THE SOCIAL AND ECONOMIC BENEFITS OF IMPROVING MENTAL HEALTH

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of over 275,000 nurses, midwives, and carers[1] across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/ life balance. Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

There are 22,123 nurses working in the mental health sector across Australia.[2] Mental health nurses work in range of environments including public and private hospitals, community clinics from large metropolitan services to regional, rural and remote communities, early family centres and schools, prisons and other justice settings, alcohol and other drug services, and primary health care organisations.

The ANMF welcomes the opportunity to make a submission to the Productivity Commission's (the Commission) inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth.

Our submission makes three primary points:

- That it is vital to support and improve the mental health and wellbeing of the general population via a comprehensive, integrated approach addressing the complex and interlinked nature of general health and wellbeing, mental health, and the social and cultural determinants of health and mental health.

- Mental Health Nurses have the expertise and qualifications to make a real difference to people's recovery journey. Implementation of successful nurse-led programs and associated interventions such as Mental Health Nurse Incentive Program (MHNIP), Nurse Practitioner models and enhanced Maternal Child Health Nurse (MCHN) approaches is essential. These models have been positively evaluated with findings demonstrating that in relation to MHNIP, mental health nurses provided cost effective community-based health care which improved overall mental health and social functioning for people,

decreased Health of the Nation Outcome Scales (HoNOS) scores, reduced hospital admissions and for some people, increased in employment when engaging with a mental health nurse.

- That supporting and improving the mental health and wellbeing of the general population is underpinned by ensuring that the health and mental health workforce that provides care for the community and individuals within it are themselves supported and enabled to be mentally healthy.

Mental health, nursing and midwifery in Australia

It is expected that the total economic costs associated with mental illness will increase six-fold over the next 30 years with costs likely to exceed A$2.8 trillion (based on 2015 Australian dollars).[3] The Australian Government must recognise that beyond mental health and suicide prevention being a national priority, that federal, state and territory, and local government collaboration and action is required to address chronic underfunding of evidenced-based mental health nurse and other initiatives, as well as recognition of the social determinants of health.

Improved access to evidenced based nursing services is essential if there is going to be a decrease in the financial burden identified above. There are many examples of cost-effective nursing care that are only funded for a short time and then disappear from our communities. For example, the previous Commonwealth funded mental health nurse incentive program, where people with a severe and persistent mental illness (and their GPs and families) had an opportunity to engage with experienced mental health nurses or the National Perinatal Depression Initiative that was highly successful at building skills amongst midwives who were working with families. Both were evaluated, results demonstrated they were effective and efficient and did make a positive difference, however, they were not maintained by the Federal Government. Instead, funds for these initiatives were redirected to Primary Health Networks whereby there is no requirement to continue to employ nurses or midwives for the community to access.

Mental health and suicide prevention are not discrete issues, but link to a broad range of factors including housing, education, social services, racism, and discrimination. The ANMF is therefore pleased to note the Commissions' broad ranging scope for the present inquiry and special focus on homelessness, social services, education, and workplaces. The ANMF is keen to draw the commission's attention to the additional challenges faced by members of socially and economically marginalised groups including: Aboriginal and Torres Strait Islander people; gender and sexually diverse people; people living in regional, rural, and remote areas; the homeless; older people; refugees/asylum seekers; and culturally and linguistically diverse people.

To improve mental health and suicide prevention in Australia, a cross-portfolio approach must be taken to ensure that social determinants of health linked with mental health and suicide are recognised and prioritised,

inclusive of adequate funding for mental health promotion, prevention, and effective mental health nursing interventions, especially for groups at particular risk.

Greater data collection, linkage, and coordination are also required to improve access to, and delivery of, high-quality mental health and suicide prevention services, when and where they are needed. This means that a national system should be funded and established to support the collection, analysis, and use of mental health and suicide evidence to enable improved preventive and well-being focussed interventions.

As the Commission recognises, Australian governments, employers, and other organisations devote significant resources to promoting the best possible mental health and wellbeing outcomes for community members. This includes the delivery of a range of health and social services and work within the general community with people affected by poor mental health, as well as the at-risk community.

Across health and social services and sectors, nurses, midwives, and carers make up the largest proportion of healthcare staff, and so are responsible for most of the care and support provided to consumers of mental health services. As of 2017, there were 323,122 registered and employed nurses and midwives across Australia.[4]

All health, maternity, and aged care has an inherent mental health component. The nursing and midwifery workforce play a central part in providing high quality, holistic, and accessible mental health care to individuals in need; from women as they prepare for the birth of their baby, to older Australians during end of life care. For example, at a large hospital in Victoria, the data regarding implementation of the Perinatal Emotional Health Program (PEHP) found an average reduction in length of stay within maternity services of 1.7 days; calculated a saving of $2635 per patient per stay or $806,310 p.a. based on 306 admissions in 2014.[5] All nurses and midwives provide a degree of mental health care as part of their roles, such as early identification of mental health risks or issues and the need for further support or follow up, with many mental health nurses also possessing post-graduate mental health specialist qualifications.

The provision of quality health, maternity, and aged care involves a holistic approach to the needs of the individual which incorporates their mental, psychological, environmental, cultural, spiritual, and physical health and well-being.[6] Beyond providing care for people affected by mental health issues, nurses and midwives also occupy a vital role in mental health and wellbeing promotion, ensuring that the wider population, including those at risk of mental ill health, are supported in the community and institutions such as schools, universities, aged care facilities and justice facilities.

Other specific issues that need to be addressed to improve the care of people experiencing mental ill health include:

- Increased awareness amongst Emergency Departments (ED) and General Practitioners of the predictors

and a capacity for clinical mental health services to be accessed without delay, preferably before the person leaves the ED;

- If financial difficulties or homelessness are present, measures to ensure that the person is going to receive advice on debts, housing, and employment must be arranged as soon as possible, preferably prioritising this person;

- Strengthen specialist services and risk management for people who are misusing alcohol or drugs.

- Introduce or maintain assertive outreach services; and

- Continue the successful safety focus on inpatients wards, including measures to prevent absconding and ensure safe design support for people who are acutely suicidal to be able to remain within the acute ward for the time that is required to shift their thinking towards living, is also essential.

