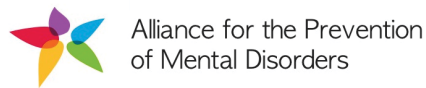


Focusing on prevention

A joint submission to the Productivity Commission inquiry into mental health

April 2019



Foreword from VicHealth CEO

Every Australian deserves the opportunity to live a healthy, happy life. As a community, we want our loved ones, neighbours and colleagues to experience good mental health and wellbeing too. Yet many Australians are experiencing avoidable mental conditions and related physical illness.

VicHealth commends the Australian Government's initiative in establishing the Productivity Commission's important inquiry into mental health, as we believe it can make significant and lasting improvements to Australians' lives.

VicHealth is honoured to submit this joint submission to the Productivity Commission. To develop the submission, VicHealth and Prevention United brought together the coalition of leading experts listed in Appendix 2 of this submission. They represent decades of experience in preventing mental conditions, promoting mental wellbeing and improving physical health.

By developing this submission with experts from diverse health areas, we have demonstrated that a common action plan for prevention requires collaboration and input from a wide range of organisations and sectors. It is only with a united effort can we begin to make inroads into improving the health and wellbeing of all Australians.

Dr Lyn Roberts AO
Acting CEO

Key messages

- Mental health conditions are not inevitable and there is now considerable scientific evidence that shows many conditions are preventable. There is also good evidence showing that the prevention of mental health conditions is cost-effective and can produce savings.
- Currently, we are at a point where the prevalence and impact of mental health conditions has not fallen over the last 25 years despite substantial government investment in a broad suite of mental health reforms, which have primarily focused on early identification and treatment. This concerning lack of progress highlights the urgent need for new approaches such as a stronger focus on prevention.
- Prevention needs to be a core pillar of Australia's efforts to reduce the significant personal and economic impacts of mental health conditions. We need a clear plan, greater investment, more evidence-based prevention programs across a range of settings, strong public policies, increased research and evaluation, and better monitoring.
- While preventing mental health conditions will generate significant social and economic benefits, linking this with efforts to improve the prevention and management of closely related co-morbid conditions such as chronic disease, alcohol and substance misuse, and problem gambling, has the potential to generate even greater gains.
- These various groups of conditions share numerous risk factors, are independent risk factors for each other, and frequently co-occur. Each group of conditions has significant adverse impacts, which are substantially increased when they occur together. Integrated approaches to prevention should therefore be pursued as much as possible.
- Action is needed across a range of health and non-health settings including online, the home, education settings, workplaces, sport and recreational clubs, the arts, health sector services, housing, local communities and in public policy. Given the need for multi-sector action, coordination and integration are critical and will require national oversight, robust collaborations and cross-portfolio funding mechanisms.
- Ultimately success lies in seeing prevention and treatment as complementary rather than competing approaches and making prevention a central pillar of both our mental health and health system.
- There is clear public support for prevention, as the recent public consultation on the Terms of Reference for the Royal Commission into Mental Health in Victoria has highlighted.

Recommendations

1. The Australian Government should reinstate prevention as a core priority in national mental health plans.
2. In the interim, the Australian Government should develop and implement a whole-of-government blueprint for the prevention of mental health conditions over the period 2019–2022. This should link to the Fifth National Mental Health and Suicide Prevention Plan and the National Framework on Chronic Disease.
3. That the Australian Government implement a progressive funding increase for the prevention of mental health conditions over the next 5-10 years that brings it in line with public health funding for health promotion and illness prevention.
4. The Australian Government should ensure that its efforts to prevent mental health conditions are linked to and reinforce efforts to prevent chronic disease, alcohol and substance misuse, and problem gambling.
5. The Australian Government's prevention campaigns, programs and public policies should prioritise:
 - i. The antenatal period, childhood, adolescence and young adulthood;
 - ii. Risk and protective factors shared across multiple conditions such as child maltreatment, family violence, bullying, discrimination, smoking, poor quality diet, physical inactivity, loneliness, and the social determinants of health (e.g. education, employment, housing);
 - iii. Individuals with an existing condition to help prevent multi-morbidity;
 - iv. Groups at increased risk based on gender, sexual orientation, disability, geographic, socioeconomic status or cultural identity;
 - v. Education settings and workplaces, due to their key role in enabling economic participation;
 - vi. Health sector services because of their critical role in the prevention of multi-morbidity;
 - vii. Regulatory decisions, including those that reduce or mitigate exposure to products and product promotions that may contribute to or exacerbate mental health conditions.
6. The Australian Government should identify and fast-track the scaling-up of locally developed and rigorously evaluated prevention initiatives that are available but under-utilised. Priority should be given to programs with positive results from randomised controlled trials and economic evaluations. Support should also be provided to prevention initiatives that show promise but require further evaluation.
7. The Australian Government should support the development and implementation of professional development initiatives that encourage and enable clinicians and practitioners from diverse sectors to take an integrated approach to health and mental health promotion.
8. The Australian Government should provide funding for collaborative research that brings together researchers working on the prevention of mental health conditions, alcohol and substance misuse, problem gambling and/or chronic disease.
9. Research funding bodies such as the National Health and Medical Research Council, Australian Research Council and the Medical Research Future Fund should encourage researchers to collect data to determine if multi-morbidity is potentially being prevented through their prevention interventions.

10. The Australian Government should provide support for strategies to better monitor the impact of prevention initiatives through a comprehensive approach to surveillance including:
- i. Repeating the National Survey of Mental Health and Wellbeing (adult version)
 - ii. Regularly conducting the Australian Health Survey with the inclusion of anthropometric and biomedical measures;
 - iii. Routine screening for and central reporting of comorbid conditions among individuals with a chronic disease or a mental health condition in all publicly funded, or subsidised, health and mental health services, using standardised and validated data collection and assessment tools.

Executive summary

Mental health conditions are not inevitable and there is now considerable scientific evidence showing that it is possible to prevent many conditions. There is also good evidence to show that prevention is cost-effective and can produce savings. Prevention needs to be a central pillar of our mental health system. There is clear public support for prevention, as the recent public consultation on the Terms of Reference for the Royal Commission into Mental Health in Victoria has highlighted.

The impact of mental ill-health

Around 4.8 million Australians are living with a mental health condition and, at some point in their life, around 1 in 2 Australians will experience a diagnosable mental health condition. These conditions have significant negative impacts on people's lives, and the lives of carers and significant others. These impacts occur across multiple life domains, including on education and employment outcomes. These in turn contribute to socioeconomic disadvantage. At a societal level, mental health conditions create significant costs relating to healthcare, welfare and business, which the National Mental Health Commission estimates to be around \$70 billion, or 4% of GDP annually.

Mental health policy in Australia

Australia's approach to these conditions is driven by the National Mental Health Strategy. Since its introduction in 1992, this Strategy has led to a series of major reforms across Commonwealth, State and Territory funded programs that have aimed to increase the availability and uptake of mental health supports and services, and enhance their quality. These reforms have been backed by a substantial increase in government spending.

Despite this significant reform agenda, there has been little to no improvement in the key population-level indicators of success. The prevalence of mental health conditions has not fallen over the last 25 years, the disability burden associated with these conditions has barely changed, the suicide rate remains tragically high, and life expectancy among people with these conditions remains significantly lower than the general population. This concerning lack of progress in reducing the prevalence and impact of mental health conditions highlights the urgent need for new approaches.

Harnessing the benefits of prevention for multiple mental and physical health conditions

The prevention of mental health conditions will generate significant personal and societal benefits; however, these gains could be further maximised by linking efforts to prevent mental health conditions with efforts to prevent several closely related groups of conditions. There is a wealth of epidemiological data showing considerable intersectionality between mental health conditions, chronic disease, alcohol and substance misuse, and problem gambling. These various groups of conditions share numerous risk factors, are independent risk factors for each other, and frequently co-occur. Each group of conditions has significant adverse impacts which are substantially increased when they occur together. Integrated approaches to prevention should therefore be pursued as much as possible.

The essential building blocks of prevention

A lifespan approach

Prevention initiatives need to be informed by the epidemiology of mental health conditions and these other related conditions, as well as by research evidence about what works. Ultimately the foundations for good physical and mental wellbeing are laid down in the early decades of life and so some priority needs to be given to prevention initiatives during the antenatal, childhood, adolescent and young adult period, although prevention initiatives are needed across the whole lifespan.

Focus on risk and protective factors

Success depends on tackling the various risk and protective factors that influence the onset of mental health and related conditions, although initiatives focused on people with subthreshold symptoms, to prevent their progression into a ‘full-blown’ condition also have a place. Risk and protective factors are distributed across multiple social environments and so prevention initiatives are needed across a range of health and non-health settings including online, the home, education settings, workplaces, sport and recreational clubs, the arts, health sector services, housing, local communities and in public policy. Strategies need to be targeted at the general population as well as clinical populations. These approaches also need to take account of the uneven distribution of risk and protective factors along dimensions such as gender, sexual orientation, geography, socioeconomic status and cultural identity.

Reach, scale and methodologies

Because of the high prevalence of mental health and related conditions, prevention initiatives need to be able to reach large numbers. Scalable solutions are important. Effective prevention will require a mix of strategies including public education/awareness campaigns; personal and peer-to-peer skills-building programs; the creation of mentally healthy organisational environments; local community mobilisation initiatives; mentally healthy public policies, particularly those targeted to the social determinants of health; and service system initiatives.

Using and building the evidence base

Evidence-based prevention programs do exist, but many are poorly utilised. Priority should initially be given to increasing the reach and adoption of those strategies that have been developed locally and evaluated rigorously, especially those that have positive results from randomised controlled trials and economic analyses. Less well researched but promising initiatives should also be resourced to support further localised trials and evaluations. Funding to research new and better prevention initiatives – particularly those that integrate mental health and physical health promotion – is also essential.

Coordination and integration

Given the need for multi-sector action, coordination and integration are critical. This will require national oversight, robust collaborations and funding mechanisms that allow resources from one portfolio (e.g. education) to be used to achieve outcomes in another (e.g. mental health). We also need to more clearly define what constitutes a prevention intervention so that we can keep track of exactly how much funding is spent and where it is going.

Monitoring progress

Monitoring the impacts of this funding is crucial to determine whether we are making a difference. This could be achieved through research studies, data collection in key settings such as schools, workplaces and health sector services, as well as through whole-of-population surveys. This data should include monitoring of risk and protective factors; changes in individuals’ knowledge, attitudes, beliefs and behaviours; process changes in organisations’ practices and policies; incidence and/or prevalence of key conditions; and data on morbidity and mortality.

Mental health conditions, alcohol and substance misuse, problem gambling and chronic disease exact a heavy toll on individuals, their loved ones and society more broadly. We need to find better ways to tackle mental health conditions and other closely related public health issues. We believe that success lies in seeing prevention and treatment as complementary rather than competing approaches and making prevention a central pillar of both our mental health and health system.

