]

Although the DSM diagnostic criteria is far from the most effective and accurate, the recent text revision has reprimanded some of its biggest flaws that contributed to its incidences of misdiagnosis. An example of this is the increase in women who have been previously misdiagnosed with depressive or personality disorders, that are now being diagnosed with autism spectrum disorder (ASD). As previous iterations of the DSM contained an androcentric diagnostic criteria which failed to encompass alternative presentations of neurodiversity, there has been a high incidence of misdiagnosis. [15] Due to a late diagnosis and thus a delay or lack of treatment, these women have been found to develop comorbidities that overshadow the root issue, with many women only reaching an appropriate diagnosis after years of comorbidity treatment. [15] Thankfully these challenges are beginning to be addressed with the latest edition DSM-5-TR. Although still not the most accurate diagnostic criteria, it has slowly begun to reflect the sociocultural influences on mental health, and a deeper understanding of various risk factors including racism, discrimination, the use of non-stigmatising language, and many more. [12]

Components of an Effective Mental Health System

Promotion, Prevention, and Early Intervention

In order to mitigate the burden associated with mental disorders, mitigation strategies such as mental health promotion, mental health illness prevention, and other early intervention strategies must be implemented prior to and concurrently with treatment. [16] Such strategies bolster mental health outcomes and provide the opportunity for intersectional responses to healthcare challenges. [16] However, the efficacy of these strategies become inconsequential and even counterproductive if it fails to appropriately address the underlying causes of mental illness and mental distress. It is then important to impart caution and to discuss a particular nuance of these strategies. One seemingly common approach to anti-stigma and mental health promotion campaigns is to attribute the causes of mental illness and mental distress to an almost exclusively biological and genetic (biogenetic) cause. These strategies fall short of their goals because they assume that attribution of mental illness to a biogenetic model will have a positive impact on the perspective of mental illness and those impacted by it. They have been repeatedly shown to be ineffective in achieving their goals of raising awareness and reducing the stigma around mental health, and furthermore have not demonstrated efficacy in addressing any underlying social causes of mental distress either. [17, 18]

In order to appropriately provide a response that would improve accessibility and efficacy for various demographics within a healthcare system, strategy design should instead consider the factors and underlying social determinants of health, such as: age, culture, race, sexual identity, gender identity, socioeconomic status, and geographical location as examples, but with many more to be mentioned. [19] In order to cater to underserved communities and demographics, or those with higher barriers to care, implementing more focused policy will be necessary. There are many other at-risk groups worth mentioning as well. Such a policy should aim to remove barriers and access to care for groups such as: children and adolescents, the elderly, individuals with disability, patients of addiction and substance abuse, the incarcerated, communities affected by intergenerational trauma, women in vulnerable situations, those who have experienced trauma, and more specifically children who have experienced adverse events. [19] Efficacy of such strategies and policy are enhanced by utilising a “multi-pronged” approach. Below is further discussion and elaboration on the importance of mental health promotion, prevention, and early intervention in mental health policy. [20]

Mental Health Promotion

Mental health promotion refers to any action taken to improve psychological, social and emotional wellbeing among populations and individuals. [21] These actions, by

aiming to improve mental health, help individuals increase their ability to realise their potential, to better cope with normal stressors of life, and to participate meaningfully within their community. As such, health promotion is not restricted to those with disordered mental health, but seeks to enhance mental health generally and of everyone in the community. [22] This is achieved through supporting communities and providing individuals with resources necessary to improve healthcare accessibility and to decrease the risk of mental disorders. Other mental health promotion strategies can also be approached by targeting health literacy gaps via media campaigns and community groups. [19] This in turn can promote community and individual action, encourage help-seeking behaviours and promote environments which are free of mental-health related stigma. [19] As these strategies of mental health promotion aim to improve the mental health of the community, they should also be approached in tandem with other efforts that also tackle the underlying social stressors and causes of mental distress. While the mention of these strategies are siloed in their own discussions, it must not be mistaken that the need for a multifaceted approach is absolutely necessary.

Mental Disorder Prevention

Mental disorder prevention involves strategies which attempt to decrease the severity and incidence of symptoms arising from mental illness. This is achieved by minimising risk factors, and enhancing protective factors for individuals and communities. Such primordial preventative measures may seek to address social and political factors, and especially disparities, which can directly or indirectly exacerbate experiences of mental illness. Preventative measures may be classified as either universal, selective or indicated interventions according to their intensity. [19]

Universal preventive interventions target the general public and seek to provide interventions for those who have not necessarily been identified as being at risk of developing a mental health disorder. [21] For example, a mental health or substance abuse curriculum provided for school children may be categorised as universal prevention. [22] Selective preventative interventions are targeted towards individuals or subgroups who are predisposed to being at a greater risk of developing a certain mental, emotional or behavioural disorder. [21] Such predisposing factors may be biological, psychological, social, or a combination of these. [23] For example, such interventions may include a mental health support group for children with exposure to domestic violence. [22] Indicated preventive interventions are targeted towards individuals identified as being at a high risk of developing a mental, emotional or behavioural disorder. [21] These individuals may typically display some identifiable signs or symptoms of such disorders, but do not yet fulfil all diagnostic criteria. [20] Such interventions may include a program seeking to develop healthy

coping mechanisms provided to young people in child serving systems due to behavioural challenges. [22] Additional classification models may further define prevention as according to the stage of development at which it is ideally employed. This however, is generally secondary to intensity classification. [20]

Early Intervention of Mental Disorder

Early intervention refers to interventions that target people displaying the early signs and symptoms of, or those experiencing their first episode of, a mental disorder. [88] Such early intervention seeks to impede the progression of subsyndromal symptoms and prevent development of a diagnosable disorder. [24] Alternatively, such interventions may seek to limit the impact and severity of those symptoms associated with the disorder following onset. [24]

Early interventions most frequently require an individual focus, although may be aided by group work and support groups. Additionally, such interventions should continue beyond symptom onset and resolution, due to the frequently episodic nature of mental health disorders and their symptoms. [20] To maximise the success of these early interventions, care should be taken to recognise social and political factors contributing to individuals' experience with mental disorders, as addressing such factors may alleviate stressors giving rise to disordered symptoms thus avoiding an excessive pathologizing of patients. [25] By extension, it would be prudent to take a cautious and thorough approach in identifying patients for early intervention. Otherwise, hasty and ill-informed practice may result in harmful targeting of individuals that are otherwise exhibiting normal behaviour. [25]

Trauma-Informed Care

Trauma-Informed Care (TIC) is a strengths-based framework which centres upon the notion that trauma affects affected individuals' physical and mental wellbeing, and attempts to create a safe environment to prevent re-traumatisation. [26, 27] There is no universally agreed definition for 'trauma'. However, most will agree that it refers to an event, a series of events, or a set of circumstances that an individual experiences as physically or emotionally harmful, and incurs lasting adverse effects across mental, physical, social, emotional, or spiritual domains. [28] Sweeney and Taggart, who write from their positions as researchers and trauma survivors, stipulate that TIC undertakes sensitive enquiry into trauma experiences and refers individuals to evidence-based trauma-specific support, while prioritising trustworthiness and transparency in communications and working in partnership with trauma survivors to design, deliver and evaluate services. [29] TIC is a relatively new approach and there are few studies which evaluate its efficacy in Australia, however early indications are promising and warrant further clinical use and further investigation. [30]

Collaborative Care, Integrated Crisis Care, and After Care

The process of deinstitutionalisation in mental healthcare in Australia requires the ongoing maintenance and improvement of an effective network of collaborative medical, allied health and community mental health providers and organisations. [31-33] In Australia, a range of interventions involving this type of collaboration have been successful in treating mental health comorbidities. [31, 34] Organisations have also been successful in pioneering linkages between healthcare professionals working across healthcare disciplines. [35-37] For example, between GPs, psychiatrists, psychologists, public and community health workers, police and ambulance services, and mental health nurses, social workers and counsellors. [36-38] Sustaining such a network in collaborative mental healthcare delivery requires optimisation of the capacity of the workforce to deliver the right skills in mental healthcare across diverse communities and locations within funding constraints, particularly in rural areas, where highly skilled and specialised practitioners are a scarce resource. [39]

Small scale community mental health programs, particularly in rural settings, are well-recognised as being better able to foster collaborative working relationships among local health professionals, leading to better community engagement, and resulting in better mental health outcomes in their communities. [33, 38, 39] However, collaborative mental healthcare delivery models in Australia are often siloed by the structure of the healthcare system they exist in, leaving small-scale community programs vulnerable to shifting policy and funding priorities and staff turnover, and struggling to form a comprehensive network of services that are responsive to unique communities they serve. [31, 35-38]