Assessment approach

The ANMF is supportive of the assessment approach and components proposed by the Commission. In addition to the components described, the ANMF recommends that the Commission also examine maternity services and the work of midwives as interventions to improve perinatal mental health outcomes for women.

Midwives work with women and their families throughout the pregnancy journey; from planning and preparing, to at least six weeks postpartum. Similarly, maternal and child health nurses are involved in the care of mothers, children and families from birth to school age. They are therefore uniquely positioned to make early identification of women and families at risk and experiencing mental illness. In Victoria, there are enhanced Maternal and Child Health Nurse (MCHN) services to provide specialist interventions for families at risk who are already engaging with the services related to the birth of a child/children. Women and men can both experience mental health issues during pregnancy, as well as after the birth. The role of midwives and maternal and child health nurses is critical to promoting optimal mental health and in turn strengthening the capacity of mothers and families to provide a safe and nurturing environment for their infant and young child. Given optimal maternal health and wellbeing is an enabler to optimal child health, wellbeing and development – and given the first 1000 days of a child's life are pivotal to future health outcomes - the importance of supporting midwives and maternal and child health nurses to make early identification, intervention and referral cannot be overstated. Recognition of the opportunities they have to engage with families is significant to mental health and wellbeing assessment and promotion for mothers, babies, and families as they can be effectively involved in detection and initial management of mental health issues.

Perinatal Mental Health

Severe perinatal depression, anxiety and exposure to intimate partner violence are among the leading causes of maternal death. Maternal depression during pregnancy is associated with preterm birth, low birthweight and early cessation of breastfeeding.

Currently the emphasis of maternal health surveillance is predominantly on women's health in pregnancy and the immediate postpartum period.[7] The ANMF argues that maternal support and treatment to improve mental health and wellbeing should be available especially to women with identified risk factors from pre-conception until the child is 12 months of age.

Higher demand for mental health services and longer length of stay in maternity units is one economic cost of not providing comprehensive prevention and early intervention strategies to pregnant women and women planning a pregnancy. The loss to society and the broader economy is even greater. Early experiences determine whether a child's developing brain architecture provides a strong or weak foundation for all future learning, behaviour, and health.[8]

Mental health problems during a child's early years can have enduring consequences if left unresolved not only by placing individuals at increased risk of difficulties in adult life, but also by placing increased pressure on limited community service resources. Suffering and negative outcomes can also cause intergenerational cycles which become larger problems to address.[9]

There is robust evidence that the onset of many adult psychological problems have their origins in childhood and adolescence. Families affected by parental mental illness are at particularly high risk of compromised mental health.[10]

A Pricewaterhouse Coopers report in 2014 estimated that the projected costs for not treating perinatal depression and anxiety in 2013 was $538 million (i.e. from conception through to the first year of a child's life).

If the prevalence of women affected by perinatal depression was reduced by just 5% (15,500 women) in 2013, total costs in the first two years could be reduced by $147 million.

The majority of women in Australia receive antenatal care from midwives employed in the public hospital system. The National Perinatal Depression Initiative which ran from 2008 to 2014 provided mental health nurses and psychology services which were in many cases co-located with antenatal clinics in public hospitals. At Sunshine Hospital, the Perinatal Emotional Health Program (PEHP) demonstrated an average reduction in length of stay within the maternity services of 1.7 days, calculating a saving of $2635 per patient bed day or $806,310 per annum based on 306 patients in 2014.

The National Perinatal Depression Initiative facilitated capacity building of the midwifery workforce as well as providing a known and immediate referral point when required. When the funding for this program ceased,

some service funding was maintained by some state governments however the integrity of the program was significantly compromised.

The Centre for Perinatal Excellence (CoPE) was funded by the Commonwealth Government to develop the National Perinatal Mental Health Guideline and to provide accredited training for health professionals. Additionally, COPE are involved in the development of electronic assessment and education tools for women and their families. These are very important initiatives and ANMF looks forward to hearing the outcome of ongoing research into the effectiveness of these tools and the role of midwives, mental health nurses and maternal and child health nurses going forward.

Midwives and mental health nurses are cost effective health professionals well placed to provide holistic care to women. The nursing and midwifery workforce must be supported to continue to expand their knowledge of the specialty of perinatal mental health.

Women regularly disclose personal information to a midwife during an antenatal clinic visit and it is critical that clinical guidelines and accessible referral points are available. Midwives report that an inability to appropriately refer a woman who requires additional support or treatment occurs regularly in some antenatal clinics.

In contemporary practice, most hospital employed midwives screen women antenatally and re- test postnatally using the Edinburgh postnatal depression scale.   This screen forms part of the antenatal clinic template of visits. Additionally midwives discuss family violence, substance misuse and other psychosocial issues as part of the usual holistic woman centred approach to care. Capacity building the midwifery workforce in the area of perinatal mental health makes economic sense as the improved ability to detect and refer women who require support or treatment will greatly improve prevention and early intervention to minimise the known costs of perinatal depression on society.

Gender and sexually diverse mental health

Mental ill health disproportionally impacts upon people from gender and sexually diverse (GSD) groups.[11] As a conservative estimate, GSD people are likely to account for at least 11% of the total Australian population based upon the most recent surveys. This estimate is conservative, as reliance on self-reporting and issues with definitions are likely to have significantly underestimated the actual number of GSD people within the Australian community. The proportion of younger people who identify as GSD people is also greater than older population groups, indicating that over the coming years, the proportion of GSD identifying people is likely to increase.

Despite recent advances in achieving equality for GSD people, such as the legalisation of marriage between members of the same sex, GSD people can experience persistent marginalisation, discrimination, and stigma both within the wider community and its institutions such as schools and workplaces, and within health and

mental health care contexts. Further, the discrepancies between GSD people and the mainstream population can interact with other social and demographic factors in a compounding fashion. For example, being a GSD person who is also a member of another disadvantaged/marginalised group such as an Aboriginal and/or Torres Strait Islander Australian, a member of a culturally and linguistically diverse (CALD) group, socioeconomically disadvantaged, living in regional or remote Australia, or indeed a woman, can mean that a person faces further challenges to accessing safe, effective, quality health and mental health care and poorer health and mental health outcomes.