The personal, social and economic context

Mental wellbeing and mental health condition*

The World Health Organization defines mental health as a state of well-being in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.¹ Others emphasise the hedonic and eudemonic nature of mental wellbeing and define it more simply as feeling good emotionally, functioning well psychologically and socially, and having a sense of meaning and purpose in life.^{2 3}

The term mental health condition is an umbrella term for conditions that may be diagnosed according to criteria outlined in the World Health Organisation International Classification of Disease 10th Edition or the American Psychiatric Association Diagnostic and Statistical Manual 5th Edition. Mental health conditions are common, and it is estimated that there are currently around 4.8 million Australians living with a mental health condition.^{4 5} These conditions may affect people from all backgrounds, although the prevalence of various conditions is not equally distributed. Prevalence varies by gender, socioeconomic status, sexual orientation, disability, and cultural identity.^{6 7 8} These conditions may occur at any age; however, they commonly commence in childhood, adolescence or early adulthood. Around 50% of all lifetime conditions occur by the age of 14 and 75% occur by the age of 24.⁹

Mental wellbeing and mental health conditions occur on a continuum. The traditional single continuum model positions mental wellbeing at one end of the continuum, subthreshold symptoms somewhere along the middle, and mental health conditions at the opposite end of the continuum. The more recent dual continuum model proposes that mental wellbeing and mental health conditions are two correlated, but independent phenomena.¹⁰ This model positions low mental wellbeing (languishing) at the end of the first continuum, moderate mental wellbeing somewhere in the middle, and high mental wellbeing (flourishing) at the opposite end of this first continuum. This model then positions no symptoms of a mental health condition at one end of the second continuum, subthreshold symptoms somewhere in the middle, and mental health conditions at the opposite end of the second continuum.^{11 12} This relationship is shown in Figure 1.

Mental wellbeing is important for individuals and society.¹³ High levels of mental wellbeing are associated with better learning, increased creativity, greater productivity, more pro-social behaviours, better physical health and longevity.¹⁴ By contrast, low levels of mental wellbeing – even in the absence of a mental health condition – or the experience of a mental health condition itself can both have significant negative consequences, although the latter is usually more profound.

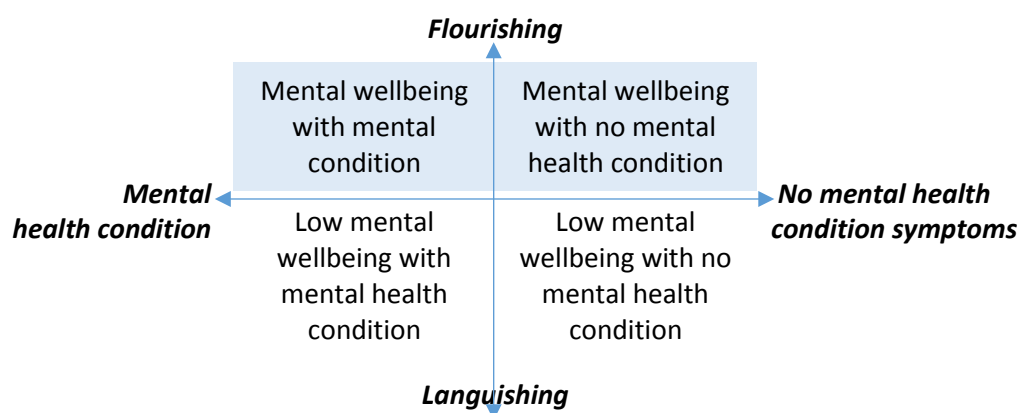


Figure 1: Dual-dimensional representation of mental wellbeing and mental health conditions, adapted from Keyes, C. (2013). *Mental Health as a Complete State: How the Salutogenic Perspective Completes the Picture. Bridging Occupational, Organizational and Public Health: A Transdisciplinary Approach*. 179-192.

* Please see Appendix 1 Glossary for definitions of terms used throughout this submission.

The impact of mental health conditions

Mental health conditions cause distress and can lead to significant adverse impacts in multiple life domains, some of which may endure for decades. The impact of these conditions on education and employment outcomes are particularly problematic from a personal and economic perspective.

Education impacts

Mental health conditions impact on school engagement, attendance, performance and retention. Data from the Australian 'Young Minds Matter' national survey shows that more than 1 in 4 (28.4%) students with a 12-month disorder failed to experience good school connectedness and almost 1 in 3 (32.1%) failed to experience good school engagement. By contrast only 1 in 9 (11.3%) students without a mental health condition failed to experience good school connectedness and 1 in 5 (19.8%) failed to experience good engagement. Absenteeism was also higher among students with a mental health condition. Students with a mental health condition missed twice as many school days as students without a condition (25.8 days per year compared with 11.3 days per year) across years 7-12.^{15 16}

Academic performance was also compromised. The survey data showed that on average, students with a mental health condition scored lower than students with no condition in every NAPLAN domain and year level. By year 9 students with a mental health condition were 1.5-2.8 years behind students with no condition.¹⁷ Other research shows that young people with a mental health condition are less likely to complete year 12.^{18 19}

Employment impacts

The impacts of mental health conditions on employment are just as significant. Young people with a mental health condition are more likely to not be in education, employment or training (NEET) compared to other young people.²⁰ A study conducted through headspace centres in Melbourne and Sydney found that 19% of headspace clients aged 12-25 who participated in the survey were NEET compared to 11% of the general youth population.²¹ Across all ages, individuals with a mental health condition are three times more likely to be unemployed than others in the general population.²²

Furthermore, people with a mental health condition who are employed are more likely to be in poorly paid jobs compared to people without a condition. For people in work, mental health conditions also contribute to presenteeism (under-productivity at work), absenteeism (sick leave) and early retirement due to ill-health.^{23 24 25} While some of these negative employment outcomes result from the impact of the condition or treatment, much is also driven by stigma, discrimination and a lack of support, which results in a lack of opportunity.

Economic impacts

The resulting economic impacts for individuals and society are profound. Mental health conditions are a major contributor to social disadvantage and poverty. It is estimated that around 20% of people with a moderate mental health condition and around 36% with a severe condition are living in poverty.²⁶ Ultimately the link between mental health conditions and poverty is bidirectional, with each increasing the risk of the other. This can lead to a vicious cycle with mental health conditions contributing to disadvantage and vice versa which may contribute to the intergenerational transmission of poverty.²⁷

At a societal level, the estimated costs vary according to the methodology used to calculate costs and what costs are included (e.g. healthcare, lost productivity, carer/family costs, lost taxation, housing support, welfare payments, etc.).^{28 29} While mental health conditions are only one possible contributing factor to early school leaving and for young people to be NEET, these two factors create substantial fiscal and social costs. A study by the Mitchell Institute estimated that the total lifetime fiscal cost among the Australian cohort of early school leavers in 2014 was \$12.6 billion while the social costs for this group were estimated to be \$23.3 billion in any given year. They further estimated that the full lifetime fiscal burden of the cohort of young people who were NEET in 2014

amounted to \$18.8 billion that year and to \$50.5 billion across the lifetime of this cohort if they remained disengaged from education, training and employment over the course of their life.³⁰

Studies that have focused more specifically on the costs of mental health conditions have also found significant impacts on individuals, health services and society. An Access Economics report found that mental health conditions among young people aged 12-25 cost the Australian community \$10.6 billion in 2009 (health care costs, reduced productivity, foregone income taxes and welfare benefits).³¹ A 2002 Access Economics report found that schizophrenia cost \$1.85 billion in 2001 (healthcare costs, loss of earnings, premature death, carers' costs, forgone taxation and welfare payments).³² A more recent analysis estimated that in 2014, the total cost to society from psychotic disorders was \$6.1 billion (health care costs and loss of productivity).³³

A recent report from Deakin University estimated that depression, anxiety and substance-use cost the community \$12.8 billion annually in direct and indirect costs (\$974 million in health care costs and \$11.8 billion in productivity loss). Additional costs to governments included \$1.23 billion in forgone income taxes and \$12.9 billion in welfare benefits.³⁴ The National Mental Health Commission estimates that overall mental health conditions cost the community up to \$70 billion annually, or 4% of GDP.³⁵

Disability and mortality

Psychosocial disability is common. In 2011, mental and substance use disorders were the leading cause of non-fatal burden of disease, accounting for almost a quarter (23.6%) of all years lost due to disability.³⁶ This disability burden is particularly evident among people aged under 50 years – accounting for between one-quarter to one-half (28–47%) of the health loss in this age group.³⁷

Premature death is another major issue. People with a serious mental health condition are twice as likely to die prematurely as people in the general population and their life expectancy is on average 10-17 years shorter than others in the community, in part through death by suicide, but mostly because of premature death from chronic disease.^{38 39 40} Overall mental health and substance misuse conditions account for 12% of the total burden of injury and disease in Australia.⁴¹

Current mental health policies

Governments across Australia have long understood the need to take action to reduce the impact of mental health conditions on individuals, their loved ones, and the community. While each jurisdiction has its own approach, much of this action is influenced by the National Mental Health Strategy.

The National Mental Health Strategy

The National Mental Health Strategy commenced in 1992. It is underpinned by several key documents including the National Mental Health Policy, National Mental Health Plans and the Mental Health Statement of Rights and Responsibilities. These policies and plans, which are endorsed at the level of First Ministers through the Council of Australian Governments, or through the Commonwealth, State and Territory Health Ministers, have set the agenda in mental health for over a quarter of a century.⁴²

Mental health reforms

Since its introduction in 1992, the National Mental Health Strategy has generated a series of sweeping reforms of Commonwealth, State and Territory Government funded mental health supports and services. One key focus of these reforms has been to increase the proportion of people with a mental health condition who access treatment (closing the treatment gap). The National Survey of Mental Health and Wellbeing in 1997 and 2007 found that around two thirds of people who had experienced a mental health condition in the 12 months prior to each survey had not accessed a mental health service.^{43 44} This treatment gap became a major focus for intervention and contributed to the development of programs to increase the community's mental 'health' literacy, reduce stigma and encourage help-seeking (e.g. Beyond Blue). Initiatives were also designed to increase the availability and affordability of mental health services so that more people could access them where and when they needed (e.g. Better Outcomes in Mental Health Care, Better Access, headspace, youth early psychosis programs, eMPRAC and Head to Health).

Another focus has been to reduce the quality gap. These efforts have focused on increasing the proportion of people accessing treatment who receive culturally-appropriate, person-centred, evidence-based assistance tailored to their needs and preferences. Considerable investment has gone into reducing the quality gap via a range of measures. Some of the reforms designed to increase access (e.g. Better Outcomes, headspace, youth early psychosis programs) also aimed to improve quality by upskilling practitioners or by promoting more holistic, user-friendly service provision. Other initiatives to reduce the quality gap have included: increasing consumer and carer input into service development; developing treatment guidelines; articulating service standards and various reporting and accountability measures; introducing outcomes monitoring; implementing culturally sensitive practice initiatives; and adopting a human rights approach to mental health legislation.

Another element of the 'quality agenda' has been to move towards a recovery focus that emphasises the importance of working towards outcomes that are meaningful to the consumer (and carers), including those relating to social and economic participation. This has contributed to a strong emphasis on providing consumers and carers with access to 'non-clinical' psychosocial services including those designed to promote independence and/or improve socioeconomic outcomes (e.g. Personal Helpers and Mentors, Partners in Recovery, the NDIS, Job Active, Disability Employment Services, trials of Individual Placement Support).⁴⁵

Other major reforms include: enhancing primary care services; increasing access to psychologists, allied mental health professionals, mental health nurses, and peer workers; creating new community and inpatient specialist mental health service models; changing the way supports and services are funded (e.g. through Primary Health Network commissioning); and strengthening governance and oversight arrangements (e.g. through the National Mental Health Commission).