Within the Medicare subsidised system, general practitioners are the most frequent providers of mental healthcare, providing services to community members with needs that are complex and require long-term follow-up care. General practitioners demonstrate a need and a willingness to work collaboratively with other medical and allied health professionals in long-term complex mental healthcare delivery. However, they find that Australia's mental health care delivery model lacks cross-disciplinary coordination, and is crisis-driven to the extent that funding and focus in policy falls away even in the immediate need for after-care following mental health crises. [38, 40]

Case management programs are a model of mental healthcare that serve community members needing ongoing care as part of early intervention, follow-up care after a mental health crisis, and long-term management of complex conditions and co-morbidities. [33, 38, 40] A case management program involves a care coordinator, or a care coordinating organisation, linking community members to medical, allied health, and other community professionals for both therapeutic

services, and services that benefit psychosocial health such as employment, housing, and social connectedness. Australian examples of this type of program have shown success in improving the psychosocial health of community members receiving care for their mental health, but further research is needed to establish the extent of success and potential for improvement in impact on mental health outcomes, like rates of hospital admission. [33, 37, 41]

Expanding the scope of mental healthcare integration to consider biopsychosocial health, two distinct categories of healthcare recipient emerge; those that systems of healthcare consider to be primarily physically ill, but at risk of developing co-morbid mental illness, and those who are considered to be primarily mentally ill, who develop physical comorbidities. [42] In Australia, integrated healthcare programs designed to mitigate the risk of developing poor mental health due to physical illness such as cancer, and life events strongly connected to physical health such as pregnancy and child-birth, do exist and are shown to be effective. However, they are often underutilised, lacking in consistency of quality, and reliant on under-resourced general practitioners and patients themselves for service coordination. [43, 44] Integrated healthcare programs for those who are considered to be primarily mentally ill with physical comorbidities are thus lacking. People with mental illness frequently experience their physical health symptoms being attributed to their mental health, resulting in under treatment and worse health outcomes than people without mental ill health who have the same physical health conditions. [42]

Service continuity between child and adolescent mental health services (CAMHS) and adult mental health services (AMHS) is also an issue related to integration of systems of mental healthcare in Australia. [45, 46] The Australian national standard for transitions in care calls for timely, relevant and structured handover between mental health practitioners in order to maximise optimal outcomes and promote wellness. [47] However, service gaps that often leave patients exiting CAMHS without adequate support in transition to AMHS persist. [40, 45, 46, 48]

Australian governments both at the federal and state level recognise the importance of an integrated, multidisciplinary approach to mental healthcare and support service delivery, underpinned by good coordination between service providers, ease of access and understanding for service users, and good communication across all stakeholders. [49-54] Service integration in mental healthcare needs buy-in from all stakeholders to be effective in each of these aspects. [40, 41, 55] Efforts in collaborative service provision that are not responsive to this need can result in medical and allied health professionals being unable to contribute at an optimum level, and community members receiving mental healthcare to not fully engage with the services offered to them. [40, 41, 52, 56] Recognition of what is required to get integrated mental healthcare right has not yet translated to high quality

collaborative care that is accessible, easy to navigate, and engageable, across Australia's health system. [40]

Community Led Mental Health Services and Peer Support

Community led mental health services are essential to ensuring that individuals across the country can access support that is tailored to their needs and is situated within their own community and support system. They also help reduce the burden on other front-line mental health professionals such as general practitioners. These predominantly government-funded or not-for-profit health care outpatient clinics provided support to nearly 481,500 patients in 2020 to 2021 with around 10.2 million community mental health care service contacts being provided. [57] Examples of these include but are not limited to Flourish Australia, Neami National, the Rural Adversity Mental Health Program (RAMHP), AIDS council of NSW (ACON) and The Essential Network (TEN). [58] To highlight how forms of community and peer support health services have been implemented in the past, these examples are discussed in further detail.

Services such as Neami National and Flourish Australia provide vital psychosocial support to over 27,000 individuals within their own community in rural, regional and metropolitan areas all across Australia. They provide key interventions such as peer support, employment services and overall encourage general wellbeing in individuals. [59, 60]

Those living in rural or regional communities are often over-represented in poor mental health outcomes. [61] This makes the existence of targeted services such as RAMHP particularly vital in helping people from those areas access mental health support. Between July of 2016 and December of 2020, this service linked 11,499 people to mental health related services and resources and provided social support services to 2% or 740 of those individuals. [62]

Similarly, ACON is a service designed to target those in the LGBTQIASB+ community who also experience disproportionate levels of poor mental health outcomes. The peer work program was only launched in 2021 yet provided 625 peer work occasions of service to the community. Another of their programs, "Trans Vitality ", similarly provides peer support and education to those who identify as transgender in the community and have provided over 1830 hours of counselling care, coordination and peer support to over 300 clients. [63]

The Essential Network (TEN) provides resources and support that target health care professionals and is open to healthcare workers of any background including students, allied health, nursing and administrative staff. [64] Particularly of note, the

"Hand n Hand" Program provides one to one or group peer support services with individuals of similar age, profession and experience. Upon professional evaluation it was shown the individuals reported that the peer support provided by the Hand n Hand Program helped them feel less alone and provided a safe space for them to discuss issues. 50% of respondents said they felt heard and understood, and 44.4% reported feeling less alone. [65]

Despite these services being available, the existence of other, more targeted peer support avenues demonstrate that more can be done to support not only vulnerable groups within the population, but other mental health professionals for example general practitioners or other front-line mental health workers. Peer review groups (PRGs) which are commonly used and endorsed by psychiatrists. PRGs are shown to contribute to the reduction of vulnerability to stress and burnout among participants. Furthermore, a study evaluating the service demonstrated that 97.4% of participants agreed it provided a safe space for reflection and peer support, and over 75% rated their participation as being beneficial to well-being, stress reduction, and to improving clinical care. [66]

Social Prescribing

Social prescribing or community referral involves enabling health professionals to refer people to local or community non-clinical services and encourage underserved and often isolated individuals to partake in various activities such as gardening, cooking, or sports. Of its many endeavours, it reduces feelings of loneliness and isolation that can arise from poor mental wellbeing and a breakdown of social supports which are critical to positive outcomes. It has a broader scope than community mental health services by focusing on the holistic needs of individuals. Those thought to benefit from this include people with mild or longer-term mental health conditions, those with complex needs, those who are more socially isolated or those who frequently attend primary or secondary health care services. [67] These individuals are also likely those who most benefit from the aforementioned mental health support structures and plans currently in place by the government.

As a mental health intervention, social prescribing not only improves the individual's sense of holistic wellness, but it also serves to reduce the burden on primary or secondary healthcare services. Hence, it contributes to reducing some of the burden on existing mental health support structures and the health system in general. [68] Although not formally implemented into Australia's healthcare funding, the Royal Australian College of General Practitioners (RACGP), among other organisations are looking to have become a more prominent aspect of primary and preventative patient care and thus it should be incorporated more explicitly into mental health support structures across Australia. [69] However, in order to successfully develop

and integrate social prescribing as a mental health support structure, a framework and plan is needed.

Autonomy in Mental Health Care

The importance of respecting and acknowledging a patient's autonomy extends beyond the basic human rights that are deserved to all individuals. Behaviour is only considered autonomous if it is self-initiated, and free from external constraints. [70] Patient decisions on their own healthcare management may oftentimes be dictated by their healthcare providers or family members. The principles of healthcare are heavily influenced by the traditional four pillars of biomedical ethics, first introduced by Beauchamp and Childress. These are the principles of non-maleficence, beneficence, justice, and autonomy. However, it is historically known, even in today's healthcare, that the patient's autonomy in mental health care is frequently neglected or ignored. [71] It goes without saying then that a strong mental health support system is necessitated by mental health care that respects the individual's autonomy. This means sharing the healthcare decision-making power with the patient and placing the final decision in the hands of the patient, regardless of whether the decision contradicts that of the healthcare professional. [72] In doing so, this protects the patient from unwanted or unnecessary intervention that may do more harm than good. [73] Appreciating the patient's role in contributing to the decision-making of their own care is related to a movement towards a patient-centred and shared decision-making model of healthcare. In combination, this implies the importance of acknowledging the patient's right to choose what services, and the types of services they choose to engage with as well. These models of healthcare, which places the patient's autonomy front and centre, are crucial in an effective mental health support system.