Gender and sexually diverse people are a disadvantaged group whose general health, health risk factors, and especially mental health appear to be poorer than the mainstream population. Gender and sexually diverse people have:[12]

- experienced and continue to experience systematic marginalisation and discrimination in the community and healthcare systems;

- higher rates of smoking and alcohol consumption;

- poorer access and engagement with health and mental health services;

- greater risk of poor mental health, especially depression, anxiety, and psychological distress;

- poorer health and mental health outcomes;

- greater risk and rates of self-harm, suicidal behaviours, ideation, and death from suicide; and

- higher incidence of homelessness,[13] a compounding factor for the development and exacerbation of mental ill health (see also 'Housing and homelessness, below).

Health and mental health care professionals may require focussed, evidence-informed information, education, and support to provide safe, quality care to GSD people. This is because GSD people and the specific issues they face and that are important to them may not receive sufficient coverage and attention in current health and mental health care preparatory or continuing professional development programs.

The ANMF urges the Commission to identify GSD people as a key group within their inquiry. Supporting and resourcing focussed research, initiatives, and programs addressing the disproportionate mental health burden faced by GSD people in Australia has the capacity to make a significant and meaningful difference to a considerable proportion of the Australian population, their families, and significant others.

Aboriginal and Torres Strait Islander mental health

The Australian health and mental health system is failing Aboriginal and Torres Strait Islander peoples. These communities are challenged by high rates of suicide and poorer mental health outcomes than populations.

Mental ill health among Aboriginal and Torres Strait Islander peoples has arisen from historic dispossession, ongoing racism, and difficulties connecting to Aboriginal and Torres Strait Islander identity, country, and community.[14] These challenges are amplified by unequal access to meaningful and ongoing education, social services, and employment. The Australian Bureau of Statistics data shows that Aboriginal and Torres Strait Islander people are twice as likely to die by suicide than other Australians, that Aboriginal children aged 1–14 years are nine times more likely to die by suicide than non-Indigenous children, that young adults aged 15–24 years are four times more likely to die by suicide, and that Aboriginal people are now three times more likely to be hospitalised for intentional self-harm than other Australians.

Indigenous mental health is a key national priority and of concern to the ANMF and its members. Hospital-based care may be inappropriate and harmful for the mental health care of Aboriginal and Torres Strait Islanders peoples, particularly for those who live in regional or remote communities. Aboriginal people may benefit from models of mental health care that allow them to stay within their communities, connected to country, and out of distant metropolitan hospitals.[15] Any review of mental health and wellbeing in Australia must also consider the Aboriginal and Torres Strait Islander population. Within the Closing the Gap Strategy and the National Strategic Framework for Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing there are plans and frameworks in place on how to provide mental health support and services. Dedicated mental health funding must go hand-in-hand with these programs. Further, the mental health and wellbeing of Aboriginal and Torres Strait Islander people in custody is a major concern, with high rates of mental ill health and suicide among incarcerated Aboriginal and Torres Strait Islander Australians.[16]

People with psychosocial disabilities

The ANMF commends the Commission for extending the scope of the inquiry to examine the interface between the National Disability Insurance Scheme (NDIS) and other services for those with a mental illness, and any new developments which have significant implications for population mental health, participation and productivity. While potentially beyond the scope of the present inquiry, the ANMF would like to draw the Commission's attention to the issue of insufficient funding for the NDIS particularly in relation to the high level of care needed by some accessing the scheme which requires the skills of qualified nurses.

Not everyone who experiences mental ill health also experiences a disability, but for people who do, it can be severe, longstanding and impact upon recovery. People with a disability because of a mental health condition may qualify for support provided through the NDIS.

Any examination of the role of improving mental health to support economic participation and enhancing productivity and economic growth, must consider the role that the NDIS has in supporting people with a psychosocial disability.

The NDIS funds disability supports that are not clinical in nature and that focus on a person's functional ability. Supportive services extend to those that enable a person with a mental illness or psychiatric condition to undertake activities of daily living and participate in the community and social and economic life. The NDIS supports people who experience disability to exercise their rights to the same opportunities as others within the community. The NDIS can link people with disability to services within the community and/or provide funding for people to get individualised support for example, by supporting participation in daily activities and to enjoy community/work life relevant to individual interests and needs.

The founding principles underpinning the NDIS are similar to the principles of mental health recovery. The NDIS defines recovery as "achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, whilst living with or recovering from mental health issues".[17]

Engaging with the community through social participation, education, and employment helps build resilience and purpose for people who experience a disability. The NDIS is committed to funding supports that help participants increase their independence and social and economic participation. Nurses may provide some of the support available through the NDIS to people who experience mental ill health as well as a disability.

The NDIS is designed to work alongside existing government service systems, including health, education, housing, and mental health specific treatment services. People with mental health issues often require support from a range of sources such as community, family, friends, local or private mental health services and other mainstream systems. The NDIS works closely and in partnership with these other support systems but does not replace them.

Structural weaknesses in healthcare

As identified by the Commission and by past reviews, a crucial weakness in the Australian healthcare system arises from a lack of coordination of mental healthcare across providers. Enrolled Nurses are underutilised in this co-ordination role and we contend that they would provide a cost-effective solution in improving care co-ordination and stopping people from falling through the gaps. The present inquiry has the opportunity to address issues with fragmented, uncoordinated care in mental health.

An important step toward addressing deficiencies in the current system is to enable the nursing and midwifery workforce to work to their full scope of practice. Mental health services in Australia should make greater use of the skills and scope of practice of the nurse, nurse practitioner, and midwife workforce by ensuing greater involvement of the professions in acute and primary care (including in general practice, schools, and community) as well as residential aged care. A shift away from generic 'case-management' models that have the potential to de-skill highly qualified health practitioners is an imperative. Nurse, midwife, and nurse practitioner-led models of care in mental health should be trialled and expanded.

Along with ensuring that nurses and midwives are supported to work to their full scope of practice, greater acknowledgment from multidisciplinary healthcare professionals, policy makers, and the wider community would assist in growing a broader and clearer understanding of the importance and value of nurse and midwife work in the area of mental health.

Nurse practitioners and mental health

There is a substantial body of literature pertaining to the role of the nurse practitioner with considerable evidence suggesting high quality and effective care and that health consumers highly value the care provided by nurse practitioners either working independently or in collaboration with broader healthcare teams.[18, 19, 20] While there is less evidence specifically focussed upon mental health care provided by nurse practitioners, what evidence exists indicates that this phenomena persists.