These reforms have been backed by a substantial increase in government spending. Data from the Australian Institute of Health and Welfare show that in per capita terms, national spending on mental health increased from \$144 per person in 1992–93 to \$373 in 2015–16.⁴⁶ Overall, in 2015–16 total mental health expenditure was \$9 billion and mental health expenditure accounted for 7.7% of all health expenditure.⁴⁷ Taking a different approach, the National Mental Health Commission found that in 2012–13 the Commonwealth Government on its own spent \$9.6 billion on mental health. This amount included the Disability Support Pension, Medicare, the Pharmaceuticals Benefits Scheme and other payments; programs and services with Commonwealth agencies and payments to states and territories; and funding allocated by the Department of Health, the Department of Social Services and the Department of the Prime Minister and Cabinet on programs delivered by NGOs.⁴⁸

Strengths and limitations of current policy approaches

While mental health expenditure (7.7% of all health expenditure) is well below the burden of disease caused by these conditions (12%) there has nevertheless been an increase in investment in mental health over the last 25 years and this investment has made a difference.

Research shows that Australians are now more aware about mental health conditions, public attitudes towards mental health services have changed, stigma levels have fallen and help-seeking has increased and service availability has expanded compared to earlier decades.^{49 50} The treatment gap is slowly closing and research studies and Medicare data show that a greater number and proportion of people with a mental health condition are accessing services, especially those provided by general practitioners, psychologists and other allied mental health practitioners, however, there are still many individuals with a mental health condition who do not access services.^{51 52 53}

Efforts to close the quality gap are also showing some signs of success. The majority of State/Territory funded mental health services are meeting national service standards and consumers are reporting high levels of satisfaction with headspace services and reasonably high levels of satisfaction with State/Territory funded community and inpatient mental health services.^{54 55 56 57} Furthermore, outcomes associated with the use of Better Access and headspace services are reasonably good although outcomes associated with the use of State/Territory funded services are more variable, being better for those receiving inpatient care than community-based care.^{58 59 60 61 62} There is therefore clearly more that needs to be done to close the quality gap.

However, while there have been some significant improvements, at an aggregate level there has been little to no improvement in other key population level metrics commonly used to define success. Data from two national surveys of mental health and wellbeing (child/adolescent and adult), regular National Health Surveys, research studies and other sources (e.g. [headspace national survey](#)) show that the prevalence of mental health conditions has not fallen in the last 25 years and is appears to be increasing among some segments of the population (e.g. young women).^{63 64 65 66} Furthermore, the 2011 Burden of Disease study shows that there has been no real reduction in the disability burden associated with mental health conditions, while suicide data show no sustained reductions in suicide rates.^{67 68} Improving the physical health of people with a mental health condition is another area where there has been limited progress.

This is not to suggest that these reforms have been a failure – many have led to genuine improvements. It also does not suggest that there is no point investing further in improving supports and services for people with a mental health condition. A strong mental healthcare system is vital and more needs to be done to strengthen and improve our current system. However, the lack of progress in reducing the prevalence and impact of mental health conditions over the last quarter of a century does highlight that new solutions are also urgently needed. Prevention is one such solution.

Focusing on prevention

What is prevention?

Prevention can be classified in various ways. One commonly used approach is to distinguish between primary, secondary and tertiary prevention, where primary prevention focuses on preventing a condition from ever occurring, secondary prevention focuses on preventing a condition from progressing or recurring, and tertiary prevention focuses on preventing disability and handicap.⁶⁹

Another common classification system focuses on the target group for the intervention. Universal prevention initiatives target the whole population, selective interventions target people at elevated risk and indicated prevention intervention targets people with the early signs and symptoms of a condition (e.g. subthreshold depression).⁷⁰ While the various types and approaches to prevention are all important, this paper focuses predominantly on primary prevention, through universal, selective and/or indicated means.

The benefits of prevention

While prevention has been part of Australia's National Mental Health Strategy since 1992, having been included in the First, Second, Third and Fourth National Mental Health Plans and the COAG Roadmap for National Mental Health Reform 2012–2022, sustained investment in prevention has not materialised and we have little to show for the policy emphasis. The recent National Mental Health Commission (NMHC) National Review of Mental Health Programmes and Services noted that in 2012–13 the Commonwealth Government spent \$22.4 million on mental illness prevention programs compared to over \$3.6 billion on clinical and psychosocial services for people with a mental health condition.⁷¹ More recently, the Fifth National Mental Health and Suicide Prevention Plan – endorsed by COAG in August 2017 – did not include a specific focus on the prevention of mental health conditions, making it the first National Mental Health Plan to omit this priority.

Mental health conditions are not inevitable and there is now good scientific evidence to show that many conditions can be prevented.^{72 73 74} There is also good evidence to show that a focus on prevention is cost-effective.^{75 76 77 78} A 2011 economic analysis of prevention-focused mental health interventions by Mihalopoulos and others concluded that: “interventions designed to prevent adult and childhood depression, suicide, and childhood anxiety provide very good value for money.”⁷⁹ In 2011 Knapp and others reviewed 15 prevention and early intervention initiatives and found that most of the initiatives provided value for money, many were low cost, several were self-financing, and most had pay-offs spread over many years.⁸⁰ A more recent review echoes these findings and also highlights the cost-saving benefits of prevention that start early in life, such as parenting programs and school-based programs.^{81 82}

However, rather than utilising the major scientific advances that are occurring in this field, and applying this evidence effectively, governments appear to be ignoring prevention as a potential solution to our mental health crisis and are primarily focused on measures designed to assist people *after* they have become unwell.⁸³ This situation is out-of-step with the situation in other areas of health and needs to change. Australia needs to implement a twin-track approach that focuses simultaneously on preventing mental health conditions *and* on providing high-quality supports and services for people living with a mental health condition, and their carers.^{84 85 86} Prevention and treatment are complementary, not competing endeavours. Both are important and reducing the personal and social impact of mental health conditions requires a concomitant focus on both.

Risk and protective factors

Initiatives to prevent mental health conditions generally focus on increasing the protective factors that reduce the likelihood of becoming unwell or reducing the risk factors that increase the odds. However, prevention can also be achieved by intervening when subthreshold symptoms emerge

in an attempt to avert the progression into a 'full-blown' mental health condition.⁸⁷ There are a substantial number of risk and protective factors that influence the development of mental health conditions and this creates some complexity, but also some opportunities.⁸⁸

Because prevention mostly operates through interventions that address risk and protective factors, changes in these factors can sometimes produce multiple benefits. Many of the risk and protective factors for mental health conditions overlap with risk and protective factors for several other conditions and addressing these factors can lead to substantial cross-over benefits for the prevention of these related conditions. The link between mental health conditions and chronic disease is a case in point.

The link between mental health conditions and chronic disease

Chronic diseases include conditions such as diabetes, cardiovascular disease, lung disease, cancer, kidney disease and some musculoskeletal conditions. Like mental health conditions, chronic diseases are common. Based on self-report data from the 2017-18 National Health Survey, it is estimated that 4.9% of Australian adults aged 18 years and over have diabetes, 4.8% have heart disease, stroke or other vascular disease, 2.5% have chronic obstructive pulmonary disease (COPD), 1.8% have cancer and 1% have kidney disease. In total, just under half (47.3%) of adult Australians have one or more chronic conditions.⁸⁹

Like mental health conditions, chronic diseases impact on workforce participation and productivity and are a significant cause of disability. They are also the leading cause of premature death in Australia.^{90 91 92 93} And like mental health conditions, the impact of chronic disease ripples out to affect their loved ones as well. These personal costs are matched by the economic costs of these conditions. Chronic disease is a major driver of community and hospital-based health service utilisation and these conditions therefore drive up health system costs. For example, cardiovascular disease (CVD) accounts for over 12% of all health care expenditure (\$7.5 billion each year) while overall, chronic disease costs the health system \$27 billion every year.^{94 95}

Mental health conditions and chronic disease share several risk factors

Mental health conditions and chronic disease share much in common, including several risk factors. Certain risk factors occur at different times across the life span, while others occur across all ages. One major group of shared risk factors are adverse childhood experiences (ACEs). While different researchers include slightly different experiences under this umbrella, the most commonly described ACEs include child maltreatment (physical, emotional, sexual abuse or neglect), exposure to family violence and having a parent with a severe mental illness, alcohol/substance use disorder or history of incarceration.⁹⁶ Research shows that individuals who are exposed to these experiences while growing-up are at increased risk of developing a mental health and/or physical health condition during the course of their life compared to individuals who are not.^{97 98 99}

The greater the number of ACEs a person is exposed to the greater their risk of experiencing these various conditions.¹⁰⁰ Among people who had been exposed to four or more ACEs as children there were: "weak-modest relationships for physical inactivity, overweight or obesity, and diabetes; moderate relationships for smoking, heavy alcohol use, poor self-rated health, cancer, heart disease, and respiratory disease; strong for sexual risk taking, mental ill health, and problematic alcohol use; and strongest for problematic drug use and interpersonal and self-directed violence".¹⁰¹ Given the particularly high association between ACEs and mental health conditions, some experts argue that the prevention of ACEs needs to become a core focus of efforts to prevent mental health conditions.^{102 103 104 105} The evidence also shows that the prevention of ACEs can contribute to the prevention of chronic disease as well.

Another risk factor that is sometimes listed as an ACE is bullying, although in reality this stressor may occur across the lifespan.¹⁰⁶ Other such whole-of-lifespan stressors include racism, homophobia and transphobia, harassment and discrimination. All of these experiences are associated with both mental health conditions and physical health conditions.^{107 108 109 110 111 112} Reducing any or all of these risk factors will therefore have flow-on benefits for both categories of conditions.

Smoking, unhealthy eating, lack of physical activity and poor sleep hygiene are another set of risk factors that can impact on both mental and physical health. Individuals who smoke are twice as likely to experience depression than former smokers or never smokers, and smoking has also been linked to an increased risk of psychosis, and the onset of psychosis at an earlier age.^{113 114} Smokers are also at high risk of lung disease, cardiovascular disease, cancers and other health conditions. Regular physical activity protects against chronic disease and has also been found to both prevent the risk of depression and to assist in treating depression.¹¹⁵ A prospective cohort study, found that: “12% of future cases of depression could have been prevented if all participants had engaged in at least one hour of physical activity each week”.¹¹⁶

Diet quality is another important shared risk (and protective) factor for mental health conditions and chronic disease. Poor quality diets contribute to diabetes, cardiovascular disease and cancers. Cross-sectional and prospective observational studies have shown highly consistent associations between diet quality and depression risk. People who consume low quality diets are at higher risk for depression than people who consume high quality diets (e.g. high intake of fruit and vegetables, fish, and whole grain products), independent of socioeconomic factors, lifestyle behaviours and body weight. These relationships do not appear to be explained by reverse causality.^{117 118}

At an experimental level, the recent Supporting the Modification of Lifestyle in Lowered Emotional States (SMILES) randomised control trial found that providing people with clinical depression with dietary support from dietitians to increase adherence to a healthy diet led to significantly greater improvements in depression symptoms compared to a control group who did not receive such support, and this intervention was cost-effective as well.¹¹⁹ Similarly, the HELFIMED randomised controlled trial showed substantial reductions in depressive symptoms after an intervention focused on dietary improvement.¹²⁰ A recent meta-analysis confirmed the benefit of addressing diet for depression and depressive symptoms and also reported better outcomes from the use of nutrition professionals such as dietitians.¹²¹ There is also emerging evidence for early life nutrition as a risk factor for mental health conditions in young people, pointing to the importance of addressing the food environment to aid in prevention efforts.^{122 123}

Loneliness is another shared risk factor and there is a strong association between loneliness, social isolation and early death.¹²⁴ Perhaps the biggest group of shared risk factors are the social determinants of health such as gender, ethnicity, education, employment, housing and income. Mental health conditions and physical health conditions are more common among people from disadvantaged backgrounds than people from more advantaged backgrounds.^{125 126} This social gradient occurs across the entire socioeconomic spectrum with people in the highest socioeconomic quintile having lower rates of illness than people in the lowest quintile.