Patient-centred care is a framework that recruits the patient as a collaborative partner with the healthcare provider. [74] Healthcare decisions are made with the patient, rather than by the healthcare professional, for the patient. This ensures that the patient's own specific health needs and desired health outcomes are prioritised. More than that, it respects the preferences, values, cultural traditions, and socioeconomic conditions of the patient. [74] By focusing on the patient's needs and perceptions as an integral component of their own healthcare, this brings us away from a healthcare model that has been historically paternalistic and deficit-focused. [75] In one study, primary care physicians that engaged in patient-centred care were found to have patients experiencing better recovery, better emotional health, requiring fewer diagnostic tests, and fewer referrals. [76] Patient-centred care is also positively correlated with the patient's wellbeing, social wellbeing, and satisfaction with care. [77] This approach thus can be extended into psychiatric and mental health care to ensure the patient's needs are best met.

A closely related model is the shared decision-making model of healthcare which emphasises the patient's role in making decisions on their own healthcare, rather than leaving the impetus to the healthcare professional. [78] This encourages patients to understand their own health problems, the pros and cons of their healthcare options, but furthermore their goals and values. By fostering proactivity and autonomy, the patient's health literacy for biomedical and other health epistemologies improves. [79] Low health literacy has been found to increase comorbidity and reduce accessibility to healthcare. [80] Even worse is seen in elderly patients where low health literacy is associated with a nearly two-fold increase in mortality. [81] In short, the focus on a patient's autonomy extends much further into these models of care. They have far-reaching effects beyond human rights considerations alone, and hold the capacity to drastically improve the wellbeing and outcome of patients.

Australia's Mental Health System

Governance

Governance refers to the framework of institutions, systems, and processes which instruct a government on how they ought to manage an issue. Effective governance strives to meet three roles, as outlined by the Productivity Commission: [82]

1. Encouraging closer coordination and integration of services, and
2. Promoting public trust in decision making, and
3. Assisting governments to achieve the aims and actions to which they commit.

Federal, state and territory governments are jointly responsible for mental health policy and the provision of mental health-related services. [82] The Australian Government is responsible for national policies, regulation, funding, and delivery of primary care through Medicare, including the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Schedule (PBS). Meanwhile, state and territory governments play a key role in administering health services in public hospitals, community mental health services and ambulance services. States and territories are especially important in terms of promoting awareness of and preventing mental illness, as well as reducing stigma.

The National Mental Health Strategy directs mental health policy at a national level, with some ancillary direction from the National Disability Strategy. For a number of reasons, it is not fit for purpose. Firstly, the Strategy fails to outline how health and non-health sectors should collaborate in achieving whole-of-government mental health reform in Australia, despite declaring to do so in its vision statement. It lacks clarity about roles and responsibilities across all mental health-related services. The

Strategy is also not linked with funding commitments, representing a key reason why governments have failed to successfully implement past reforms. A variety of other national and regional policies have been designed and implemented with a view to improve population mental health. These include the Fifth National Mental Health and Suicide Prevention Plan, the National Mental Health Suicide Prevention Agreement, Vision 2030, National Mental Health Policy, the National Mental Health and Wellbeing Pandemic Response Plan, and the National Mental Health Workforce Strategy Taskforce. These plans lack clarity, cohesion, and accountability, resulting in significant gaps, duplication and fragmentation of responsibilities. A more strategic and cross-portfolio approach to mental health is required.

History of the Australian Mental Health Care Plan

The first National Mental Health Plan in Australia was established in 1993 - 1998, and involved a shift in services from stand alone psychiatric hospitals to community based services that are more accessible to the general public. The second plan (1998 - 2003) focused on the principles of mental health promotion, prevention and quality; a notable contribution to this was the marked increase of funding in these areas. The third National Mental Health Care Plan (2003 - 2008) focused on promotion and prevention, increasing service responsiveness, strengthening quality, and fostering research. The third plan lacked state incentives and accountability mechanisms, leaving it open to many flaws. [83]

With the second latest edition being the fourth National Mental Health Care Strategy, this plan identifies 5 priority areas including Social inclusion and recovery, Prevention and early intervention, Service access, Coordination and Continuity of care, Quality improvement and innovation and finally Accountability—measuring and reporting progress. [84] These five action areas made a solid foundation for the current strategy to build upon.

Changes in the Number of Covered Sessions

Since 2006, a 'Mental Health Treatment Plan' has been provided to those with a mental illness diagnosis to claim up to 10 individual and 10 group based sessions each calendar year. [85-86] It should be noted that the plan typically begins with 6 sessions to gauge the amount of assistance each individual needs. This plan pays the whole cost for bulk billing sessions and offers a rebate for private sessions. As a response to the COVID-19 pandemic and rise in mental healthcare needs, this plan was changed to support up to 20 sessions in one calendar year. Despite overwhelming support by many groups including the Australian Psychiatrist Society, this change was reverted by the Health Minister after they deemed that the program

was not serving all people equally and was benefiting some groups better than others, and with the shortage in the workforce that the additional sessions were increasing wait times. [87, 88] Frustratingly, the Melbourne University evaluation in which the Australian Government was basing these decisions on still recommended that the additional sessions be maintained on the basis of supporting those with more complex mental health needs. [89]

The Current Mental Health Care Plan and its Deficiencies

Australia's current approach to mental health care has been largely shaped by the COVID-19 pandemic with an increased awareness of the importance of mental health, primary prevention and early intervention in supporting individuals with their mental health and resilience. Since 2019, evaluations, inquiries and acts have been passed to challenge the current approach to various aspects of mental health. These included an evaluation of the Better Access initiative in 2022, the Productivity Commission Report on Mental Health in 2020 and South Australia's Suicide Prevention Act of 2021.

The Better Access scheme, enacted in 2006, is an initiative that aims to improve treatment and management of mental illness within the community through subsidised sessions with a mental health professional. [90] In 2022, an independent evaluation was undertaken that involved surveying front-line mental health workers such as general practitioners, clinical psychologists, social workers and occupational therapists. The main concerns raised were focused on affordability, wait times, and an inadequate number of subsidised sessions. The review found that in 2021, 47% of all Better Access services involved a co-payment by the consumer and the median co-payment was $74. [91] Due to this, those with the lowest incomes were the least likely to access services and were also faced with longer median wait times. [91] Access was further complicated by many Better Access providers being at capacity, with one in three being unable to see new consumers in 2022 which has increased from one in four in 2021, and one in one hundred before the pandemic. [91] Similarly, providers felt their compensation to be inadequate with scheduled fees reportedly not keeping pace with indexation and the cost of running a private practice. For group sessions in particular, many found it difficult to arrange and financially unviable. Over 50% of participating psychologists and occupational therapists also disagreed or strongly disagreed that the Better Access program enabled them to provide consumers with mental healthcare that is affordable, as did over 30% of social workers and over 25% of clinical psychologists. [91] Session numbers were another primary concern brought up by the review. Ten more individual sessions were subsidised as part of the scheme during the COVID-19 pandemic, but were terminated on the 31st of December 2022. Many providers and participants criticised this decision as well as the "one size fits all" approach to

the scheme. The review found that around half of the two thirds receiving care in a 2021 survey had attended or were more likely to attend more than ten sessions and additionally three quarters of participants felt that the additional ten sessions should be retained as a standard offering. [91] More frequent sessions may also be correlated with better client outcomes, with more clinically significant gains found in those attending once a week and more significant deterioration in those attending once a fortnight. [92] The frequency of treatment initially may also have an impact on longer term outcomes, particularly within the first three months for those with depression, anxiety or personality disorders, further highlighting the systemic inadequacy the 10 currently subsidised sessions provides for many individuals. [93]

Future Directions and Focuses

The Productivity Commission Report on Mental Health in 2020 covered all aspects of Australia's current mental health approach, from a government to an individual level. It included 24 recommendations on a wide variety of topics targeting underserved groups - for example the homeless, children, tertiary students and Aboriginal and Torres Strait Islander people, as well as advocating for more extensive and accessible support structures. This report led to the development of the National Suicide Prevention Act Legislation of 2021, the first of its kind at the national level. The Act aims to address the prevalence of and to reduce the incidence of suicide by establishing a prevention plan, a council, and guidelines to better implement training and education programs in addition to policies, campaigns and programs to assist in both primary prevention and early identification. [94] The act focuses on 5 pillars, these being prevention and early intervention, suicide prevention, treatment, support for the vulnerable and a focus on workforce and governance, thus highlighting key focus areas to which government funding can be directed. [95]

A Shortage In Healthcare Professionals

On the discussion of Australia's mental health system, it is imperative to briefly discuss the healthcare workforce shortage and more specifically in mental health care. While access to mental health support is already a difficult process wrought with barriers to access and long wait times, these deficiencies are in part caused by a workforce shortage. With increasing demands every year and supply not being met, approximately 2 in 3 Australian patients wait more than 12 weeks to receive any mental health care. [96] These wait times are in part due to the slow rate in new psychologists and mental health workers, as well as an increased need. While only 1 in 100 psychologists stated to not being able to take on new clients pre-pandemic, it is currently reported that now 1 in 3 psychologists are unable to take on any new clients. [96] The problem is further exacerbated in rural Australia as well. For every

100,000 people, there are 19 psychologists available in rural South Australia, compared to 589 psychologists in inner Perth. Across the nation, that measures up to nearly 90% of all psychiatrists working in the cities. [97] Nearly 30% of all Australians live in rural or remote environments, and yet there is both a drastically reduced quantity of support, and less accessible support for them. [98] Even though the prevalence of mental health illness in rural and remote Australia may be equal compared to regional and urban parts of Australia, rural and remote Australians experience much worse mental health outcomes. [98] As one metric, the suicide rate is double in remote Australia compared to major cities (9.4 per 100,000 persons to 18.1 per 100,000 persons). [99] With the mental healthcare system being stretched thin and patients experiencing longer wait times just for an appointment, considerations must be made immediately for strategies in increasing the number of psychiatric training programs and reducing the wait times and existing burden on the healthcare system.