One area where nurse practitioners can be especially effective in mental health is in emergency departments where the mental health nurse practitioner role enhances access to specialised mental health care and also supports emergency staff.[21]

Nurse practitioners working in private practice and primary healthcare can also be an effective and accessible model of care ensuring better access and timeliness of care for people in the absence of, or where there is limited or stretched, general practice resources.

A key role of the primary mental health nurse practitioner is the provision of mental health care and support along with the assessment and management of physical conditions that can precede, coexist alongside or be exacerbated or caused by, mental ill health. Nurse practitioners working in primary health care can support and provide significant benefits to health consumers and can provide invaluable onsite support to medical providers or work in private practice themselves.

Nurse practitioners working in primary mental health can increase patient participation in treatment plans which is vital for effective and integrated mental health care. Follow-through with referrals and follow-up visits are important to health consumers, but barriers such as inconvenience, transportation problems, stigma, and cost can make this difficult. Nurse practitioners can improve primary mental health care recovery rates and outcomes by detecting and assessing mental ill health or risk early, scheduling specialist referrals and appointments, and through the implementation of evidence-based treatment approaches.

Nurse practitioners working in primary mental health can improve integration between nursing, medical, and specialist care. As the Commission is aware, health consumers with chronic mental illness are at increased risk for multiple physical health problems. Mood, anxiety, and psychotic disorders frequently result in damaging health behaviours, such as a sedentary lifestyle, poor eating and sleeping habits, strained personal and

professional relationships, and poor lifestyle choices and coping skills (smoking, substance abuse, physical or emotional abuse, and anger outbursts). Further, while newer pharmacological treatments tend to have fewer negative side effects than previous generations of medicines, some medicines still increase a person's risk of obesity, cardiovascular problems, and diabetes. Nurse practitioners are educated and experienced in working in partnership with health consumers and the rest of the health care team to identify, manage, and treat these multiple complex conditions faced by people experiencing mental ill health.

Overall, mental and physical health care can be fragmented because there isn't enough collaboration between care providers. A nurse practitioner in primary care is optimally placed to bridge this gap. By addressing the interplay of physical and mental health and providing an integrated approach to care, the nurse practitioner can help restore better mental health and assist recovery.

Restrictions on scope of practice

Nurses, including specially trained mental health nurses, represent the largest proportion of professionals working in the Australian mental health system and provide care to individuals and communities throughout Australia from metropolitan locations to regional and remote sites. Nurses are well positioned to understand the complex interrelationship between physical and mental health and to respond to the high premature mortality/morbidity rates of individuals being treated for mental health issues caused by physical illnesses, such as cardiac disease, diabetes, and metabolic related orders.

Mental health services are increasingly delivered in the community by primary health care providers, however nurses and mental health nurses are underfunded which limits community access to these vital services and the ability of nurses to provide necessary care and preventive interventions. Further, a shortage of mental health nurses is expected to be the largest sector in the overall nursing workforce shortage of at least 19,000 nurses by 2030. Workforce planning is vital to ensuring that the supply of healthcare professionals, including nurses and midwives, is enough to meet the demands of Australia's growing and aging population. Some states have commenced effective action plans to mitigate against these Health Workforce Australia (HWA) workforce projections including:

- promoting mental health nursing as a career of choice;
- providing scholarships to contribute towards the postgraduate course fees;
- Improving the safety for everyone in mental health wards and clinics;
- Introducing clinical supervision and resilience building programs within workplaces;
- Regulating workload to ensure that nurses are able to provide people/patients with the time they deserve; and
- Reducing insecure work practices.

The nursing workforce, like the Australian population in general, is ageing. The mental health nursing workforce may be additionally stretched in the future by the fact that mental health nursing is not a priority career pathway for many junior nurses.

Early prevention, early diagnosis, and identifying suicide risk in the treatment and management of mental health problems are essential in achieving positive outcomes for individuals. Often a first point of contact for people in the community, nurses are, on many occasions, best placed to ensure these critical interventions occur through timely referral and care. This is especially vital in rural, regional, and remote areas where access to specialised mental health services and general practice is more limited and can also be true for disadvantaged metropolitan populations in the community (e.g. socially, culturally, and linguistically diverse and/or disadvantaged people) and in aged care.

Better choice and more accessible mental health care could be provided to people through different models of care, such as mental health nurse-led models, including mental health nurse practitioner-led models; an increase in school nurse positions in the public school sector (for early intervention); and, quarantining of the Mental Health Nurse Incentive Payment (MHNIP) funding within Primary Health Networks to enable reinstitution of the excellent work that had been undertaken by mental health nurses in keeping people well and living in their community. Mental health nurses, nurse practitioners, and skilled registered nurses are also well positioned to provide necessary care to residents in aged care facilities and people receiving aged care and/or disability support in the community. Providing positions for mental health nurse practitioners with funding models which broaden access for people seeking mental health care and which facilitate viable and sustainable practice operation would be one way to address the access issues faced by Australian consumers.

Mental health services must also be appropriately tailored, and accessible to provide effective, safe, and meaningful care to the diverse Australian population. Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse people (including asylum seekers, new migrants, and refugees), socially disadvantaged, and sexually and gender diverse people all face barriers to accessing safe, quality care that meets their specific needs and preferences.

The ANMF advocates that all people experiencing mental health conditions should have access to effective, quality mental health care that acknowledges their particular needs and preferences for culturally safe and appropriate care particularly for Aboriginal and Torres Strait Islander people, and those from socially, culturally and linguistically diverse and/or disadvantaged backgrounds including asylum seekers, new migrants, and refugees, and sexually and gender diverse people.

As a workforce development strategy, the ANMF considers initiatives need to be developed and incentives need to be in place to retain the experienced mental health nursing workforce and recruit and mentor nurses new to

mental health, to help grow the mental health nursing workforce. This includes transition to practice programs to equip both newly qualified and experienced registered nurses and midwives with the specialist skills required in mental health nursing.