Disadvantage is not evenly spread and people from certain communities such as Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse minority or refugee communities and people with a disability, are more likely to experience socioeconomic disadvantage than others in the community. Addressing these social determinants needs to be a key focus of prevention efforts in mental and physical health.

Mental disorders and chronic disease are also risk factors for each other

Not only do mental health conditions and chronic disease share a number of major risk factors, but research also shows that there is strong evidence for a bi-directional association between these two groups of conditions which are independent risk factors for each other.^{127 128}

People with a mental health condition are at a higher risk of experiencing a chronic disease than people in the general population and most of the excess mortality associated with mental health conditions results from the presence of comorbid chronic disease, rather than from suicide.¹²⁹ For example, people with a mental health condition are 90% more likely to be diagnosed with bowel cancer than people in the general population and six times more likely to die from cardiovascular disease.^{130 131}

A number of factors contribute to this increased risk, including a high prevalence of risk factors for chronic disease – including smoking and poor metabolic health – among people living with a mental health condition. Compared to the general population, women with a mental illness are nearly 70% more likely to be smokers and men with mental illness are nearly 40% more likely.¹³² Mental health conditions can also lead to chronic disease through the side-effects of treatment. Medications used to treat mental health conditions, such as those used in bipolar disorder and schizophrenia, may lead to weight gain, impaired glucose metabolism and hypertension. These in turn increase the risk of type 2 diabetes and cardiovascular disease. Other potential contributing factors for chronic disease include increased levels of loneliness, stress and poverty. Improving the way we support people with a mental health condition to protect their physical health may reduce the incidence of chronic disease.¹³³ One of the keys to achieving this is through a concerted effort to address these various risk factors. Failing to address them will only serve to perpetuate inequalities.

On the other side of the equation, people with a chronic disease are at higher risk of experiencing a mental health condition than the general population. Here again, the reasons are complex and multi-factorial. For example, chronic diseases may contribute to mental health conditions through activation of the stress response, or their psychological impacts (e.g. loss of identity, health, financial security or independence), or impacts on quality of life (need for regular treatment, functional impairments) or from chronic pain.

Mental health conditions after heart attack and stroke are common.^{134 135} One-third of stroke survivors will experience depression and between 20–25% will experience anxiety.¹³⁶ Furthermore, a significant proportion of stroke survivors are dependent on carers, most of whom are informal supports such as family and friends, and this support can come at a significant cost, with an estimated 30–68% of carers for stroke survivors experiencing anxiety or depression.¹³⁷ Preventing the occurrence of mental health conditions among people with a chronic disease, and their carers, is therefore just as critical as preventing mental health conditions among people who are otherwise well.

Mental health conditions and chronic disease often co-occur

The other major area of overlap is multi-morbidity. An estimated 12% of the general population have both a mental health condition and a chronic physical condition.¹³⁸ Data from the 2007 National Survey of Mental Health and Wellbeing suggest that among individuals with a 12 month mood or anxiety condition, 46% also had a chronic physical condition, while among survey participants with a chronic disease 28% also had a mental health condition.¹³⁹ Overall it is estimated that 2.4 million people are living with both a mental health condition and a chronic physical health condition.¹⁴⁰ Notably, women are 1.6 times more likely than men to experience a comorbid mental health condition and chronic disease.¹⁴¹ People from a low socioeconomic background and Aboriginal and Torres Strait Islander people are also at increased risk.¹⁴²

Mental health conditions and chronic disease interact and compound each other increasing the risk of poorer treatment outcomes, poor quality of life, disability and premature death.¹⁴³ For example, one meta-analysis suggested that depression leads to a two to threefold increase in negative outcomes for people with acute coronary disease.¹⁴⁴ This creates a significant additional burden for the individual across multiple life domains including in relation to work. Multi-morbidity increases the risk of poor labour force participation and unemployment.¹⁴⁵ Compared with employed people, those not in the labour force are nearly 70% more likely to have comorbidity, and those who are unemployed are 45% more likely. This in turn increases the risk of poverty.

One study found that people with multi-morbidities experience drastically lower incomes and receive up to 200 times more in welfare payments from government than those with no health conditions.¹⁴⁶ Apart from its impacts on labour force participation, multi-morbidity also impacts on productivity through its effects on absenteeism and presenteeism among people in work. It also impacts on health care costs. Multi-morbidity often leads to increased use of primary care, specialist or hospital-based procedures and services and/or pharmaceuticals. Research shows that the costs of treating co-existing mental and physical conditions are significantly greater than the costs of treating the physical conditions alone.¹⁴⁷

The links between mental health conditions and other conditions

While the intersections between mental health conditions and chronic disease are considerable the overlaps do not end there. Mental health conditions are also strongly associated with alcohol and substance misuse. There is also a strong association between suicide and alcohol and substance misuse. Data from the 2007 National Survey of Mental Health and Wellbeing suggest that around one in five (21.4%) people with a substance use disorder also have a mood disorder and one in three (33.5%) have an anxiety disorder.¹⁴⁸ An Australian study found that among people with an alcohol disorder, 20% also met the criteria for a panic disorder, 13% for agoraphobia, 17% for social phobia, 15% for obsessive compulsive disorder, 24% for post-traumatic stress disorder and 17% for general anxiety disorder.¹⁴⁹ Other research found that one-third of people who enter drug treatment have attempted suicide and around ten per cent have attempted suicide in the preceding twelve months.¹⁵⁰

As with chronic disease, the relationship between mental health conditions and alcohol and substance misuse is bidirectional – each may contribute to the onset of the other. They can also interact and complicate recovery. Substance misuse has a significant negative impact on recovery from a mental health condition. Cigarette smoking may worsen the symptoms of conditions and may reduce the effectiveness of psychotropic medications as a result of altered liver metabolism. Alcohol can exaggerate depression, impair decision making and reduce impulse control. Cannabis can trigger or exacerbate psychotic symptoms among individuals living with schizophrenia or other psychotic disorders.¹⁵¹ It is crucial for people's recovery that this co-morbidity is accurately diagnosed, and integrated treatment is provided, otherwise outcomes risks being compromised.¹⁵²

There is also a strong correlation between mental health conditions and problem gambling. Victorian prevalence studies from 2008 and 2014 show high prevalence of mental health conditions among those who experience harm from gambling.¹⁵³ The 2008 study, using the Kessler 10 instrument, found 39% of problem gamblers were likely to have a severe (24%) or moderate (15%) mental health condition.¹⁵⁴ The 2014 survey asked about actual diagnoses. Among people at moderate risk of problem gambling, 24% had been diagnosed with depression and 20% had been diagnosed with an anxiety conditions, while among problem gamblers 41% were diagnosed with depression and 39% were diagnosed with an anxiety condition.¹⁵⁵

More broadly, a systematic review of population studies found that 37.4% of problem and pathological gamblers had a comorbid anxiety disorder, 37.9 % had any mood disorder, and 57.5% a comorbid substance use disorder.¹⁵⁶ While many people with a mental health condition do not participate in gambling, one study found those who did gamble were far more likely than the general population to have problems with their gambling and were almost four times more likely to be in the moderate risk group gambling group and more than six times as likely to be a problem gambler.¹⁵⁷ Gambling comes at a cost to the individual and the community. *The Social Cost of Gambling to Victoria*, estimated the total emotional and psychological costs to Victorian gamblers at \$1.59 billion per annum. Within this figure, depression contributed \$177 million and suicide attempts and ideation another \$289 million.¹⁵⁸

The nature of the links between mental health conditions, alcohol and substance misuse are similar to the links between mental health conditions and chronic disease in that these groups of conditions share common risk factors, have a bidirectional association with each other, and are frequently co-morbid.¹⁵⁹ Mental health conditions and problem gambling likewise share similar risk factors and are often co-morbid. In terms of directions of causation between mental health conditions and gambling issues there is no definitive evidence, however it would be fair to say that given the overlap between the two that prevention efforts focussed on mental health conditions and/or gambling harm are likely to have reciprocal and synergistic benefits.

How much burden can be averted?

The 2011 Burden of Disease study estimated that 21% of the burden associated with mental health conditions is preventable.¹⁶⁰ These estimates are based on the 29 behavioural, dietary, metabolic and environmental risk factors included in the analysis rather than all known modifiable risk factors relevant to mental health conditions, and so the proportion of the burden that can be averted through prevention is potentially much higher. The proportion of the burden that can be averted through prevention compares favourably with the burden that could be averted through treatment, which for depression has been estimated to be around 30% although this would require 100% coverage and compliance with evidence-based treatments, something that is very difficult to achieve.¹⁶¹ With respect to chronic disease, it is estimated that 39% of the burden associated with respiratory conditions is preventable, 42% for kidney disease, 44% for cancer is potentially preventable, and 69% of the burden associated with cardiovascular disease is preventable.¹⁶² Ultimately, given the significant links between mental health conditions, chronic disease, alcohol and substance misuse and problem gambling, an integrated approach to prevention is likely to produce significant benefits.

What's required?

An increased focus on prevention is important from a number of perspectives. Prevention helps to avert the distress, disruption, disability and premature death that ill-health can cause. It can also help to prevent the stigma and social exclusion that comes with having a mental health condition. Prevention helps to reduce the need for treatments that can be emotionally stressful, time consuming and costly and which in themselves may have significant impacts on mental and physical wellbeing.

Prevention is also the logical thing to do from a scientific perspective and from an economic perspective as we have the knowledge and strategies to make a difference and many of these interventions are cost-effective and have the potential to save money. For prevention to become a core pillar in Australia's efforts to reduce the personal and economic costs of mental health conditions, and other closely associated co-morbid conditions, we need a clear plan, greater investment, more integrated evidence-based prevention programs across a range of settings, strong public policies, increased research and better monitoring.

A clear plan

As noted, while prevention has been part of Australia's National Mental Health Strategy since 1992 it has failed to gain traction. One reason for the lack of progress is that there is no clear blueprint for how the government should proceed. The 2000 National Action Plan for Promotion, Prevention and Early Intervention (PPEI) provided some direction on prevention but was too high-level and lacked detail about the priority targets for intervention (i.e. key risk and protective factors), or specific interventions that could be used to address them.¹⁶³

Australia needs a clear and up-to-date, evidence-based, priority-driven and actionable blueprint for the prevention of common mental disorders. This blueprint should link to the Fifth National Mental Health and Suicide Prevention Plan and the National Framework on Chronic Disease. It is also critical that all future National Mental Health Plans include prevention as a priority issue so that prevention becomes a central policy pillar.