Lack of Support for Healthcare Professionals

The endemicity of COVID-19 in Australia has foregrounded an issue that has been long-standing beyond the virus' initial outbreak: lacklustre mental health support for healthcare professionals. [100] The pandemic spotlighted the mental health needs of healthcare professionals as a public health concern and threat to quality healthcare delivery. [101] Within their work, healthcare professionals are exposed to multiple stressors, such as large patient volumes and insufficient resources, that negatively affect their physical, emotional, and mental well-being. [102,103] Given the relationship between poor mental health and risk of burnout, promotion of evidence-based interventions and support for healthcare professionals needs to occur proactively - a pertinent fact given the projected shortfall of 18 million healthcare professionals worldwide by 2030. [104]

To proactively address mental health stressors amongst healthcare professionals, such stressors must be recognised - many of which are unique to their profession. The notion of vicarious traumatisation has recently gained attention in the context of healthcare, whereby healthcare professionals develop traumatic stress secondary to the distressing stories and experiences of their patients. [105] Such stress can be augmented when considering innate trauma responses and interpersonal conflicts. [106] Studies have detailed syndromes associated with vicarious traumatisation, including loss of appetite, insomnia, irritability, and inattention; however, symptoms may remain subclinical, or healthcare professionals may feel conflicted to disclose mental health issues. [107]

This internalised conflict stems from the perceived stigma associated with healthcare professionals experiencing 'stress' and 'mental health problems', particularly in the context of medical licence withdrawal. [108] Without proactively challenging these stigmas and facilitating accessible mental health support, healthcare professionals fail to disclose mental health issues and seek help, leading to over-reliance on self-treatment, low peer support, and increased risk of suicide. [109]

During the COVID-19 pandemic, temporary appraisals and gifts for healthcare professionals became widely practised - this included free lunches/snacks, clapping and posters, and songs thanking "healthcare heroes". [100] Though acting as "short term mood boosters", studies indicate that these temporary acknowledgements can mask the serious health and mental well-being challenges healthcare professionals face. [110] Additionally, the repeated reference of healthcare professionals as "heroes" may act as a barrier for seeking mental health support: "heroes help others, they don't need help". [100]

Though these appraisals became most pertinent during the COVID-19 pandemic, it underscores the importance of investing in protective and preventive measures for healthcare professionals' mental health that is proactive, sustainable, and evidence-based. Irrespective of the presence of public health emergencies, healthcare professionals need adequate support systems that address the unique and multifaceted stressors of working in healthcare. [111]

Currently, there is an onus on healthcare professionals to recognise and manage their own stress, burnout, and/or depression, with few resources readily available to support this process. [100] Institution-provided stress management and mindfulness practice support have shown measurable efficacy in reducing stress/burnout and promoting resilience in healthcare professionals. [100,112] In addition, peer-to-peer support groups or professional support pathways can be established to facilitate debriefing following traumatising clinical experiences. [113] Peer support groups and professional support pathways help with overcoming barriers of receiving help and support by providing alternative and additional avenues of help. Hence, they work in conjunction with existing pathways. These professional support pathways can also allow healthcare professionals to express their needs and inspire change at an organisational level, such as through policy change and/or integration of self-care plans into workplace culture and practice. [114]

Breach in Human Rights and Autonomy

In the context of mental health, the right to autonomy refers to having the capacity and power to make decisions regarding one's own mental health care. Problematically, legislated substitute decision making and coercion into treatment for psychiatric patients takes away that right. [115] As stated by the WHO, it must be emphasised that this sets a precedent for patients to also lose their right to informed consent, confidentiality, and privacy. [115] Particularly in Australia, legislation for a treatment authority or treatment order can permit the treatment of a person with mental illness without their consent. Although there may be slightly differing processes of approving them, all treatment orders must meet certain criteria. The patient in which an authorised psychiatrist is applying the treatment authority for must be diagnosed with a mental illness, does not have capacity to consent, and if not treated, is a risk of harm to others, or is at risk of deterioration or harm to themselves. [116-119] The use of these treatment orders enable authorised psychiatrists and physicians to protect patients from imminent danger. However, the evidence for the efficacy of treatment orders is weak and inconsistent. [120] The selection criteria requiring the person to have been diagnosed with mental illness can also be interpreted as discriminatory, because it assumes that mental disorder is an implication for mental incapacity and lack of decision-making capacity. [121] Current legislation should update the criteria as a move towards capacity-based criteria. In one study, it was found that even among very mentally ill patients admitted to acute psychiatric wards, approximately 50% of patients retain mental decision-making capacity. [122] Using diagnosis of mental illness as a criteria causes systemic stereotyping and associates mental disorder with incapacity. Historically, the agency of patients with severe mental illness are typically already disregarded in their diagnosis and management. [97] A meta-analysis done in 2020 investigating schizophrenic and bipolar patients found that over 70% of them understood treatment options to the point of having capacity to make their own healthcare decisions. [70] Furthermore, a second look must be strongly considered regarding laws around treatment authority and orders.

An example of capacity-based treatment authorisations can be seen in Norway, which was implemented in 2017. Norway sets an example of how treatment orders can be used to protect patients but for many others, provide an avenue for patient-centred care for psychiatric patients that still present with the capacity for decision making. Their goal was to increase patient autonomy, legal protection, and to reduce the use of coercion into treatment. [123] As a result, patients reported feelings of greater autonomy, freedom, and respect. [124] It must also be noted that for the overwhelming majority of patients there were no changes in the treatment and care of the patients after the new change in legislation. The only difference being that the treatment was not coerced or involuntary, but rather agreed upon with the patient in

a shared-decision making model. Unsurprisingly, healthcare professionals were found to be much more likely to involve their patients in discussion and listen to their opinions with this change. [124] Patients reported to participate more actively in collaboration, offered their own opinion, and in general felt they were more respected. Lastly, patients reported that after years of having their medical decisions made for them, they became passive and detached from their own healthcare treatment. As discussed previously, a patient's lack of engagement in their own health problems and healthcare fosters low health literacy and worsens health outcomes in a number of departments.

Although the evidence in favour of capacity-based treatment authorisations are not plentiful, the human rights violations of treatment orders must be considered and brought into the spotlight. Current legislation also provides an avenue for misuse or systematic discrimination. One group investigating the rates of Australian and New Zealander community treatment orders (mandatory treatment for patients living in the social community) found that those from migrant backgrounds were 47% more likely to be on a treatment order. [96] They also found people that were "male, single, and not engaged in work, study, or home duties", were significantly more likely to be on a treatment order than any other demographic. Compared to low-usage, jurisdictions that had high usage of treatment orders were less likely to see a reduction in readmission rates. In conclusion, suggesting that treatment orders do not incur any greater benefit of recovery than other modes of healthcare management.