Health workforce configuration and capabilities

Primary Health Network funding and mental health nurse employment

With the development of the Primary Health Networks (PHNs), the Mental Health Nurse Incentive Payment (MHNIP) program was ceased and funding has been transferred to the PHN lexible funding pool. This transfer of funding has led to difficulties experienced by clients when some mental health nurses either have, or are facing, a loss of employment from their primary health care position. It places further burden on the public health system as often the people who were previously engaging with a mental health nurse have limited or no suitable alternatives and subsequently become very unwell and present in crisis to an emergency department or worse. The ANMF Victorian Branch has reported that this represents a significant loss for patients, many with complex, trauma-based mental illness, who relied on these mental health nurses.[22]

Providers of mental health nursing programs were advised by some Victorian PHNs earlier this year that their tenders to continue had been unsuccessful and would cease from 1 July 2018. These programs, funded under the MHNIP, had been successful in supporting people in Victoria with severe and persistent mental illness. The MHNIP nurses coordinated patients' mental, physical and social care including acute interventions, and identified a comprehensive range of needs such as dental appointments, public housing or National Disability Insurance Scheme advocacy. This mental health nursing model, which kept people well and living in the community, was proven through evaluation to give: greater continuity of care, greater follow-up, timely access to support, and increased compliance with treatment plans; with the outcome being improved mental and physical wellbeing and employment, and greater involvement in social and educational activities. Importantly, there was a decrease in acute hospital admissions, or, where these did occur, a reduction in the length of stay was demonstrated.

The Queensland Branch of the ANMF, the Queensland Nurses and Midwives Union (QNMU) has also reported that mental health nurse members in their state are uncertain as to future employment following transfer of the MHNIP funding, under which they worked, into the PHN. Negotiations are still in train between the mental health nurses concerned and the PHNs in their locality.

The uncertainty about the employment of mental health nurses within the PHNs is causing a disruption to the continuity of care for people with mental health illness. This situation must be speedily resolved with a reinstitution of therapeutic relationships for the mental health nurses and their patients, under the PHN funding, to avoid causing further distress to an already vulnerable group of people in our community.

Nurses in Schools

The prevalence of mental ill health is rising among children, adolescents, and young people. Early intervention is essential in supporting young people, and care provided within schools to support emotional well-being is recommended as part of this process. School nurses can have a vital role in supporting young peoples' mental health, although a number of barriers exist which impact on school nurses' ability to work in schools or grow skills and capacity dealing with mental health issues in these roles.[23] School nurses are also able to provide personalised health and wellbeing information and guidance which is vital to the provision of person-centred health and mental health care.[24]

In 2017 there were 1,545 nurses who identified as working in public or private schools.[25] States and territories have different models; in some jurisdictions school nurses work primarily in private schools while in others their numbers are higher in public school settings. In some states/territories where there are few or no school nurse positions, community nurses go into schools and conduct health screenings and vaccinations.

School nurse numbers were higher in the late 1990s but then decreased in the early 2000s. In Tasmania for example, there has been a renewed effort to increase the numbers, with the government injecting funds for new positions in 2017. In some instances, school registered nurse positions have been removed and the position downgraded to that of a 'first aider'.

Registered nurses who work in schools can take on significant roles in primary health care prevention and early intervention in a broad range of physical and mental health issues, through regular screening, immunisation, education and on-going health and mental health promotion and care. Registered nurses are trusted members of the school community and are often specifically identified by students as a trusted person in whom to confide very personal information. First-aiders are not trained or qualified to deliver the level or quality of mental health care that falls within the scope of practice of a registered nurse and are not regulated by a national body, as is the case for qualified nurses (the Nursing and Midwifery Board of Australia).

School nurse members of the ANMF have expressed that a large part of their role now relates to mental health issues, either experienced by the student themselves or family members of students. As recently reported, children as young as five are exhibiting mental illnesses including anxiety, self-harming, and significant behavioural issues that disrupt not only their education but affect the entire classroom.[26]

School nurses work within the school community team, and, also with students' general practitioners and/or other relevant local health practitioners and facilities. This is a valuable and effective approach to integrating care and increasing communication channels between schools and health networks.

The school nurse role should be acknowledged as vital in the physical and mental development of Australia's children and youth, across all geographical locations. In addition, there should be funding mechanisms for these registered nurses to have access to mental health education continuing professional development and post-graduate programs of study.[27]

There is further scope for the utilisation of qualified mental health nurses, working as case managers in school contexts. These specialised registered nurses could be effective in the support of children with behavioural/mental health disorders and also in identifying children at risk of mental or physical ill health. Because of their professional education and clinical practice, mental health nurses work with both the individual child and their family members. They are well prepared to case manage in schools and support individual teachers and health and welfare services in their management of their clients with behavioural/mental health disorders.[28]

Housing and Homelessness

The intersection between homelessness and mental ill health is a key concern for the ANMF, and as such, we are pleased to see that the Commission have chosen to focus attention on this important issue as part of the inquiry.[29] The links between mental ill health and homelessness have long been acknowledged,[30] but less so understood and effectively acted upon. The ANMF supports the premise that ill health, both physical and mental, are causes and consequences of homelessness. People experiencing homelessness often present with severe and unremitting symptoms of mental ill health and with significant barriers to accessing appropriate service provision. Current availability of accommodation is wholly inadequate, and the need for appropriate housing and mental and physical health services is urgent. For those experiencing the dual burdens of mental illness and homelessness, a 'housing first' model with integrated and supportive housing and a variety of housing options to suit the individual and their needs may be a meaningful and effective approach.

Significant mental ill health occurs in between 30–50% of people who are homeless. This may however be an underestimation, as people who are homeless also face greater isolation and poorer engagement with health and mental health systems for diagnosis, treatment, and support.

Homeless people are considerably more likely to suffer from alcohol (8.1% to 58.5% of people) and drug dependence (4.5% to 54.2% of people) than the age-matched general populations. The prevalence of psychotic illnesses and depression (2.8% to 42.3% of people) and personality disorders are also higher.[31] Models of mental health care and social care that can best meet the mental health needs of people who experience homelessness requires further investigation.

Young people who are homeless in Australia have extremely high rates of psychological distress and psychiatric disorders. Action addressing housing and mental health for young people in Australia is vital, as homeless youth are at risk of developing psychiatric disorders and possibly self-injurious behaviour the longer they are homeless.

The ANMF supports research and evaluation of current and emerging models of housing support for people with mental ill health or who are at risk of mental ill health or homelessness.