Greater investment

Prevention-specific health and mental health expenditure data is not easy to find. The National Mental Health Commission estimated that expenditure on the primary prevention of mental health conditions through the mental health budget was less than \$25 million in 2012–13. Looking at promotion and prevention more broadly, Australian Institute of Health and Welfare data show that Australia's spending on 'public health' – which includes various prevention programs – has fluctuated between 1.5 and 2.3% of total health expenditure for the last decade (around \$2.5 billion in 2015–16).¹⁶⁴ This is substantially less than the proportion spent in many other developed countries, such as New Zealand (6.4%), Finland (6.1%), Canada (5.9%), Sweden (3.9%), the United States (3.1%) and Japan (2.9%).^{165 166}

In part, the under-resourcing of prevention is probably linked to the need to ensure that there are supports and services in place for people who are unwell. While it is essential to support people with immediate health and mental healthcare needs, there appears to be an underlying assumption that we can only afford one or the other – treatment or prevention. Clearly this is not the case and experts in public health have long argued that we need to change the narrative and grow the pie, so that each area can be allocated resources sufficient to achieve its outcomes. Coupled with this, we also need to develop better ways to define and track prevention expenditure so that we can understand more easily how much is being spent and what it is being spent on.

Another crucial change is to eliminate the siloing that exists in most government funding. While it makes sense from an administrative perspective to allocate, disburse and monitor funding through a single government portfolio area, this is unhelpful for initiatives that require a cross-sectoral approach. Prevention is the key example of this requirement. The prevention of mental health and other related conditions happens in part through the mental health and healthcare system, but it also needs to happen through multiple other settings and sectors as well. Developing funding mechanisms that enable greater cross-sector action is imperative if we wish to make real progress in prevention.

Integrated programs across key settings

Prevention requires a mix of strategies at the individual, organisational and community level including public education/awareness social marketing campaigns; personal skills-building programs; local community mobilisation initiatives; the creation of mentally healthy organisational and community environments; public policies; and service system reorientation initiatives. These programs and policies need to be embedded within key settings such as the home, early childhood services, schools, tertiary education, workplaces, housing, health services, sport and recreation settings, the arts, physical environments and local communities. They also need to be embedded in public policies.

Wherever possible initiatives to prevent mental health conditions need to leverage and complement efforts to prevent chronic disease, alcohol and substance misuse and problem gambling – and vice versa – to maximise the benefits for individuals and our economy. Collaboration in program delivery is important and would help overcome the current problem that sees different prevention agencies working independently in the same setting. A key focus should be to enhance what's already happening in prevention rather than reinventing the wheel, while also tackling the gaps that remain.

Efforts to address the risk and protective factors that are associated with multiple conditions, particularly those that have a significant association with various conditions, are particularly important.¹⁶⁷ Examples include child maltreatment, exposure to family violence, bullying, discrimination, smoking, poor quality diet, physical inactivity, loneliness and the social determinants of health (e.g. unemployment, poor education, inadequate housing etc.).

It is important to note that some groups in the community may have lower access to certain protective factors or be more exposed to certain risk factors and this may vary by gender, sexual orientation, geography, socio-economic status, disability, ethnicity and cultural identity among other factors. We therefore require a framework that takes these critical differences into account. For example, data show that one in three women over the age of 15 years has experienced physical violence, usually by a man that is known to her.¹⁶⁸ Exposure to violence increases the risk of post-traumatic stress disorder seven fold, the likelihood of developing depression by nearly threefold and the likelihood of suicidal ideation by three and a half times compared to women with no experience of domestic violence.^{169 170} Gender inequality is a key driver of violence against women, restricts access to opportunities for women and contributes to their overrepresentation in poverty statistics.¹⁷¹

Programs are required across the lifespan. From the perspective of mental health conditions and alcohol and substance misuse, particular emphasis needs to be given to action during the antenatal period, childhood, adolescent and young adulthood, since prevention initiatives need to precede the time of peak onset of the condition, and both of these groups of conditions tend to first occur at an early age. However, these conditions and chronic disease occur across the lifespan and so prevention efforts cannot just focus on children and young people, but also need to be targeted to individuals and groups throughout the life course. Action in key settings can help to ensure that prevention programs cover the key risk and protective factors as well as all ages and stages of life.

Social marketing

While the community's 'illness' literacy (i.e. knowing the signs and symptoms of particular conditions) is reasonably high, their 'mental wellbeing' literacy (i.e. knowing what to do to stay well) is lower. Efforts are required to increase messaging around wellness and prevention. There is a long history of Commonwealth, State and Territory based public awareness/education campaigns targeted to the prevention of chronic disease, alcohol and substance misuse and even problem gambling. Within the mental health arena, the majority of social marketing campaigns have focused on raising people's awareness about the signs and symptoms of common mental health conditions, destigmatising these conditions and encouraging help-seeking by people with a mental health condition or on suicide prevention, rather than on promoting mental wellbeing or preventing mental health conditions.

There have been some jurisdiction-level mental health promotion campaigns such as VicHealth's 'Together we do better' campaign, and the Act Belong Commit (ABC) campaign managed by Mentally Healthy WA, although these have been time limited (the former) and relatively small scale (the latter). An opportunity exists to implement a specific public awareness campaign targeted to the prevention of mental health conditions. This campaign could potentially draw on existing campaigns such as ABC while adapting to include some messaging and resources that focus specifically on prevention.

Like any intervention, social marketing campaigns need to be theory (and data) informed and subject to robust evaluation. There are a range of theoretical frameworks that are used to inform social marketing campaigns, and each has its strengths and limitations. In recent times, VicHealth has worked extensively with the behavioural insights approach to improving health across a range of settings.¹⁷² Most famously adopted by the Cameron government in the UK, behavioural insights are effective, evidence-based approaches to 'nudging' desired behaviours. VicHealth's BI programs across healthy eating, increasing physical activity and reducing consumption of sugary drinks have demonstrated that population-level increases in physical and mental health is achievable.¹⁷³ Most recently, VicHealth has used behavioural insights approaches to address gender inequality by tackling gender imbalances in recruitment and hiring practices, and increased the involvement and representation of women in sport through the This Girl Can campaign and Media Bias trials.¹⁷⁴

It is also important when encouraging the public to adopt behaviours to prevent mental health conditions, that we don't inadvertently create or increase stigma. To blame individuals, or to give the impression of blaming, will alienate the people that prevention efforts seek to engage.

Antenatal settings and the home

Many of the antecedents for mental health conditions, chronic disease and other related conditions have their origins during the antenatal period, childhood and adolescence. Human development begins in the womb (and potentially pre-conception as well) and is influenced by the complex interaction between various individual and environmental factors that operate together. Our experiences and environments in the antenatal and childhood period can have enduring impacts on psychosocial and physical development, including on our biological systems, and early adverse experiences can increase the risk for later adverse outcomes.¹⁷⁵

The first 1000 days of life are particularly critical. A poor start to life in the first 1000 days may lead to a cascade of negative biopsychosocial changes that have lifelong adverse impacts.¹⁷⁶ This period, and the childhood and adolescent period more broadly, are therefore an important period for action in health and mental health promotion. The prevention of adverse childhood experiences is particularly crucial. Research suggests that preventing child maltreatment could reduce the prevalence of anxiety and depression by around 20–25%.¹⁷⁷ One study found that family violence accounted for 2.9% of the total disease and injury burden for women of all ages, while for women 18–44 years of age, family violence accounted for 7.9% of the overall burden.¹⁷⁸

It is essential that we support parents and give children every opportunity to have a positive start to life. Reducing the negative impacts of socioeconomic disadvantage on parents and families is critical. Programs to identify and manage parental perinatal depression through antenatal and post-natal health services can make a significant difference. Programs that promote positive parenting are another useful element. Parenting programs that focus on promoting secure attachment, emotion regulation, communication skills, boundary setting, and conflict resolution are effective in the prevention of certain mental health conditions and alcohol and substance misuse.^{179 180} Several evidence-based programs exist, but many lack reach. Investment is required to determine how we can improve reach and uptake as well as to scale-up these proven approaches. Investment is also required to develop more effective and sustainable interventions.

Early learning services and schools

Early learning services and schools are another key setting for action. While research into primary prevention programs based in early learning services is limited, there is evidence that high quality early education and care can improve learning outcomes for children from vulnerable families. There is also considerable evidence to show that school-based programs are effective for the prevention of depression and anxiety conditions, as well as for alcohol and substance misuse.^{181 182 183 184 185} Various approaches to implementation exist.

One common approach is to use a whole-of-school approach based on the World Health Organization Health Promoting Schools Framework.¹⁸⁶ In Australia, there are two variations to this approach – a mental health specific whole-of-school approach as exemplified by the Australian Government’s Mental Health in Education Program (i.e. the Beyond Blue Be You program) and an integrated health promotion approach that includes mental health alongside other health issues as exemplified by the Victorian Government funded Achievement Program managed by the Cancer Council Victoria. Both have their strengths. The other approach focuses on classroom-based curriculum programs. Examples include mental health programs targeted to building social and emotional skills and/or resilience (e.g. Friends for Life, Aussie Optimism), those targeted to preventing alcohol and substance misuse (e.g. School Health and Alcohol Harm Reduction Project, Climate Schools), those targeted to both groups of conditions (Climate Schools Combined), and some targeted to bullying.

Research shows that both classroom-based and whole-of-school approaches are effective. More of the evidence relates to classroom-based programs embedded within the school curriculum, however there is also good evidence to suggest that multi-component, whole-of-school frameworks that focus on how children are taught, what they’re taught (e.g. resilience, social and emotional skills, decision making) and on creating a positive and inclusive school climate (e.g. school leadership, student and parent participation) are also effective. Whole-of-schools approaches to bullying have also been found to reduce bullying perpetration and victimisation.^{187 188 189}

Ultimately the two approaches are complementary. Many schools currently adopt a whole-of-school framework and then include specific classroom-based programs under this umbrella. This enables them to combine a focus on individual skill development with a focus on creating a healthy/mentally healthy school environment through organisational practices and policies. Some schools also actively align their mental health promotion initiatives with their broader health promotion activities (e.g. healthful nutrition and physical activity initiatives). This is ideal since there is research to show that aligning programs with mental health objectives with those with physical health objectives can reduce risks for both categories of conditions.¹⁹⁰

While Australia is making reasonable use of schools as a setting for prevention there is scope for improvement with respect to reach, adoption, program fidelity (for classroom-based programs), parent engagement, and monitoring and evaluation. Not all schools use available programs or use them in ways that maximise their benefits. This in part reflects varying levels of

engagement/commitment to health/mental health promotion within schools, the confidence of teachers to deliver the initiatives, particularly some of the more specialised classroom-based programs, and more importantly, time and resource constraints. Schools and their staff are doing an excellent job of promoting student wellbeing within the limited time and resources they have available. Additional resourcing coupled with dedicated health promotion/mental health promotion personnel in schools would substantially increase the likelihood that these initiatives are adopted fully, with greater fidelity and in a more integrated fashion. Insufficient monitoring and evaluation of programs, in particular tracking of their impact on risk and protective factors and on student-level outcomes, is also a major problem. Improved tracking of these metrics would enable funders to better assess whether these investments are producing the desired results, or whether they need to be strengthened, and how.