The Missing Middle - Service Gaps in Mental Health Care

In 2014, the Australian National Mental Health Commission identified a significant gap in the delivery of mental health care to individuals experiencing moderate mental illness. [125] These individuals, whilst requiring help beyond that which can be provided by a GP, don't yet qualify for treatment on a hospital level, nor should they. [125] Because those in this group find themselves in a service gap between two ends of the spectrum of mental health care, the "missing middle" has been frequently used to describe this group. Those considered within the missing middle include: those who aren't receiving services for their mental health needs, those who are accessing services but are underserved, those on long waiting lists, those who have exhausted affordable care provided by their mental health care plan, and those who fail to access care following the receipt of such a plan. [126] Initially, these gaps in care were attributed as being a consequence of incorrect funding incentives, which overfunded crisis treatment relative to care delivered prior to severe disorder onset. [125] Such asymmetric funding allows for cyclical treatment which neglects the ongoing needs of patients prior to, and following, hospitalisation. [127]

Furthermore, failure to sufficiently integrate mental health care into other healthcare platforms was identified as a contributing factor in need of correction. [128]

The burden arising from the absence of a comprehensive, accessible continuum of healthcare is distributed unequally amongst Australian populations. The 'Understanding the Missing Middle' report by the ACT Government found factors giving rise to a need for intersectional and culturally competent care to be significant predictors of an individual's inability to access middle mental healthcare. [126] This demonstrates that not only is funding of care for those experiencing moderate illness insufficient, but is consequently not specialised enough to cater to the needs of a diverse population in Australia. [129]

Reformed service models must be employed to ensure services which cater to and are tolerant of patients of variable backgrounds become accessible to those in need of them. [96] Although the Mental Health and Suicide Prevention Plan will make attempts to improve upon current models by decreasing wait times, and increasing provision of care to young people, this plan largely neglects the need of rural communities. [130] Additional funding of care which expands services in rural areas is pertinent as, for example, approximately ⅘ of the funding given to treatment under this plan will expand Early Psychosis Youth Services only in metropolitan areas. [130]

Additionally, Aboriginal and Torres Strait Islander communities remain particularly underserved in health promotion, disorder prevention, early intervention and treatment. Services which take into account Aboriginal and Torres Strait Islanders' understanding of mental, emotional, social, and behavioural wellbeing are underemployed. [98] Furthermore, practitioners remain insufficiently educated, thus leading to a shortage of workers who can provide culturally competent care. Moreover, underrepresentation of Aboriginal and Torres Strait Islander populations in health service workforces remains a barrier to addressing current practitioner-patient mistrust, a consequence of Australia's history of persecution of Aboriginal and Torres Strait Islander populations. [125] Therefore, health care models must be reformed to better include consideration of Aboriginal and Torres Strait Islander understandings as well as include Aboriginal and Torres Strait Islander populations in healthcare decisions, policies, and workforces. [131] Therefore, healthcare models ought to be reformed so that Aboriginal and Torres Strait Islander populations are better involved in healthcare decisions, policies and workforces, and their various perspectives and understandings regarding mental health receive greater consideration. [131]

The merits of increasing Aboriginal and Torres Strait Islanders' access to holistic and culturally determined care is evidenced by the outcomes of existing, although limited, programs such as the Youth Initiative Project. [132] Such programs, however, are frequently limited by a lack of funding or resources. [133] Thus, in addition to reforming care to further Aboriginal and Torres Strait Islander involvement in mental health care, successful programs which exist currently should be identified, reviewed as to direct future programs, and enabled to expand where possible. [132]

References

1. WHO. Mental health [Internet]. World Health Organization; 2022. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response
2. Lawrence D, Hancock KJ, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: Retrospective analysis of population based registers. BMJ. 2013 May 21;346. doi:10.1136/bmj.f2539
3. SNMMI. Mental disorders [Internet]. Society of Nuclear Medicine and Molecular Imaging; 2022. Available from: https://www.snmmi.org/Patients/Disease_Condition/Content.aspx?ItemNumber=13344
4. Australian Bureau of Statistics. National Study of Mental Health and Wellbeing [Internet]. Canberra: ABS; 2020-21. Available from: https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-21
5. AIHW. Mental health [Internet]. Canberra: AIHW; 2023. Available from: https://www.aihw.gov.au/mental-health/topic-areas/mental-illness
6. AIHW. Indigenous health and wellbeing [Internet]. Canberra: AIHW; 2023. Available from: https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing
7. AMA. Mental Health, Position Summary, Executive Statement [Internet]. Canberra; 2018. Available from: https://www.ama.com.au/sites/default/files/2023-01/Mental_Health_2018_Position_Statement.pdf
8. RACGP. Mental health care in general practice – Position statement [Internet]. Canberra; 2021. Available from: https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/mental-health-care-in-general-practice
9. AIHW. People with disability in Australia [Internet]. Canberra: AIHW; 2023. Available from: https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/health/health-status
10. Hill A, Bourne A, MnCair R, Carman M, Lyons A. Private Lives 3. Australian Research Centre in Sex, Health and Society; La Trobe University. 2021. Available from: https://www.latrobe.edu.au/arcshs/work/private-lives-3
11. Ayano G, Demelash S, Yohannes Z, Haile K, Tulu M, Assefa D, Tesfaye A, Haile K, Solomon M, Chaka A, Tsegay L. Misdiagnosis, detection rate, and associated factors of severe psychiatric disorders in specialized psychiatry centers in Ethiopia [Internet]. Ann Gen Psychiatry. 2021 Feb 02;20(1):10. Available from:

https://annals-general-psychiatry.biomedcentral.com/articles/10.1186/s12991-021-00333-7

12. Australian Psychological Society. New release: DSM-5 gets an update [Internet]. Melbourne, Australia: Australian Psychological Society (APS); 2022. Available from: https://psychology.org.au/for-members/publications/inpsych/2022/winter-2022/new-release-dsm-5-gets-an-update
13. Allsopp K, Read J, Corcoran R, Kinderman P. Heterogeneity in Psychiatric Diagnostic Classification. Psychiatry Research. 2019;279:15–22. doi:10.1016/j.psychres.2019.07.005
14. Hengartner MP, Lehmann SN. Why psychiatric research must abandon traditional diagnostic classification and adopt a fully dimensional scope: Two solutions to a persistent problem. Frontiers in Psychiatry. 2017;8. doi:10.3389/fpsyt.2017.00101
15. Arky B, Nash W, Epstein SF. Why Many Autistic Girls Are Overlooked [Internet]. United States of America: Child Mind Institute; 2023 Jun 16. Available from: https://childmind.org/article/autistic-girls-overlooked-undiagnosed-autism/
16. NS1. Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of Results [Internet]. Canberra: ABS; 2007. Available from: https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2007
17. Stuart H. Reducing the stigma of mental illness. Glob Ment Health (Camb). 2016;3:e17.
18. Angermeyer MC, Holzinger A, Carta MG, Schomerus G. Biogenetic explanations and public acceptance of mental illness: systematic review of population studies. Br J Psychiatry. 2011;199(5):367-72.
19. Gender Equality Commission. Applying Intersectionality; 2023 [internet]. Available from https://www.genderequalitycommission.vic.gov.au/applying-intersectionality/print-all
20. O'Connell ME, Boat T, and Warner KE, Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth and Young Adults: Research Advances and Promising Interventions, National Research Council. Preventing Mental, Emotional and Behaviour Disorders Among Young People: Progress and Possibilities [Internet]. 1 Edition. Washington (DC): The National Academies Press; 2009. Chapter [3], Defining the Scope of Prevention. Available from: https://www.ncbi.nlm.nih.gov/books/NBK32775/
21. Gordon RS. An Operational Classification of Disease Prevention. Public Health Rep. 1983;98(2):107-109
22. Interagency Working Group of Youth Programs. Mental Health Promotion and Prevention; 2023 [internet]. Available from: https://youth.gov/youth-topics/youth-mental-health/mental-health-promotion-prevention#_ftn

23. ACAMH. Genetics research informing mental health care [Internet]. London; The Bridge. 2021. DOI: 10.13056/acamh.17446
24. Parliament of Australia. Chapter 7 - Promotion, prevention and early intervention; 2023 [internet]. Available from: https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/c07
25. Mortimer A, Brown T. Early intervention in psychosis: another triumph of hope over experience?: Early intervention in psychosis. Prog Neurol Psychiatry. 2015 May;19(3):10–4.
26. Saunders KR, McGuinness E, Barnett P, Foye U, Sears J, Carlisle S, et al. A scoping review of trauma informed approaches in acute, crisis, emergency, and residential mental health care. BMC Psychiatry. 2023;23(1). doi:10.1186/s12888-023-05016-z
27. Center for Substance Abuse Treatment. Trauma-Informed Care in Behavioral Health Services. Rockville: Substance Abuse and Mental Health Services Administration US; 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 1, Trauma-Informed Care: A Sociocultural Perspective. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207195/
28. Huang LN, Flatow R, Biggs T, Afayee S, Smith K, Clark T. SAMHSA's Concept of Truama and Guidance for a Trauma-Informed Approach. 2014.
29. Sweeney A, Taggart D. Misunderstanding trauma-informed approaches in mental health. Taylor & Francis; 2018. pp. 383–7.
30. Wilson, A., Hutchinson, M. and Hurley, J. (2017), Literature review of trauma-informed care: Implications for mental health nurses working in acute inpatient settings in Australia. Int J Mental Health Nurs, 26: 326-343. https://doi.org/10.1111/inm.12344
31. Cheetham A, Arunogiri S, Lubman D. Integrated care – panacea or white elephant? A review of integrated care approaches in Australia over the past two decades. Advances in Dual Diagnosis. 2023;16(1):3-16. Available from: https://www.emerald.com/insight/content/doi/10.1108/ADD-10-2022-0026 doi: 10.1108/ADD-10-2022-0026
32. Dunlop R, Pols H. Deinstitutionalisation and mental health activism in Australia: emerging voices of individuals with lived experience of severe mental distress, 1975–1985. History Australia. 2022;19(1):92-114. Available from: https://www.tandfonline.com/doi/full/10.1080/14490854.2022.2028559 doi: 10.1080/14490854.2022.2028559
33. O'Donnell R, Savaglio M, Vicary D, Skouteris H. Effect of community mental health care programs in Australia: a systematic review. Australian Journal of Primary Health. 2020;26(6):443-51. Available from: https://www.proquest.com/docview/2472002647 doi: 10.1071/PY20147