In Victoria, supportive residential services (SRSs) are privately owned businesses that provide a shared living environment and personal support to individuals of varying age range. Many residents in 'Pension Level' SRS originally came from the closures of psychiatric institutions; today this population is ageing and suffering from increasingly debilitating chronic diseases related to a lifetime of poor symptom management, social isolation, poor diet, and the adverse effects of long-term psychotropic medication. Residents experience a wide range of psychological, physical, intellectual and alcohol and other drug related disabilities. The SRS residents living with chronic, complex and enduring mental illness are some of the most marginalised and vulnerable members of our community. Overall, they are cared for by an unskilled workforce. A review of the provision of service for those within SRS who experience mental illness is timely, along with improvements to implementation and support for a better skilled and qualified workforce including nurses and mental health nurses and improved integration with primary care, general practice, allied health, and specialist services.

Along with this, integration of service systems to better facilitate care of people experiencing homelessness and mental ill health, as well as those at risk, is required. This could involve;

- review of current resourcing and provision of care models;

- recognition of the social determinants of health and the impact of adverse childhood experience and trauma on future health outcomes;

- integration of services such as health, housing and mental health to better facilitate intervention for the prevention of ill health and recovery from ill health;

- recognition of chronic disease and comorbid health on mental illness and more effective hospital discharge planning;

- access for marginalised groups who may be precluded from receiving care due to 'no formal diagnosis' being recorded such as those who are Medicare ineligible, with poor support networks and / or no significant other, and;

- enhanced training and education for emergency services, first responders, and health and mental health care staff on complex presentations and how to respond and provide care to people who are experiencing homelessness and mental ill health, in the least restrictive way.

Further examples of successful approaches in Victoria include: [32]

- The provision of nurse-led homeless persons programs that employ mental health nurses to work alongside drug and alcohol nurses, community nurses and HIV nurses all of whom are trained in the

trauma informed care approach and have good knowledge of the services available to ensure their patients' needs can be addressed;

- The continuation of 'fast track' appropriate public housing for people with these complex needs at an earlier point than the current 15 years or more with a requirement for ongoing engagement with the nursing service;

- Recognition of recent data on triggers for 'new homelessness' to ensure that victims of domestic violence (and their children) can access safe refuges and be protected to make transitions to affordable housing;

- Encouragement of partnerships/amalgamations/mergers between homeless services to reduce expenditure on overheads and allow funds to go to direct service provision; and

- Ensuring that there is interface with homeless strategy that increases the availability of accommodation.

Regional and remote areas

The 2018 Senate Community Affairs References Committee Inquiry into Accessibility and quality of mental health services in rural and remote Australia highlighted the fact that although Australians living in rural and remote areas are impacted by mental disorders at the same rate as people living in major cities, they experience unique barriers to receiving care. Specialist mental health nurses and an overall well-equipped workforce of trained registered nurses is vital to the delivery of mental health care to meet Australia's current and future needs. ANMF contends that nurses, midwives and nurse practitioners are currently underutilised in meeting the demand for mental health care, across all geographical areas, but especially in rural and remote settings. Additionally, further planning and action is required to attract and retain nurses and midwives to train and work in regional and remote locations.

The ANMF supports funding arrangements that increase access to and the quality of mental health services for those who live in rural and remote areas. We note the Mental Health Medicare Benefits Schedule (MBS) Review Taskforce has as one of their goals, affordable and universal access for all Australians including those who live in rural and remote locations and consideration as to whether telehealth services are delivering the mental health care that is needed.[33] We support this goal to ensure mental health care is accessible for all Australians.

Education and continuing professional development

All nurses and midwives address mental health in their preparatory education including both theoretical learning and clinical practice.

This means that the scope of practice of all nurses and midwives includes initial assessment of presenting mental health problems, and awareness of early interventions including referral for acute and on-going management.

Importantly, nurses and midwives are able to assess comorbid physical health issues, which may be contributory factors in mental ill health.

In order to build mental health knowledge and capacity in the nursing and midwifery workforce the following are essential:

- Continuing professional development opportunities should be available (both time release and funding) for the on-going updating of mental health knowledge base for all nurses and midwives.
- Enabling the expansion of knowledge base by undertaking post graduate mental health courses to equip nurses and midwives for context specific mental health practice.
- Targeted quarantined scholarships for mental health study at postgraduate level for registered nurses, and for nurse practitioners, to work in rural and remote areas.
- Provision of positions for mental health nurse practitioners with funding models which broaden access for people seeking mental health care and which facilitate viable and sustainable practice operation.

Mental Health Nurse Training

To ensure a viable current and future mental health nursing workforce, specific mental health nursing courses which include theoretical and clinical components, must continue to be offered at post graduate level so that nurses and midwives who work intensively in mental health patient care contexts have the appropriate and unique skillset required for specialist nursing mental health practice.

In the case of the South Australian ANMF Branch, the current provisions as set out in the Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2016 (NMEA) state that:

> "a Registered Nurse (Mental Health) in a mental health service, ward, unit or team means a registered nurse who is either enrolled in an approved mental health course or who holds qualifications in mental health practice."[34]

There has been a steady increase in demand from mental health consumers across the sector in the last five years coupled with a lack of an appropriately trained and qualified mental health nurse workforce. This has ultimately put increased pressures on nurses working in mental health. In addition, it appears that the average age of mental health nurses is higher than that of nurses and midwives more generally; about 3 in 5 mental health nurses (58.8%) were aged 45 and above in 2016; a third (32.7%) were aged 55 and older and 1 in 20 (5.2%) were aged 65 and over.[35] This contrasts with about 2 in 5 nurses and midwives being aged 50 and over in 2015 (39.0%) with an average age of 44.4 years.[36] It is expected that mental health nursing will suffer from a greater number of retiring workers sooner than the general nursing and midwifery workforce which may have dire consequences for an already constrained sector. One of the biggest barriers and challenges contributing to this issue is the lack of access to timely education for those wishing to pursue a career pathway in mental health.

To address this gap in South Australia, the ANMF (SA Branch) has formed partnership with Flinders University to provide South Australian Nurses with more streamlined access to post-graduate studies by enabling them to springboard from a related Continuing Professional Development course delivered by the Australian Nursing and Midwifery Education Centre. This piece of work is crucial given the requirements in South Australia outlined above, as well as the broader issue that ideally qualified mental health nurses - or those studying towards such qualifications - should provide specific and specialist nursing care for mental health patients. Mental health is already chronically understaffed and there are hospital beds that remain unopened because there are not enough qualified mental health nurses across the country, let alone in South Australia.