Workplaces

Workplaces are another key important setting for action. Work is generally good for our mental wellbeing. It provides a sense of purpose, structure, social contact and reward that contribute to self-esteem, positive self-identity, friendships and relationships along with access to the material resources necessary for life and for personal growth. However, not all work and working environments are good for our mental wellbeing and research shows that certain job or workplace characteristics can actually contribute to mental health conditions such as depression, anxiety conditions and post-traumatic stress disorder.¹⁹¹

For example, drawing on data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey researchers found that people who experienced psychosocial job adversity factors such as: high job demands and job complexity; low job control; low perceived job security; low marketability; and effort-reward imbalance, consistently had an increased risk of mental health conditions compared to others not exposed to these factors.¹⁹²

While in Australia there have been reasonably long-standing efforts to reduce injury and promote physical health through workplace-based programs, workplace mental health is a relatively new area, although one which is growing rapidly. A number of different approaches exist. Some workplace mental health programs focus on keeping people well at work, others focus on supporting workers who develop or already have a mental health condition to maintain or enter into employment, while some target both.

Among the prevention programs some focus on individual workers, such as those that aim to build 'resilience' of workers to better enable them to manage personal and work-related stressors, while others focus on the organisational policies, practices and culture that may contribute to poor mental health. These programs may target issues such as leadership and line management, organisational justice, job stress and eliminating bullying, harassment and discrimination. A combination of each of these approaches is likely to be best. The Beyond Blue managed Heads Up initiative lists nine key characteristics of a mentally healthy workplace: prioritising mental health; trusting fair and respectful culture; open and honest leadership; good job design; workload management; employee development; inclusion and influence; work life balance and mental health support.

Australia is making some use of workplaces as a setting for prevention, however there is considerable scope for improvement. There are still too few workplaces taking a structured approach to mental health promotion and not enough that integrate health and mental health promotion. Reach, adoption and integration therefore need to be prioritised as do efforts with respect to program fidelity, monitoring and evaluation. As with school-based initiatives, the focus should be on supporting workplaces to adopt evidence-based strategies that have been rigorously evaluated and found to be effective and cost-effective, while continuing to support promising initiatives that need to be further evaluated.

Increasing uptake, adoption, program fidelity and monitoring is likely to be more difficult in workplaces than in education settings given the significantly greater diversity and number of workplaces compared to early learning services and schools. Self-directed programs, particularly those available online such as the Beyond Blue Heads Up program, can help to reach workplaces, however, they do not guarantee uptake. 'Hands-on' consultancy programs such as those provided by the Black Dog Institute and Everymind provide more guidance and support and assist with adoption and program fidelity but are far more difficult to scale-up. Both approaches are ultimately valid, and both need further support.

Existing self-directed programs could potentially be enhanced by a program guide, similar to the one developed by Beyond Blue for the National Education Initiative (Be You). This would require funding to undertake a comprehensive audit and review of existing evidence-based workplace mental wellbeing programs and publishing these results so that employers and business owners can access the information to support their decision making. The national roll-out of a recognition program like the Achievement Program may also be helpful as it would give employers and business owners a clear sense of the minimum standards they should aim to achieve and provide some recognition for their efforts, which could they could use to attract customers and employees.

Improved workplace health/mental health promotion activities are important for workers of all ages, young workers are worthy of particular attention. Adolescence and young adulthood are generally understood as a critical time to intervene to support mental wellbeing. In the transition to adulthood, young people are experiencing increasing pressures that can trigger underlying predispositions to mental ill-health. The experience of unemployment and under-employment is one of these pressures. Youth unemployment is higher than unemployment among other age groups and rates of mental health conditions are higher among young people who are un- and under-employment compared to other young people. Enduring, large-scale social changes, otherwise known as 'megatrends' are changing the nature of work. These pressures include automation of some jobs, increased competition in a globalised marketplace and loss of job security associated with the 'gig economy'¹⁹³. These megatrends have specific impacts on young people from refugee and migrant backgrounds and those living in rural and regional areas.¹⁹⁴ Young people have called for greater support in negotiating these pressures so that they can effectively enter and compete in this changing work environment.¹⁹⁵ Promising local initiatives that support young people in the workforce, such as the [Youth Friendly Employers Program](#) show considerable promise.

The health system

Better prevention strategies are also required among clinical populations. Given the high risk of co-morbidity, increased efforts are needed to support people who are already experiencing one group of conditions, to prevent them from experiencing another group of conditions. Preventing chronic disease among people with a mental health condition is a case in point, as is the reverse situation. The health system is therefore another major setting for action. This includes primary and community health services, hospitals, mental health services, and alcohol and other drug services. Health professionals working in these service settings have a crucial role to play in working to avert the development of co-morbidities. Clinicians need to take a more integrated approach to health/mental health promotion as do public health professionals. Organisation-level and system interventions including education, resources, training, and evidence-based clinical guidelines are also required.

From a mental health service perspective, programs such as 'Keeping the Body in Mind' which is being trialled at the Bondi Youth Early Psychosis program in Sydney and similar programs in other parts of Australia demonstrate the feasibility and benefits of taking an integrated approach to health and mental health promotion within mental health services. Integrated health promotion programs like these need to be more widely available across mental health services. Importantly however, best practice health promotion activities, such as smoking cessation treatment, should also be

systematically embedded as part of routine care across the entire health sector. This is important given that not all people with a mental health condition will be in contact with formalised mental health services and their main point of contact with the health system may be via primary care, other community health or hospital-based services. Services such as Quitline, available in all states and territories, provide evidence-based smoking cessation behavioural interventions and many have tailored programs for people with a mental health condition. The National Mental Health Commission has developed a national consensus statement, *Equally Well*, which aims to improve the physical health of people living with mental illness and State and Territory governments are introducing initiatives to achieve this.¹⁹⁶

Changes in Medicare rebates could also potentially help to prevent chronic disease among people living with a mental health condition. The Mood and Food Centre at Deakin University has recommending introducing Medicare items that enable people with a mental health condition to access accredited dietitian services upon referral from general practitioners or psychiatrists. This would also involve explicitly including mental health conditions within the definition of chronic diseases covered by Chronic Disease Management items.

The mental wellbeing of people with a chronic disease is another area that also needs attention. For example, many stroke survivors report that their physical disabilities are more likely to be addressed than their psychological problems, with mood disorders such as depression and anxiety often remaining undiagnosed.¹⁹⁷ For a number of years, the Stroke Foundation has been utilising the results from its National Stroke Audit as a tool to advocate for improved assessment of mood disorders following a stroke. Between 2012 and 2018, the proportion of patients undergoing assessment for mood disorders rose from 34% to 56%; however, results from the 2018 National Stroke Audit Rehabilitation Services Report showed that while approximately 50% of patients had some degree of mood impairment, one third of services reported no access to clinical psychologists or neuropsychologists in rehabilitation units.¹⁹⁸

Ensuring all Australian stroke survivors have access to services for the assessment, diagnosis and treatment of mood disorders, regardless of where they live, should be a key priority for the Australian Government. In Australia, unlike in Europe and the UK, there is no published post-stroke mood assessment pathway. In addition, while there is clear evidence for psychological interventions and pharmacological treatment for mood disorders in the general population, the evidence for such interventions in people following stroke is limited.

Pilot projects have been undertaken in Australia to try and address some of these knowledge gaps. A recent research project in the Wide Bay Hospital and Health Service in Queensland was focused on the impact of developing and implementing a post-stroke mood assessment pathway in conjunction with staff training. Results showed that following implementation of the pathway, the rate of mood screening increased by 19%, discussions with patients regarding mood increased by 7%, and the use of interventions targeting low mood increased by 40%. In Victoria, a recent pilot study at Echuca Hospital has examined the effectiveness of teleneuropsychology in assessing and treating mood disorders in stroke rehabilitation (i.e. telehealth neuropsychological assessment). The results of this study showed that 12 months post-implementation, the rate of mood screening and goal setting for mood had increased significantly, and patients now had access to therapeutic interventions via teleneuropsychology. Since the completion of the pilot, Safer Care Victoria has implemented teleneuropsychology in three additional health services.

Ultimately, we need to recognise that mental health and physical health are intertwined. We therefore need to get better at integrating the two at the level of prevention and management if we want to reduce the morbidity and mortality that these groups of conditions can cause individually, and which are further magnified when they occur together. Better screening would assist, and the Australian Health Policy Collaboration recommends the routine use of validated mental health

assessments among individuals with a chronic disease and Absolute Cardiovascular Risk Assessments among individuals living with a mental health condition in all publicly funded, or subsidised, health and mental health services.¹⁹⁹

Sport

Sport is another potential setting for health and mental health promotion. Involvement in sport has the obvious benefits of increasing physical activity, but it also has psychological and social benefits as well. Participation in sport can help to boost self-esteem and self-efficacy, which help to protect against the development of mental health conditions. Sport, particularly team sports, can also lead to friendships and relationships which are generally good for our mental wellbeing. Voluntary sporting clubs operate in most towns and suburbs across the country and bring together people of diverse backgrounds. They provide non-playing members, as well playing members, with regular social contact, and broader social connections which helps community bonding, reduces isolation and loneliness and promotes mental as well as physical health. Health promotion programs in these clubs reach many individuals in the community and effect social change.²⁰⁰

The Australian Government and organisations like VicHealth have been significant supporters of the Alcohol and Drug Foundation's Good Sports program. Pre-post studies and a randomised controlled trial have shown that the program reduces risky drinking in participating sports clubs.²⁰¹ An adaptation of the program that included the introduction of healthy canteen component to complement its primary focus on alcohol harm reduction found that sports clubs could also help contribute to shifts towards more healthy food options in sports clubs and more healthy food selection by athletes and spectators.²⁰² In some states Good Sports also has a focus on mental health and illicit drug use, further demonstrating the potential for implementing an integrated approach to health and mental health promotion through sporting clubs.

Local community led initiatives

Place-based community mobilisation approaches also hold considerable promise as vehicles to prevent mental health conditions, chronic disease, alcohol and substance misuse, and problem gambling. A key focus of these initiatives is to promote community participation and decision making and encourage broad cross-sector collaboration between interested stakeholders. Another key element is to work towards a shared view of the issues and the possible solutions, many of which focus on shifting the balance of protective and risk factors within the local community.²⁰³ By their nature these initiatives foster social connection and build social capital, which are valuable in their own right, as well as targeting the perceived underlying causes of a particular issue (e.g. depression), in their community.²⁰⁴

In Australia, several community-based programs currently aim to create positive social environments through community engagement and action. These types of initiatives have been used to tackle a variety of conditions. Loneliness is a risk factor for multiple conditions. Loneliness is associated with increased physical and mental health problems and with greater disability and premature death.²⁰⁵

²⁰⁶ ²⁰⁷ While there have been trials of various approaches to reduce loneliness, the evidence for their effectiveness is quite limited, and further research is needed.²⁰⁸ ²⁰⁹ There is some emerging evidence to suggest that loneliness could also potentially be tackled through place-based initiatives. For example, the 'We know your name, but not your story' initiative by the Corangamite Shire in regional Victoria focuses on reducing social isolation and a sense of not belonging among young people. This initiative is part of the [VicHealth Bright Futures](#) program that focuses on creating social connections for vulnerable young people in their local area. This program is showing promising success in preventing mental ill-health through increasing social connection and support.²¹⁰ The Victorian [Libraries after Dark](#) project promotes social inclusion and safe spaces for evening recreation. Aimed at providing evening alternatives to gaming venues they work as social hubs for entertainment and interaction for the whole community.