34. Searby A, Burr D, James R, Maude P. Service integration: The perspective of Australian alcohol and other drug (AOD) nurses. International Journal of Mental Health Nursing. 2022 Aug;31(4):908-19. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/inm.12998 doi: 10.1111/inm.12998
35. Nash L, Isobel S, Thomas M, Nguyen T, van der Pol R. Clinician stakeholder experiences of a new youth mental health model in Australia: A qualitative study. Early Intervention in Psychiatry. 2021 Dec;15(6):1637–43. Available from: https://onlinelibrary.wiley.com/doi/10.1111/eip.13104 doi: 10.1111/eip.13104
36. Beere D, Page IS, Diminic S, Harris M. A mixed methods evaluation of an integrated adult mental health service model. BMC Health Services Research. 2019;19:691. Available from: https://www.proquest.com/docview/2305798752 doi: 10.1186/s12913-019-4501-7
37. Long JC, Ruane C, Ellis LA, Lake R, Roux AL, Testa L, Shand F, Torok M, Zurynski Y. Networks to strengthen community social capital for suicide prevention in regional Australia: the LifeSpan suicide prevention initiative. International Journal of Mental Health Systems. 2022;16:10. Available from: https://www.proquest.com/docview/2630510795 doi: 10.1186/s13033-022-00524-z
38. Fitzpatrick SJ, Perkins D, Handley T, Brown D, Luland T, Corvan E. Coordinating mental and physical health care in rural Australia: an integrated model for primary care settings. International Journal of Integrated Care. 2018 Apr-Jun;18(2):19. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6095085 doi: 10.5334/ijic.3943
39. Somerville L, Davis A, Elliott AL, Terrill D, Austin N, Philip K. Building allied health workforce capacity: a strategic approach to workforce innovation. Australian Health Review. 2015;39(3):264-70. Available from: https://www.proquest.com/docview/1716904603 doi: 10.1071/AH14211
40. Petrie K, Baldwin P, Crawford J, Harvey SB. The voice of mental health practice in Australia: a mixed-method cross-sectional study of gaps and areas of need. Australian and New Zealand Journal of Public Health. 2021 Aug;45(4):318-24. Available from: https://www.proquest.com/docview/2557874403 doi: 10.1111/1753-6405.13078
41. Leet A, Dennis S, Muller J, Walsh S, Bowen-Salter H, Kernot J. Demonstrating the processes and outcomes of a rural Community Mental Health Rehabilitation Service: a realist evaluation. PLoS One 2021 Nov;16(11):e0260250. Available from:

https://www.proquest.com/docview/2601449326 doi: 10.1371/journal.pone.0260250

42. Happell B, Platania-Phung C, Watkins A, Scholz B, Curtis J, Goss J, Niyonsenga T, Stanton R. Developing an evidence-based specialist nursing role to improve the physical health care of people with mental illness. Issues in Mental Health Nursing. 2019;40(10):832-38. Available from: https://www.tandfonline.com/doi/abs/10.1080/01612840.2019.1584655 doi: 10.1080/01612840.2019.1584655
43. Gulliver A, Morse AR, Banfield M. Cancer survivors' experiences of navigating the Australian health care system for physical and mental health care needs. International Journal of Environmental Research and Public Health. 2023;20(5):3988. Available from: https://www.proquest.com/docview/2785195837 doi: 10.3390/ijerph20053988
44. Teychenne, M, Apostolopoulos, M, France-Ratcliffe, M, Chua, E, Hall, S, Opie, RS, Blunden S, Duncan MJ, Olander EK, Koorts H. Factors relating to sustainability and scalability of the 'Food, Move, Sleep (FOMOS) for Postnatal Mental Health' program: qualitative perspectives from key stakeholders across Australia. Health Promotion Journal of Australia. 2023. Available from: https://onlinelibrary.wiley.com/doi/full/10.1002/hpja.767 doi: 10.1002/hpja.767
45. Perera RH, Rogers SL, Edwards S, Hudman P, Malone C. Determinants of transition from child and adolescent to adult mental health services: a Western Australian pilot study. Australian Psychologist. 2017;52(3):184-90. Available from: https://www.tandfonline.com/doi/full/10.1111/ap.12192 doi: 10.1111/ap.12192
46. Paton K, Hiscock H. Strengthening care for children with complex mental health conditions: views of Australian clinicians. PLoS One. 2019 Apr;14(4):e0214821. Available from: https://www.proquest.com/docview/2202611463 doi: 10.1371/journal.pone.0214821
47. Safety and Quality Partnership Standing Committee. National practice standards for the mental health workforce 2013 [Internet]. Melbourne (AU): Victorian Government Department of Health; 2013 Nov. 34 p. Available from: https://www.health.gov.au/sites/default/files/documents/2021/04/national-practice-standards-for-the-mental-health-workforce-2013.pdf
48. Scholz B, Battams S, Platania-Phung C, Happell B. Transitioning from adolescent to adult mental health services: an integrative literature review. Issues in Mental Health Nursing. 2019;40(2):97-111. Available from: https://www.tandfonline.com/doi/full/10.1080/01612840.2018.1524534 doi: 10.1080/01612840.2018.1524534

49. Henderson J, Javanparast S, Baum F, Freeman T, Fuller J, Ziersch A, Mackean T. Interagency collaboration in primary mental health care: lessons from the Partners in Recovery program. International Journal of Mental Health Systems. 2019;13:37. Available from: https://www.proquest.com/docview/2242984406 doi: 10.1186/s13033-019-0297-4
50. Healthdirect Australia. Australian mental health services [Internet]. Australia: Healthdirect Australia; Available from: https://www.healthdirect.gov.au/australian-mental-health-services
51. Healthdirect Australia. Mental health where to get help [Internet]. Australia: Healthdirect Australia; Available from: https://www.healthdirect.gov.au/mental-health-where-to-get-help
52. Australian Government Department of Health and Aged Care. Better Access initiative [Internet]. Canberra: Commonwealth of Australia. Available from: https://www.health.gov.au/our-work/better-access-initiative
53. Australian Government Department of Health and Aged Care. What we're doing about suicide prevention [Internet]. Canberra: Commonwealth of Australia. Available from: https://www.health.gov.au/topics/mental-health-and-suicide-prevention/what-were-doing-about-suicide-prevention
54. Australian Government. Strengthening Medicare Taskforce Report [Internet]. Canberra: Australian Government; 2022 Dec. Available from: https://www.health.gov.au/sites/default/files/2023-02/strengthening-medicare-taskforce-report_0.pdf
55. Lawn S, Lloyd A, King A, Sweet L, Gum L. Integration of primary health services: being put together does not mean they will work together. BMC Research Notes. 2014;7:66. Available from: https://www.proquest.com/docview/1496024670 doi: 10.1186/1756-0500-7-66
56. McCalman JR, Fagan R, McDonald T, Jose S, Neal P, Blignault I, Askew D, Cadet-James Y. The availability, appropriateness, and integration of services to promote Indigenous Australian Youth wellbeing and mental health: Indigenous Youth and service provider perspectives. International Journal of Environmental Research and Public Health. 2023;20(1):375. Available from: https://www.proquest.com/docview/2761186026 doi: 10.3390/ijerph20010375
57. AIHW. Community Services - Mental Health [Internet]. Available from: https://www.aihw.gov.au/mental-health/topic-areas/community-services
58. NSWMHC. How to find mental health support [Internet]. New South Wales Mental Health Commission; 2023. Available from: https://www.nswmentalhealthcommission.com.au/how/how-find-mental-health-support