Child safety

The ANMF supports the Commission in improving the mental health of people in contact with the child protection system, including prevention and early intervention programs for parents, carers, children, and support for those children leaving out-of-home care.

Domestic violence is a risk factor for children's general psychopathology and mental ill health in later life.[37] Many children who witness violence within the home (for example domestic violence between parents or caregivers) are themselves victims of physical abuse.[38] Children who witness or are victims of domestic violence and abuse themselves are at a greater and more serious risk for experiencing long-term physical and mental health problems.[39]

There is a growing understanding that child maltreatment or exposure to domestic violence is a major risk factor for many health conditions. Multiple adverse childhood experiences (ACEs) are compounding, resulting in greater risk of poor health and mental health effects ncluding physical inactivity, overweight or obesity, diabetes, smoking, heavy alcohol use, poor self-rated health, cancer, heart disease, respiratory disease, sexual risk taking, mental ill health, problematic alcohol use, problematic drug use and interpersonal and self-directed violence. The outcomes most strongly associated with multiple ACEs represent ACE risks for the next generation such as violence, mental illness, and substance use in future relationships.[40]

While it is understood that the Commission's inquiry will not encompass legislation, government legislation and policies concerning child safety have a clear and significant impact upon the ability of health and social systems to minimise health and mental health risk and maximise the early detection of, and response to, potential risks and problems. Current child protection legislation should be improved to effectively promote and improve the mental health of children in the child protection system.

For example, under the *Child Protection Act 1999* (Qld) (the Act) mandatory reporting by healthcare staff, such as registered nurses, in contact with members of the public, section 13E(2)(a) reads:

For this section, a reportable suspicion about a child is a reasonable suspicion that the child –

(a) has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse; and

(b) may not have a parent able and willing to protect the child from the harm.

This section does not refer to the child's psychological or emotional state, implying that mandatory reporting is required only for physical or sexual abuse. This is not sufficient to adequately protect the health, wellbeing, and mental health of vulnerable children.

Mentally healthy workplaces

Workplace interventions

As the Commission recognises, there is a large cost associated with workforce mental ill-health. Nursing and midwifery are emotionally demanding professions and deficiencies in nurses' and midwives' mental wellbeing, characterised by low vitality and common mental disorders, have been linked to burnout, low productivity, absenteeism and presenteeism. Mental health nurses and other mental health workers are required to engage in effective therapeutic interactions with clients in emotionally-intense situations. An integrative systematic review identified that three related concepts are relevant in the context of workforce attrition and burnout in mental health nursing: emotional labour, emotional exhaustion (an element of burnout), and emotional intelligence (or self-protection).[41] The systematic review highlighted that emotional labour can inspire personal growth of emotional intelligence among mental health nurses. Recommendations for clinical practice included:

- promotion of supportive work environments

- involving nurses in shared decision-making

- the provision of ongoing professional development opportunities that facilitate the development of emotional intelligence and resilience among mental health nurses.

Problems with poor mental health in the nursing and midwifery workforce can exacerbate issues with workforce recruitment, retention, and turnover which are themselves significant issues in Australia.

Working people who experience mental ill health require supportive and trusting workplace environments to guard against issues such as absenteeism and presenteeism. Workers who are employed in unsupportive environments have poorer outcomes, while factors such as awareness and openness about mental illness, collegial support and managerial support can assist people experiencing mental ill health to be and feel productive and valued in the workplace. Protective factors for improved mental health among nurses have been found to include; better general health, cohabitation with a spouse or partner, healthy sleeping and eating habits, not being an informal carer as well as a paid carer, and not working nights.[42]

Employers have a responsibility to their staff in providing safe, supportive environments and for promoting mentally healthy practices in the workplace. Employers are also responsible for supporting employees who experience mental health issues.

With employers, professional and industrial organisations are important partners and advocates for promoting and supporting mentally healthy workplaces. A key priority of the ANMF and all our state and territory Branches is ensuring the health and safety of our members, as well as all nurses, midwives, and carers, at work. The ANMF provides representation, support, and advice, including helping members make a claim for workers' compensation.

The ANMF acknowledges that existing workers' compensation schemes may not adequately address workplace mental ill health. The current system can be experienced as adversarial - pitting employers against workers, dis-incentivising both claims and support. This can result in employers displaying a lack of empathy and instead rigidly adhering to budgetary factors and policies unfit for purpose, which can exacerbate the causes of mental ill health and risk for employees.

The ANMF is pleased to see that the Commission views mentally healthy workplaces as a key focus area and recommends that the Commission further endeavour to examine the suitability of workers' compensation schemes to deal effectively and fairly with mental ill health and risk.

Further, the ANMF also recommends that the Commission place special focus upon the mental health and workplace safety with regard to mental health and risk of healthcare workers themselves. By effectively supporting those who care for the overall wellbeing and mental health of the general public and community, and ensuring that their workplaces are safe, mentally healthy, and supportive, a strong, productive, and effective health and mental health workforce can be sustained.

Workplace violence in mental health

Health workers are at high risk of violence all over the world. Between 8% and 38% of health workers suffer physical violence at some point in their careers. Many more are threatened or exposed to verbal aggression.[43] As first-line health and mental health care staff, nursing staff are in close and frequent contact with mental health services consumers and their families. From a survey of more than 150 000 nurses, drawn from 160 global samples, overall, about a third of nurses have been physically assaulted, bullied, or injured, while around two-thirds have experienced nonphysical assault.[44] Violence is a frequent and critical factor that affects the workplace safety of nursing and midwifery staff and all health care staff more broadly.[45] Personal experiences of aggression or violence in the workplace lead to serious consequences for nurses and midwives, their patients, patient care, and the organisation.[46]

Nurses and other staff working in mental health cope with significant psychological and physical challenges, including exposure to verbal and physical violence. Nurses who work in mental health environments have a 20 times higher rate of physical violence than those working in public health units.[47]