Alcohol and substance misuse have been another target for community-led action. The Local Drug Action Team program (LDAT) is national initiative that is coordinated by the Alcohol and Drug Foundation and funded by the Australian Government. It targets the prevention of alcohol and substance misuse. LDATs are made up of concerned and interested individuals and organisations from the public, private, not-for-profit community sectors. LDATs assist local communities to respond to locally identified alcohol and other drug issues within their community with planned programs and activities based on evidence of effectiveness. Over 240 LDATs are currently operating across Australia.²¹¹

The value of community-led prevention initiatives for alcohol and substance misuse is also highlighted by the experience of Iceland over the past two decades where it has combined community action with policy changes to drive down adolescent substance use of all types. Iceland's approach brings together parents, schools and local agencies together to build a local social environment high in protective factors and low in risk factors for substance use. Young people are actively supported to participate in organised extracurricular and recreational activities and in supervised work alongside a responsible adult, while parents are encouraged to provide spend substantial time with their adolescents, to provide emotional support and reasonable levels of monitoring, and to participate in school, social and community events.²¹² This focus on changing the social environment is also accompanied by legislative and regulatory changes to lessen access to substances by young people. The model has contributed to an impressive reduction in adolescent use of tobacco, alcohol and cannabis while resulting in improved relationships between parents and children and the development of community social capital.^{213 214}

The Communities that Care (CtC) program also uses a community engagement approach to reduce alcohol and substance misuse as well as academic performance and antisocial and violent behaviour. This program has been extensively evaluated and this research shows substantial differences on these outcomes between communities participating in CtC and non-participating communities on these core outcomes.^{215 216} The benefits of community-led approaches has also been demonstrated in the field of physical health. Research by the Global Obesity Centre at Deakin University shows that appropriately designed and supported community mobilisation initiatives can reduce the prevalence of obesity among children. What's more, the benefits of this program extended beyond reductions in obesity and included reductions in the prevalence of depressive symptoms.²¹⁷ This highlights that working on protective and risk factors can lead to impacts across multiple conditions that share the same factors.

Public policy

Another major way to achieve prevention outcomes is through healthy/mentally healthy public policies. Much of the harm reduction that has been achieved with respect to smoking, alcohol and substance misuse, and road trauma has been achieved through data and evidence backed changes in legislation and regulation. Public policy changes have been less systematically implemented for the prevention of mental health conditions and further consideration is needed to clarify what particular policy initiatives are important to pursue.

Notwithstanding this, as previously noted, public policies directed to the prevention of chronic disease, alcohol and substance misuse are likely to have flow on benefits in reducing the risk of mental health conditions. One area that could potentially be strengthened is policies relating to gambling. Logically, in cases where the mental health issues precede gambling, there are likely benefits of reducing the risk of gambling related harm by preventing the mental health condition from developing. However, in cases where the problems with gambling lead to mental health conditions, prevention and early intervention in relation to gambling can be beneficial in acting to prevent exacerbation of harms, and possibly onset or depth of development of mental health issues.

Two avenues are open to capturing these benefits. The first relates to reducing opportunities for gambling harm by restrictions on products. This includes their form and features, their accessibility and the extent and forms of promotion of gambling permitted. This applies especially in relation to products most associated with risk of harm where regulations lag behind current best practice. The products most associated with problem gambling and gambling harm generally are, electronic gaming machines, wagering and casino games. The second relates to improved responses in systems and thinking that pick up, pre-empt and respond to the relationship between gambling and mental health conditions across government, government services and in the wider community.

More research

Spending on mental health research needs to be increased and spending on research into the prevention of mental health conditions particularly needs to be increased. This must include increased funding for research into how to reduce the incidence of mental health conditions in the general population, as well as research funding to develop more and better interventions to reduce the incidence of mental health conditions in at-risk populations such as people with a chronic disease. Research into interventions to improve the physical health of people living with a mental health condition is also vital. Many of the existing chronic disease prevention initiatives have been developed for the general population and research is required to establish the most effective approach to tackling key risk factors like smoking and metabolic health among people with a mental health condition.

In addition to increasing funding for prevention-focused mental health research, the Australian Government also has a role to play in promoting collaboration between mental health researchers and researchers working on the prevention of other related conditions such as chronic disease, alcohol and substance misuse, problem gambling and their shared risk and protective factors. As noted, these issues are highly inter-related and it makes sense to consider them collectively as well as individually. At present, most prevention research into these various is occurring in silos, with little collaboration between different groups. We need to create a more integrated approach to prevention research and the Australian Government can play a key role in facilitating this through targeted funding streams that focus specifically on this intersectionality. Research takes time and funding needs to be committed over a substantial period of time to make a difference.

Better monitoring

In addition to robust research evidence, the effective planning and implementation of prevention initiatives requires data.²¹⁸ Different types of data are required including data from research studies, data from critical settings such as schools and workplaces, health services data that relates to people with a mental health condition, chronic disease, alcohol or substance misuse or problem gambling ('clinical' populations), and whole-of-population level data.

Ideally surveillance data should be regular, use interviewer collected rather than self-report wherever possible (including anthropometric and biomedical measures), and track risk and protective factors, as well as outcomes. Effective surveillance should therefore include monitoring of: individuals' knowledge, attitudes, beliefs and behaviours, and organisations' practices and policies; risk and protective factors; incidence and/or prevalence of key conditions; and morbidity and mortality data. A combination of mental health specific and integrated surveys would be ideal to enable both a deep understanding of a particular category of disorders, while also enabling researchers and policy makers to understand the intersections between different categories of conditions.

At a research level, improvements in data collection could be achieved by placing more emphasis on collecting standardised data that covers each of the major disease groups regardless of the primary focus of the prevention research. This would require discussion and collaboration between

researchers from various sectors as well as representatives from key consumer groups to ensure that collecting these measures did not place undue burden on research participants.

At a health service level collecting data from individuals with existing health conditions would also be important. This could involve collecting data on mental wellbeing (e.g. Kessler 10) among people using government funded health services, as well as physical health data (e.g. smoking rates) among people using public mental health services. It would also be useful to collect data on whether these various individuals were given help/support/intervention to prevent the development of a co-morbid disease, as this may help to make services more accountable to provide this support.

Population-level monitoring is also crucial. Existing surveys like the National Health Survey could be strengthened to include regular including anthropometric (e.g. weight and height) and biomedical measures and a greater range of mental health measures relevant to prevention. Australia also urgently needs to conduct another national survey of mental health and wellbeing among the adult population. This survey is essential for tracking the prevalence of major conditions, their distribution and impacts, service use, social and quality of life impacts (including productivity) and other key variables that are necessary for tracking progress at a population-wide level.

While whole-of-population level data is crucial, we also need to adopt an equity focus. It is well recognised that health and mental health promotion activities can inadvertently widen health inequities, as people from more advantaged groups are either more aware of the initiatives or more able to adopt them, compared to people from less advantaged groups who may be harder to reach and remain less aware of what's available, less able to utilise the programs and services, or they find them unacceptable or culturally irrelevant. Ensuring that people from less advantaged groups are not falling behind is essential to ensuring that things are not made worse. On equity grounds, wherever possible data should be collected in a way that allows for analysis by population sub-groups such as gender, sexual orientation, race/ethnicity, Aboriginal and Torres Strait Islander status, socioeconomic status, geographic location, and disability.²¹⁹

Ideally monitoring should also be linked to targets. The Fifth National Mental Health and Suicide Prevention Plan includes a list of 24 indicators which are or could be potentially reported against to track progress. All but three of these indicators relates to people living with a mental health condition rather than population-wide mental wellbeing and are therefore not particularly useful for prevention. The National Mental Health Commission and Mental Health Australia have also proposed a set of indicators and targets that could be introduced to foster greater accountability and progress in mental health. These are likewise predominantly focused on tracking outcomes for people with a mental health condition, rather than the mental wellbeing of the general population.²²⁰ By contrast, in the area of chronic disease, groups like the Australian Health Policy Collaboration have developed indicators and targets that are highly relevant to prevention.²²¹ Their proposed indicators and targets include those related to risk factors (e.g. smoking, harmful use of alcohol, salt intake), as well as outcomes (e.g. reduced mortality). More prevention specific targets are therefore required in the mental health area.

At a reporting level, it would be useful to combine mental health data with data on other closely related conditions if we wish to foster a more integrated approach to managing mental health conditions and conditions such as chronic disease, alcohol and substance misuse and problem gambling. The Australian Health Policy Collaboration's 'Australia's Mental and Physical Health Tracker' is an excellent example of how this information can be collected and utilised (see appendix 3).²²²

Summary and recommendations

Mental health conditions are a major public health issue. They are common, distressing, potentially disabling and cut lives short through suicide or chronic disease. Their economic impacts are considerable and start to accrue at an early age. Fifty per cent of conditions commence by age 14. The experience of mental health conditions during this developmental stage is associated with reduced school engagement, absenteeism and poorer academic performance causing young people with a mental health condition to fall behind their peers at a relatively young age. A further 25% of conditions commence between ages 15-24 with potential impacts on school completion, training, and tertiary education all of which may comprise an individual's long-term employment outcomes.

Reflecting this, mental health conditions are associated with reduced labour force participation, underemployment and unemployment. They restrict people's lives and contribute to poverty. Mental health conditions also contribute to presenteeism and absenteeism at work and early retirement due to poor health. At a societal level the National Mental Health Commission estimates that mental health conditions cost the Australian community up to \$70 billion annually, or 4% of GDP.

While mental health conditions are a major public health issue in their own right, they are closely associated with several equally problematic conditions. Mental health conditions are significantly interlinked with chronic diseases such as diabetes, cardiovascular disease and cancers, alcohol and substance misuse, and problem gambling. These various groups of conditions share numerous risk factors, are risk factors for each other, and frequently co-occur. When they do co-occur, their impacts on individuals and society are multiplied.

Governments across Australia have long understood the need to take action to reduce the impact of mental health conditions on individuals, their loved ones, and the community. While each jurisdiction has its own approach, much of this action is influenced by Australia's National Mental Health Strategy. Since its introduction in 1992, the National Mental Health Strategy has led a series of sweeping reforms of Commonwealth, State and Territory Government funded mental health supports and services. These reforms have been backed by a substantial increase in government spending.

However, despite these extensive reforms and the increased investment to fund them, there has been little to no improvement in key population-level metrics. The prevalence of mental health conditions has not fallen in the last 25 years and there has been no real reduction in the burden of disability and premature death associated with these conditions. While there is no doubt that more needs to be done to enhance supports and services for people with a mental health condition, enhancing our mental healthcare system is not the only solution. In every other National Health Priority Area there is a recognition that prevention and treatment need to go hand in hand, yet the prevention of mental health conditions remains an area that has been largely overlooked by successive governments as a solution to this crisis in favour of measures designed to assist people *after* they have become unwell.

Prevention needs to become a core pillar in Australia's efforts to reduce the personal and economic costs of mental health conditions. Mental health conditions are not inevitable and there is considerable scientific evidence to show that many conditions can be prevented. There is also evidence showing that the prevention of mental health conditions is cost-effective and can produce savings. While the prevention of mental health conditions will generate significant benefits in its own right, linking these efforts with efforts to prevent other closely related conditions has the potential to generate even greater gains. We need a clear plan, greater investment, evidence-based prevention programs across a range of settings, strong public policies, increased research and better monitoring.