59. Neami National [Internet]. Available from: https://www.neaminational.org.au/find-services
60. Flourish Australia. Find flourish australia services near you [Internet]. Available from: https://www.flourishaustralia.org.au/find-service
61. NRHA. Mental Health Factsheet, July 2021 [Internet]. 2021. Available from: https://www.ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-july2021.pdf
62. CRRMH. RAHMP Outcome Report [Internet]. Available from: https://www.crrmh.com.au/content/uploads/sites/3/RAMHP-Outcome-Report-2016-2020_FINAL.pdf
63. ACON. Annual Report 2021-2022 [Internet]. Available from: https://www.acon.org.au/wp-content/uploads/2022/10/Annual-Report-2021-2022_final.pdf
64. Black Dog Institute. TEN - The essential network for health professionals [Internet]. 2023. Available from: https://www.blackdoginstitute.org.au/the-essential-network/
65. Musgrove E, Bil D, Bridson T, McDermott B. Australian healthcare workers experiences of peer support during COVID-19: Hand-N-hand peer support. Australasian Psychiatry. 2022;30(6):722–7. doi:10.1177/10398562221128214
66. Lancaster J, Prager S, Nash L, Karageorge A. Psychiatry peer review groups in Australia: A mixed-methods exploration of structure and function. BMJ Open. 2020;10(11). doi:10.1136/bmjopen-2020-040039
67. Ewbank DB. What is Social Prescribing? [Internet]. 2020. Available from: https://www.kingsfund.org.uk/publications/social-prescribing
68. Polley, M., Bertotti, M., Kimberlee, R., Pilkington, K., & Refsum, C. (2017). A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications.
69. RACGP. Social prescribing report and recommendation [Internet]. Royal Australian College of General Practitioners; 2023. Available from: https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Advocacy/Social-prescribing-report-and-recommendation.pdf
70. Pons EV, Salvador-Carulla L, Calcedo-Barba A, Paz S, Messer T, Pacciardi B, et al. The capacity of schizophrenia and bipolar disorder individuals to make autonomous decisions about pharmacological treatments for their illness in real life: A scoping review. Health Science Reports. 2020;3(3):e179.
71. Bergamin J, Luigjes J, Kiverstein J, Bockting CL, Denys D. Defining Autonomy in Psychiatry. Front Psychiatry. 2022;13:801415.
72. Beauchamp TL, Childress JF. Principles of biomedical ethics: Oxford University Press, USA; 2001.

73. Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49(9):796-804.
74. What Is Patient-Centered Care? Catalyst Carryover. 2017;3(1).
75. Fix GM, VanDeusen Lukas C, Bolton RE, Hill JN, Mueller N, LaVela SL, et al. Patient-centred care is a way of doing things: How healthcare employees conceptualize patient-centred care. Health Expect. 2018;21(1):300-7.
76. Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49(9):796-804.
77. Kuipers SJ, Cramm JM, Nieboer AP. The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. BMC Health Services Research. 2019;19(1):13.
78. Ubel PA, Scherr KA, Fagerlin A. Autonomy: What's Shared Decision Making Have to Do With It? Am J Bioeth. 2018;18(2):W11-w2.
79. Barello S, Palamenghi L, Graffigna G. The Mediating Role of the Patient Health Engagement Model on the Relationship Between Patient Perceived Autonomy Supportive Healthcare Climate and Health Literacy Skills. International Journal of Environmental Research and Public Health. 2020;17(5):1741.
80. Sudore RL, Mehta KM, Simonsick EM, Harris TB, Newman AB, Satterfield S, et al. Limited Literacy in Older People and Disparities in Health and Healthcare Access. Journal of the American Geriatrics Society. 2006;54(5):770-6.
81. Sudore RL, Yaffe K, Satterfield S, Harris TB, Mehta KM, Simonsick EM, et al. Limited literacy and mortality in the elderly: the health, aging, and body composition study. J Gen Intern Med. 2006;21(8):806-12.
82. Productivity Commission 2020. Mental Health Report no. 95. Canberra.
83. Rosen A. Australia's national mental health strategy in historical perspective: beyond the frontier. Int Psychiatry. 2006 Oct 1;3(4):19-21. PMID: 31507866; PMCID: PMC6734702.
84. Australian Health. The Fourth National Mental Health Plan Measurement Strategy 2011. 2011;5. Canberra.
85. Jacques O. After being expanded during COVID, Medicare's popular program may soon be cut back [Internet]. ABC News; 2022. Available from: https://www.abc.net.au/news/2022-10-19/mental-health-plan-subsidy-medicare-changes/101524290
86. Services Australia. Mental health care and Medicare. 2023. Canberra.
87. Department of Health and Aged Care. Mental Health Treatment Plan. 2023. Canberra.
88. Butler J. Experts decry labor's "appalling" plan cut to number of Medicare psychologist sessions [Internet]. Guardian News and Media; 2022. Available

from: https://www.theguardian.com/australia-news/2022/dec/14/experts-decry-labors-appalling-plan-cut-to-number-of-medicare-psychologist-sessions
89. Visentin L. Mental Health Australia chair blasts government on Medicare session cuts. Sydney Morning Herald. 2022 Dec 30;
90. Better Access Initiative - Supporting Mental Health Care [Internet].. Available from: https://www.servicesaustralia.gov.au/better-access-initiative-supporting-mental-health-care?context=20
91. Australian Government. Evaluation of the Better Access Initiative. 2022(12). [Internet]. Available from: https://www.health.gov.au/sites/default/files/2022-12/executive-summary-evaluation-of-the-better-access-initiative.pdf
92. Erekson DM, Lambert MJ, Eggett DL. The relationship between session frequency and psychotherapy outcome in a naturalistic setting. Journal of Consulting and Clinical Psychology. 2015;83(6):1097–107. doi:10.1037/a0039774
93. Tiemens B, Kloos M, Spijker J, Ingenhoven T, Kampman M, Hendriks G-J. Lower versus higher frequency of sessions in starting outpatient mental health care and the risk of a chronic course; a naturalistic cohort study - BMC psychiatry [Internet]. BioMed Central; 2019. Available from: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-019-2214-4
94. South Australian Legislation. LZ [Internet]. South Australian Legislation; 2021. Available from: https://www.legislation.sa.gov.au/lz?path=%2FC%2FA%2FSUICIDE+PREVENTION+ACT+2021
95. Australian Government. National Mental Health and Suicide Prevention Plan. [Internet]. Available from: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf
96. Bleack new figures confirm depth of mental health crisis [press release]. Australian Psychological Society, June 20 2022. Available from: Bleak new figures confirm depth of mental health crisis | APS (psychology.org.au)
97. Darmawan W, Harding C, Coleman M, Samuels A. Rural workforce challenges: Why not rural psychiatry? Australas Psychiatry. 2023;31(1):8-12.
98. Gardiner FW, de Graaff B, Bishop L, Campbell JA, Mealing S, Coleman M. Mental Health Crises in Rural and Remote Australia: An Assessment of Direct Medical Costs of Air Medical Retrievals and the Implications for the Societal Burden. Air Med J. 2020;39(5):343-50.
99. Henley G, Harrison JE. Suicide and hospitalised self-harm in Australia: trends and analysis. 2014, [internet]. Available from: Suicide and hospitalised self-

harm in Australia: trends and analysis, Summary - Australian Institute of Health and Welfare (aihw.gov.au)

100. Søvold LE, Naslund JA, Kousoulis AA, Saxena S, Qoronfleh MW, Grobler C, Münter L. Prioritizing the Mental Health and Well-Being of Healthcare Workers: An Urgent Global Public Health Priority. Front. Public Health [Internet]. 2021 May 07;7(9):679397. Available from: https://doi.org/10.3389/fpubh.2021.679397
101. Khanal P, Devkota N, Dahal M, Paudel K, Joshi D. Mental health impacts among health workers during COVID-19 in a low resource setting: a cross-sectional survey from Nepal. Global Health [Internet]. 2020 Sep 25;16(1):89. Available from: https://doi.org/10.1186/s12992-020-00621-z
102. Rink LC, Oyesanya TO, Adair KC, Humphreys JC, Silva SG, Sexton JB. Stressors Among Healthcare Workers: A Summative Content Analysis. Glob Qual Nurs Res [Internet]. 2023 Mar 30;10(1). Available from: https://doi.org/10.1177/23333936231161127
103. Hannemann J, Abdalrahman A, Erim Y, Morawa E, Jerg-Bretzke L, Beschoner P, Geiser F, Hiebel N, Weidner K, Steudte-Schmiedgen S, Albus C. The impact of the COVID-19 pandemic on the mental health of medical staff considering the interplay of pandemic burden and psychosocial resources—A rapid systematic review. PloS One [Internet]. 2022 Feb 22;17(2):e0264290. Available from: https://doi.org/10.1371/journal.pone.0264290
104. World Health Organisation (WHO). Working for health and growth: investing in the health workforce - High-Level Commission on Health Employment and Economic Growth [Internet]. Geneva (Switzerland): World Health Organisation; 2016. 74 p. Available from: https://www.who.int/publications/i/item/9789241511308
105. Kim J, Chesworth B, Franchino-Olsen H, Macy RJ. A Scoping Review of Vicarious Trauma Interventions for Service Providers Working With People Who Have Experienced Traumatic Events. Trauma Violence Abuse [Internet]. 2022 Dec;23(5):1437-1460. Available from: https://doi.org/10.1177/1524838021991310
106. Sabin-Farrell R, Turpin G. Vicarious traumatization: implications for the mental health of health workers?. Clin Psychol Rev [Internet]. 2003 May;23(5):449-480. Available from: https://doi.org/10.1016/s0272-7358(03)00030-8
107. Li Z, Ge J, Yang M, Feng J, Qiao M, Jiang R, Bi J, Zhan G, Xu X, Wong L, Zhou Q, Zhou C, Pan Y, Liu S, Zhang H, Yang J, Zhu B, Hu Y, Hashimoto K, Jia Y, Wang H, Wang R, Liu C, Yang C. Vicarious traumatization in the general public, members, and non-members of medical teams aiding in COVID-19 control. Brain Behav Immun [Internet]. 2020 Aug;88(1):916-919. Available from: https://doi.org/10.1016/j.bbi.2020.03.007