Nurses exposed to verbal or physical abuse often experienced a negative psychological impact post incident.[48] Nursing staff who are exposed to violence experience increased stress, decreased work satisfaction and have adverse long-term health consequences, this reduces care quality and work morale and increases nurse turnover.[49, 50] Violence against nurses also negatively impacts recruitment and retention of staff which is a significant problem for the nursing workforce mployed in mental health.[51]

Workplace violence is a serious and growing problem that affects all health care professionals. Nursing staff experiencing violence in the workplace has become a workplace safety concern to which health institutions worldwide attach considerable importance. Strategies are needed to prevent workplace violence and manage the negative consequences experienced by healthcare workers following violent events. Hospital managements should conduct work stress reduction intervention programs and promote strategises to reduce workplace violence.[52] Health care organisations must ensure the necessary conditions for enabling and encouraging appropriate actions following violent acts according to relevant protocols. Comprehensive strategies from the perspective of nursing education and training, organisational policy, patient care and staff support are recommended to promote occupational safety in mental health care. Workplaces must also endeavour to create psychologically and physically safe environments for workers.

Nurses themselves are also in a unique position to develop and provide assistance to implement prevention programs that can decrease the incidence and prevalence of violence in healthcare environments.[53]

As part of broader work to assist public hospitals and mental health services meet their new obligations to end violence, the ANMF (Victorian Branch) has developed a new guide for health and mental health care services to end violence and aggression. The *10-Point Plan to End Violence and Aggression: A Guide for Health Services* uses a traffic-light approach to show hospitals how to move from a high risk to a low risk environment. The Guide is divided into 10 sections based on the ANMF's 10 Point Plan:

1. Improve security

2. Identify risk to staff and others

3. Include family in the development of care plans

4. Report, investigate, act

5. Prevent violence through workplace design

6. Provide education and training to healthcare staff

7. Integrate legislation, policies and procedures

8. Provide post-incident support

9. Apply anti-violence approach across all health disciplines

10. Empower staff to expect a safe workplace

The Guide articulates what a successful organisational response to the prevention of violence and aggression should look like. This work could be examined by the Commission as a potential avenue for improving the safety of mental health care environments for all staff, as well as mental health consumers and their families.

Funding arrangements

The ANMF endorses and advocates for a transition away from the current health and mental health system activity-based funding model, that can incentivise throughput and a lack of focus on improving consumer outcomes, to a value-based approach to health and mental health care. A value-based funding model aids in putting the consumer at the centre of care and is geared to driving improvements to prevention and wellbeing support, such as through mental health models that prioritise peoples' mental health rather than focussing solely on an illness/treatment-driven approach.[54, 55]

Value-based models of care encourage health systems to reward care approaches that help people to avoid becoming unwell in the first place, resulting in fewer necessary hospitalisations and treatments.[56] This can result in considerable cost-savings as people are able to remain in the community rather than having to be treated as in-patients. Alongside value-based care that focusses upon optimising the experiences and outcomes of people who engage with the health and mental health system, there must also be strong data collection and reporting systems to allow measurement and monitoring of consumer-focussed outcomes. Moving to a value-based system must occur in tandem with necessary improvements in mental health data collection, reporting, and integration.

While a movement to an entirely value-based model of mental health care is unlikely to be able to occur instantly, there is a growing global understanding that transitioning gradually from activity-based health funding models to value-based and outcome-focussed models is feasible and achievable.

Nurse or midwife-led services, and services that utilise a high level of nurse or midwife integration and involvement in care can aid meeting the growing needs and demands of mental health consumers. Supporting and funding employment of mental health nurse and nurse practitioner roles in primary health care and hospital emergency departments could be cost-effective approaches. Consumers who present at emergency departments for mental health issues experience generally longer waiting times than those with a similar severity of physical illness.[57]

Another example of effective integration of nursing roles in mental health care is at the Gold Coast University Hospital (GCUH) where a rapid response triage trial has been designed to streamline appropriate care for mental health consumers who need rapid access to care.[58]

These consumers are seen by a mental health nurse from the Mental Health, Alcohol and Other Drugs Service (AODS) and an emergency department physician. Preliminary results are positive, demonstrating receipt of targeted care plans from mental health nurses and earlier patient discharges.

Primary health network funding and mental health nursing

While nurses were once specifically funded to provide clinical therapeutic mental health care funding of the Mental Health Nurse Incentive Program (MHNIP) has been transferred to the Primary Health Networks (PHNs) where funding is now paid into the PHN flexible funding pool. Mental health services are now commissioned to local providers by PHNs which has resulted in increasing job uncertainty for mental health nurses due to reduced funding. The Australian Medical Association (AMA) has also reported that across over 200 general practitioner and psychiatry practices, patients are losing access to the mental health nursing workforce, and the treatment they provide, due to the change in funding model. The AMA has reported that by cutting salaries to mental health nurses by 40-50%, some PHNs are failing to attract or retain a viable mental health nursing workforce, resulting in the utilisation of a less qualified and appropriate workforce.[59]

These PHN funding arrangements do not incentivise service providers to deliver optimal outcomes as PHNs do not have parameters around maintaining quality and ensuring the mental health services delivered are done so by qualified, appropriate health practitioners.[60] Supporting the PHNs to deliver holistic mental health, including the necessary care provided by nurses, is imperative to ensuring the good mental health of communities.

The ANMF recommends that assessment and evaluation of PHN funding decisions be undertaken to determine if the PHNs are improving or negatively impacting mental health care access and quality.

CONCLUSION

The ANMF appreciates the opportunity to provide feedback on behalf of our members, through this initial submission to the Australian Government Productivity Commission's Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth.

As stated, each of our members provide some degree of mental health care and support, as mental health training is a component part of the training of all nurses and midwives and an integral part of health, maternity, and aged care overall. Further, a large proportion of our members who are mental health nurses also provide specialised mental health care. We have sought in our submission to outline the challenges faced by our members in providing mental health care to individuals and communities in across Australia and to draw the Commission's attention to the vital role that nurses, midwives, and carers play in the provision of mental health promotion, assessment, support, and treatment to all Australians.

The ANMF urges the Commission to act on measures to strengthen the capacity of the mental health workforce with its concomitant flow-on of creating improved mental health and well-being for all of Australia's citizens and especially those most at risk of mental ill health and poorer outcomes.

Once the draft report has been released by the Commission, we look forward to providing further input into the consultation process.

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