Prevention initiatives need to be informed by the epidemiology of mental health conditions and these closely related conditions, and by evidence about what works. Some priority needs to be given

to prevention initiatives during the antenatal, childhood, adolescent and young adult period, although prevention needs to occur across the whole lifespan. Efforts need to be directed to tackling the various risk and protective factors that influence the onset of mental health and related conditions, although it is also possible to target people with subthreshold symptoms to prevent progression into a ‘full-blown’ condition. There are potentially numerous factors that need to be tackled, however factors such as child maltreatment, family violence, bullying, discrimination, smoking, unhealthy eating, physical inactivity, loneliness and the social determinants of health are particularly influential and should be prioritised.

Action is needed across a range of health and non-health settings including online, the home, education settings, workplaces, sport and recreational clubs, the arts, health sector services, housing, local communities and in public policy. Strategies need to be targeted to the general population as well as clinical populations and these approaches need to take account the uneven distribution of risk and protective factors along dimensions such as gender, sexual orientation, geography, socioeconomic status, disability and cultural identity.

A mix of public education, skills-building programs, organisation-level change, community mobilisation and public policies that promote environments conducive to mental health will be required. Evidence-based strategies exist but many are poorly utilised, and an initial focus should therefore be to increase the reach and adoption of those strategies that have been rigorously evaluated, while providing support to promising initiatives to be further trialled and evaluated. Funding to research new and better prevention initiatives is also essential.

Given the need for multi-sector action, coordination and integration are critical and will require national oversight, robust collaborations and cross-portfolio funding mechanisms. Keeping track of prevention expenditure is crucial and mechanisms need to be developed to accurately label this expenditure to help keep track of exactly how much funding is being spent and where these funds are going. We also need to be able to monitor the impacts of this funding at multiple levels, such as through research studies, in critical settings such as schools, workplaces and health services, and at a whole-of-population level. Effective surveillance should include monitoring of: individuals’ knowledge, attitudes, beliefs and behaviours, and organisations’ practices and policies; risk and protective factors; incidence and/or prevalence of key conditions; and data on morbidity and mortality.

Recommendations

Mental health conditions, alcohol and substance misuse, problem gambling and chronic disease exact a heavy toll on individuals, their loved ones and society more broadly. We need to find new and better ways to tackle mental health conditions and these other closely related public health issues. We believe that success lies in seeing prevention and treatment as complementary rather than competing approaches and making prevention a central pillar of both our mental health and health system.

1. The Australian Government should reinstate prevention as a core priority in national mental health plans.
2. In the interim, the Australian Government should develop and implement a whole-of-government blueprint for the prevention of mental health conditions over the period 2019–2022. This should link to the Fifth National Mental Health and Suicide Prevention Plan and the National Framework on Chronic Disease.
3. That the Australian Government implement a progressive funding increase for the prevention of mental health conditions over the next 5-10 years that brings it in line with public health funding for health promotion and illness prevention.

4. The Australian Government should ensure that its efforts to prevent mental health conditions are linked to and reinforce efforts to prevent chronic disease, alcohol and substance misuse, and problem gambling.
5. The Australian Government's prevention campaigns, programs and public policies should prioritise:
 - viii. The antenatal period, childhood, adolescence and young adulthood;
 - ix. Risk and protective factors shared across multiple conditions such as child maltreatment, family violence, bullying, discrimination, smoking, poor quality diet, physical inactivity, loneliness, and the social determinants of health (e.g. education, employment, housing);
 - x. Individuals with an existing condition to help prevent multi-morbidity;
 - xi. Groups at increased risk based on gender, sexual orientation, disability, geographic, socioeconomic status or cultural identity;
 - xii. Education settings and workplaces, due to their key role in enabling economic participation;
 - xiii. Health sector services because of their critical role in the prevention of multi-morbidity;
 - xiv. Regulatory decisions, including those that reduce or mitigate exposure to products and product promotions that may contribute to or exacerbate mental health conditions.
6. The Australian Government should identify and fast-track the scaling-up of locally developed and rigorously evaluated prevention initiatives that are available but under-utilised. Priority should be given to programs with positive results from randomised controlled trials and economic evaluations. Support should also be provided to prevention initiatives that show promise but require further evaluation.
7. The Australian Government should support the development and implementation of professional development initiatives that encourage and enable clinicians and practitioners from diverse sectors to take an integrated approach to health and mental health promotion.
8. The Australian Government should provide funding for collaborative research that brings together researchers working on the prevention of mental health conditions, alcohol and substance misuse, problem gambling and/or chronic disease.
9. Research funding bodies such as the National Health and Medical Research Council, Australian Research Council and the Medical Research Future Fund should encourage researchers to collect data to determine if multi-morbidity is potentially being prevented through their prevention interventions.
10. The Australian Government should provide support for strategies to better monitor the impact of prevention initiatives through a comprehensive approach to surveillance including:
 - i. Repeating the National Survey of Mental Health and Wellbeing (adult version)
 - ii. Regularly conducting the Australian Health Survey with the inclusion of anthropometric and biomedical measures;
 - iii. Routine screening for and central reporting of comorbid conditions among individuals with a chronic disease or a mental health condition in all publicly funded, or subsidised, health and mental health services, using standardised and validated data collection and assessment tools.

Appendix 1: Glossary

This submission acknowledges that different groups express different preferences for how the experiences of mental health and mental ill-health should be understood, described and defined. It is important to acknowledge and respect this diversity of views. While the authors of this submission do not wish to suggest that certain terms and definitions are more valid than others, we recognise the need to adopt particular terms to ensure consistency. These terms and the way we define them are outlined below.

Mental wellbeing – mental wellbeing describes a positive state of mental health which consists of both hedonic and eudaimonic elements. Put simply, it is about feeling generally happy and satisfied emotionally, functioning well psychologically and socially, and having a sense of meaning or purpose in life. We believe this expression is preferable to the term mental health, as this is often used as a synonym for mental ill-health which can therefore create confusion.

Mental health condition – mental health condition is an umbrella term to describe clinically diagnosable mental disorders or mental illnesses. We have chosen to use this term rather than the terms mental disorder or mental illness, because organisations such as Beyond Blue promote its use as a non-stigmatising term preferred by people living with these conditions. Mental health conditions are often grouped into three levels of severity – mild, moderate or severe.

Subthreshold mental health condition – subthreshold mental health condition describes the situation where a person experiences some of the symptoms of a particular mental health condition, but not enough of the type, number and duration of symptoms required to meet the threshold for a diagnosis according to the criteria outlined in the World Health Organisation International Classification of Disease 10th Edition or the American Psychiatric Association Diagnostic and Statistical Manual 5th Edition. We use the term subthreshold mental health condition in preference to terms such as mental health problems, mental health issues, mental health challenges and mental health difficulties.

Chronic disease – chronic disease refers to conditions such as diabetes, cardiovascular disease, cancers, respiratory conditions, kidney diseases and other illnesses that are chronic, persistent and have ongoing impacts on a person's physical health and wellbeing.

Alcohol and substance misuse – alcohol and substance misuse is an umbrella term to encompass risky drinking, prescription drug misuse, illicit drug use, alcohol dependence, drug dependence as well as alcohol and drug related harms more broadly.

Problem gambling – In research the term is usually used to describe one specific category of gambling identified by the Problem Gambling Severity Index (PGSI) tool, however this submission uses the term problem gambling as an umbrella term that encompasses problem gambling, gambling dependence, and gambling related harm more broadly. Harms from gambling occurs to more people than fall into the most severe category of the tool, problem gambler.

Co-morbidity and Multi-morbidity – co-morbidity and multi-morbidity refer to situations where an individual experiences two or more different conditions simultaneously. These may be two or more conditions from the same class of conditions (e.g. depression and anxiety) or two or more different types of conditions (e.g. depression and diabetes).

Prevention – Prevention can be classified in various ways. One approach is to distinguish between primary, secondary and tertiary prevention, where primary prevention focuses on preventing a condition from ever occurring, secondary prevention focuses on preventing a condition from progressing or recurring, and tertiary prevention focuses on preventing disability and handicap.

Another classification system focuses on the target group for the intervention. Universal prevention initiatives target the whole population, selective interventions target people at elevated risk and indicated prevention intervention targets people with the early signs and symptoms of a condition (e.g. subthreshold conditions). While the various types and approaches to prevention are all important, this paper focuses predominantly on primary prevention, through universal, selective and/or indicated means.

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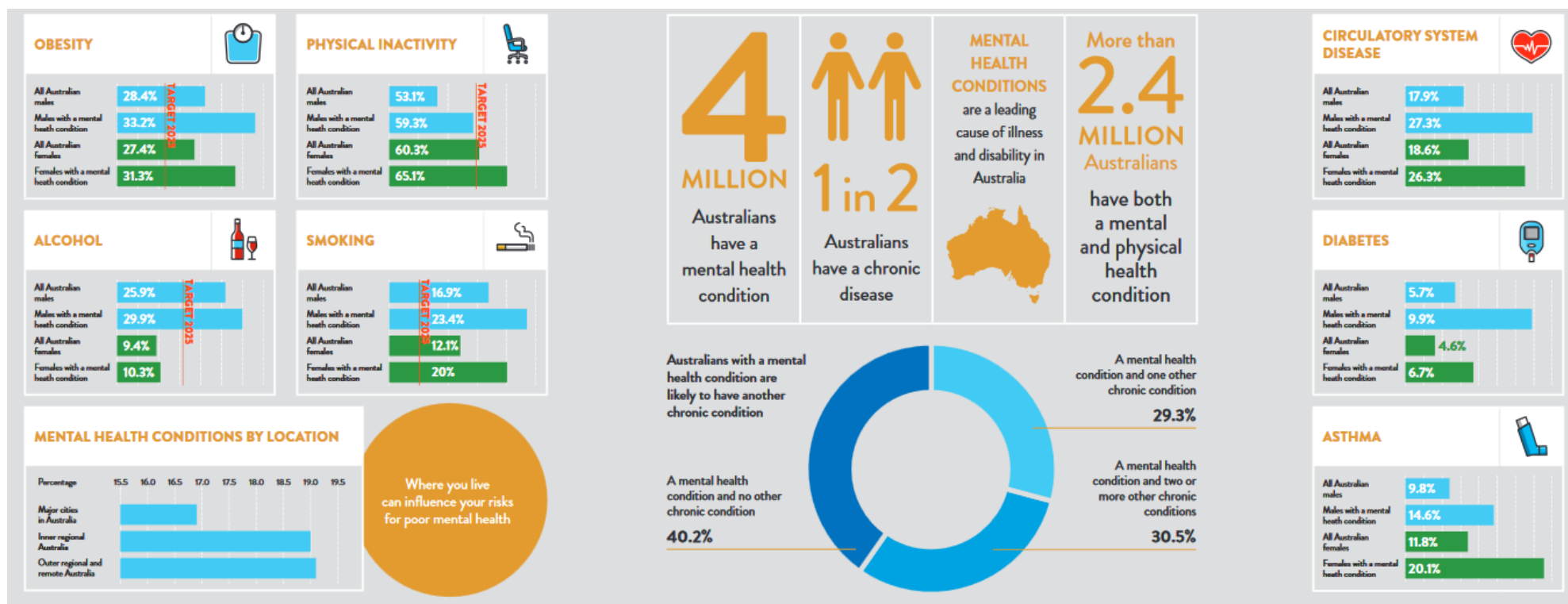
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Appendix 3: Australia's Mental and Physical Health Tracker 2018 (Australian Health Policy Collaboration)



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