108. Mehta SS, Edwards ML. Suffering in Silence: Mental Health Stigma and Physicians' Licensing Fears. Am J Psychiatry [Internet]. 2018 Nov 01;13(11):2-4. Available from: https://doi.org/10.1176/appi.ajp-rj.2018.131101
109. Knaak S, Mantler E, Szeto A. Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Healthc Manage Forum [Internet]. 2017 Mar;30(2):111-116. Available from: https://doi.org/10.1177/0840470416679413
110. Wood H, Skeggs B. Clap for carers? From care gratitude to care justice. Eur J Cult Stud [Internet]. 2020;23(4):641-647. Available from: https://doi.org/10.1177/136754942092836
111. Mahmoud NN, Rothenberger D. From Burnout to Well-Being: A Focus on Resilience. Clin Colon Rectal Surg [Internet]. 2019 Nov;32(6):415-423. Available from: https://doi.org/10.1055/s-0039-1692710
112. Goodman MJ, Schorling JB. A Mindfulness Course Decreases Burnout and Improves Well-Being among Healthcare Providers. The International Journal of Psychiatry in Medicine [Internet]. 2012 Jun 15;43(2):119-128. Available from: https://doi.org/10.2190/PM.43.2.b
113. Greenberg N, Docherty M, Gnanapragasam S, Wessely S. Managing mental health challenges faced by healthcare workers during covid-19 pandemic. BMJ [Internet]. 2020 Mar 26;368(1):m1211. Available from: https://doi.org/10.1136/bmj.m1211
114. Wiskow C, Albreht T, De Pietro C. How to Create an Attractive and Supportive Working Environment for Health Professionals [Internet]. Geneva (Switzerland): World Health Organisation; 2010 Jan. 36 p. Available from: https://apps.who.int/iris/handle/10665/332034
115. Autonomy in health decision-making - a key to recovery in mental health care: World Health Organization; 2022 [internet]. Available from: https://www.who.int/news-room/feature-stories/detail/autonomy-was-the-key-to-my-recovery#:~:text=Being%20able%20to%20make%20decisions,to%20choose%20one's%20own%20mental.
116. Mental Health Act 2016: Queensland Health; 2016 [internet]. Available from: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/about.
117. NSW Government. Mental Health Act 2007 [Internet]. 2007. Available from: https://legislation.nsw.gov.au/view/html/inforce/current/act-2007-008.
118. Victorian Legal Aid. Compulsory treatment orders [Internet]. Available from: https://www.legalaid.vic.gov.au/compulsory-treatment-orders#treatment-criteria.
119. Government of Western Australia. Inpatient treatment orders: Mental Health Commission [Internet]. 2017. Available from:

https://www.mhc.wa.gov.au/media/1412/inpatient_treatment_orders-2017.pdf.
120. Newton-Howes G, Ryan CJ. The use of community treatment orders in competent patients is not justified. The British Journal of Psychiatry. 2017;210(5):311-2.
121. Szmukler G, Kelly BD. We should replace conventional mental health law with capacity-based law. The British Journal of Psychiatry. 2016;209(6):449-53.
122. Okai D, Owen G, McGuire H, Singh S, Churchill R, Hotopf M. Mental capacity in psychiatric patients: Systematic review. Br J Psychiatry. 2007;191:291-7.
123. Wergeland NC, Fause Å, Weber AK, Fause ABO, Riley H. Health professionals' experience of treatment of patients whose community treatment order was revoked under new capacity-based mental health legislation in Norway: qualitative study. BJPsych Open. 2022;8(6):e183.
124. Wergeland NC, Fause Å, Weber AK, Fause ABO, Riley H. Increased autonomy with capacity-based mental health legislation in Norway: a qualitative study of patient experiences of having come off a community treatment order. BMC Health Services Research. 2022;22(1):454.
125. National Mental Health Commission. Report of the National Review of Mental Health Programmes and Services Summary [Internet]. 2014. Available from: https://www.mentalhealthcommission.gov.au/getmedia/6b8143f9-3841-47a9-8941-3a3cdf4d7c26/Monitoring/Contributing-Lives-Thriving-Communities-Summary.PDF
126. The Office for Mental Health and Wellbeing. Final Report: Understanding the 'Missing Middle': Children and young people with moderate to severe mental health concerns who experience difficulties accessing services [Internet] Canberra; OMHW; 2022. Available from: https://www.health.act.gov.au/sites/default/files/2022-09/Understanding%20the%20Missing%20Middle%20Report.pdf
127. Orygen. Defining the Missing Middle. 2023 [Internet]. Available from: https://www.orygen.org.au/Orygen-Institute/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/Defining-the-missing-middle
128. Patel V, Belkin GS, Chockalingam A, Cooper J, Sezena S, Unützer J. Grand Challenges: Integrating Mental Health Services into Priority Health Care Platforms. PLoS Med. 2013; 10(5)
129. Queensland Family and Child Commission. Non-systemic barriers to young people's use of mental health services [Internet] Queensland (AU); QFCC; 2023. Available from https://www.qfcc.qld.gov.au/sites/default/files/2023-02/QFCC%20Mental%20Health%20Advocacy%20Paper%20Non-

Systemic%20barriers%20to%20young%20peoples%20use%20of%20mental%20health%20services.pdf
130. Department of Health and Aged Care. Prevention Compassion Care: National Mental Health and Suicde Prevention Plan. [Internet] Canberra (AU); Commonwealth of Australia; 2021. Available from: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf
131. Australian Institute of Health and Welfare. Access to Mental Health Services. 2023 [Internet]. Available from: https://www.indigenoushpf.gov.au/measures/3-10-access-mental-health-services#:~:text=Other%20barriers%20to%20accessing%20mental,and%20effective%20diagnosis%20
132. McKendrick J, Brooks R, Hudson J, Thorpe M, Bennett P. Aboriginal and Torres Strait Islander Healing Programs. A Literature Review. HealingFoundation. 2013. Available from: https://healingfoundation.org.au/app/uploads/2017/02/Aboriginal-and-Torres-Strait-Islander-Healing-Programs-A-Literature-Review.pdf
133. Dudgeon P, Walker P, Scrine C, Shepherd C, Calma T, Ring I. Closing the Gap Clearinghouse - Effective strategies to strengthen the mental health and wellbeing of Aboriginal and Torres Strait Islander people [Internet]. AIHW;12. 2014. Available from: https://www.aihw.gov.au/getmedia/6d50a4d2-d4da-4c53-8aeb-9ec22b856dc5/ctgc-ip12-4nov2014.pdf?v=20230605181212&inline=true

Policy Details:

Name: Mental Health Support Structures (2023)

Category: Category F – Public Health in Australia

History: Reviewed and Adopted in Council 3, 2023

David Tran, Jared Evans, Samantha Stanford, Brooke Joyce, Natalie Silderberg, and Aleksandra Yates; with Jonathon Bolton (National Policy Mentor), Harry Luu (National Policy Secretary), and Connor Ryan (National Policy Officer).

Adopted Council 3, 2019

Suraj Hari (Co-Lead Author), Mikaela Dunn (Co-Lead Author), Melina Sim, Anna Li, Afreen Feroze Akbany, Jacquie Bredhauer, Jasveen Kaur, Shireen Pandher, Travis Lines (Global Health Policy Officer).