The Social and Economic Benefits of Improving Mental Health – DAA response to the Productivity Commission's Mental Health Draft Report

January 2020

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 7000 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the draft report into Mental Health by the Australian Government Productivity Commission.

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DAA interest in this consultation

As the peak body for the dietetic profession, the Dietitians Association of Australia (DAA) has an interest in the health and wellbeing of all Australians, including those with mental health disorders.

This submission extends DAA's first submission (number 232)(1) to the Australian Government Productivity Commission inquiry into Mental Health. In this submission we respond to the issues raised in sections of the draft report and the Productivity Commission's draft recommendations.

DAA welcomes the acknowledgement of dietitians in the draft report and the focus on the link between physical and mental health. However, DAA believes further provisions are needed to deliver integrated physical-mental healthcare for consumers and leverage the dietetic workforce to meet consumer mental healthcare needs.

Key messages

1. The draft report correctly links mental health and physical health, but further provisions are needed to integrate physical and mental healthcare within the mental health system.
2. There is a need for greater recognition of the role of food and nutrition in the prevention, development, treatment and management of mental illness, not just in the prevention and management of physical illness experienced by people with mental illness.
3. Accredited Practising Dietitians address both physical and mental health needs of consumers, through the provision of person-centred, evidenced based medical nutrition therapy services. More provisions are needed to increase access to dietitians, for their role in addressing both mental and physical health needs of consumers, especially through increased funding to meet community demand for services.
4. To optimise the stepped model of care, evidence-based information about food and nutrition and/or dietetic and allied health services should be integrated within each step of the model.
5. There should be core mental health training for all staff and health professionals involved in mental healthcare. Mental health clinicians should understand the connection between physical and mental health and the role of food and nutrition in the treatment, prevention and management of mental illness. Training should cover the role of different members of the workforce including dietitians.
6. The Australian government, States and Territories and other funding bodies should allocate more funding to ensure the accessibility of dietetic and allied health services.
7. Additional strategies are needed to address mental health issues experienced in Aboriginal and Torres Strait Islander communities

Corrections

1. **Volume 1 of the draft report contains an error regarding the training requirements for dietitians** (Table 11.1, vol 1, pg 374). The minimum qualification to become a dietitian is a four-year undergraduate program. The alternate pathway to training in Australia is through a post-graduate Masters program. DAA accredits dietetic training programs in Australia. Qualifications from each pathway are considered to be equivalent in terms of entrance to the profession. DAA requests that Table 11.1 and associated text is corrected to reflect this.
2. The word 'dietitian' is misspelled throughout the draft report. Consistent with Australian and international standards, DAA request that the word dietitian is spelled with a 't' and not a 'c' (i.e. dietician).(2)

Discussion

The Productivity Commission proposes a set of measures to reform Australia's mental health system, through the delivery of a person-centred approach to mental healthcare.(3) DAA agrees with this vision but are concerned that the proposed recommendations are not enough to deliver an integrated system of mental healthcare for consumers. The interrelationship between physical and mental health is well-established(4) and while this is acknowledged in the draft report, DAA observes multiple missed opportunities to optimise the delivery of integrated physical and mental healthcare to consumers.

The draft report provides insufficient recognition of the role of food and nutrition in addressing both the physical and mental health needs of consumers, despite a growing body of evidence that food impacts both physical and mental health.(5, 6) In layman's terms, the dietary patterns which keep your heart healthy and reduce your cancer risk, also keep your mind healthy.

Considering the importance of lifestyle to mental health, dietetic and allied services should have a higher priority within the Productivity Commission's proposed stepped model of care and more provisions should be made to leverage the dietetic workforce to meet consumer demand for services. DAA's previous submission to the Mental Health Inquiry (submission 232) details evidence of the health and economic benefits of nutrition intervention and the role of Accredited Practising Dietitians in addressing the mental health needs of consumers. We urge the Productivity Commission to revisit this work and re-consider how food and nutrition and dietetic services can be better recognised and leveraged to meet consumer mental healthcare needs.

A cultural shift in our understanding and appreciation for the role of food and nutrition in mental healthcare is needed and action is required to ensure that consumers have access to dietitian services to meet their combined physical and mental healthcare needs.

The following adaptations to the Productivity Commission's draft recommendations are proposed.

Part 1: The Case for major reform

Stepped Model of Care

An integrated approach to physical and mental healthcare should be embedded within each stage of the stepped model of care. Self-help resources should include evidence-based nutrition information, and access to Accredited Practising Dietitians should be facilitated within each stage of the model. Data collection, monitoring and evaluation activities should occur at each stage to inform service design and delivery.

DAA recommend the following adjustments to the stepped model of care, to better integrate physical and mental healthcare, and dietetic services:

Self-management (step 1)

- Self-help resources should include evidence-based information about food and nutrition and the importance of diet to mental health. The Australian Government Department of Health 'Eat for Health' website (https://www.eatforhealth.gov.au/) is an example of a credible source of nutrition information. Individuals seeking self-help resources should be referred to information such as this, through the national phone-line and websites that are proposed for development.
- Information about how to access Accredited Practising Dietitians should be readily available to consumers, including through the proposed expanded online portals.

Low intensity care (step 2)

- Screening for physical comorbidity should be included in this stage and information about the risk of physical comorbidity should be disseminated.
- Referral pathways to Accredited Practising Dietitians and other allied health professionals involved in physical and mental healthcare should be established and readily accessible.
- Dietary intervention, facilitated by an Accredited Practising Dietitian, should be included in this step for individuals at risk of physical comorbidity and to address mental illness.
- Clinician-supported online treatment will be helpful for consumers with mild symptoms but these services (eg MindSpot) should provide evidence-based nutrition information, developed in collaboration with the Dietitians Association of Australia or Accredited Practising Dietitians. Similar should be done for the provision of exercise and other lifestyle information.

- Clinician supported online treatment should be expanded to include healthcare providers that are qualified and credentialled to deliver care online including Accredited Practising Dietitians.

Moderate intensity treatment (step 3)

- Screening for physical comorbidity should be included in this stage.
- Referral pathways to Accredited Practising Dietitians and other allied health professionals involved in treating physical and mental health should be established.
- Dietary intervention, facilitated by an Accredited Practising Dietitian, should be explicitly embedded within this step of the model, for individuals recognised as nutritionally compromised or at increased risk of physical comorbidity.
- Accredited Practising Dietitians should be included in the Better Access program, with provision of items of sufficient number and adequate duration, to address the physical and mental healthcare needs of consumers.
- There should be enhanced access to Accredited Practising Dietitians through the Medicare program including specific items for mental health dietetic services and items for both short and long consultations, with adequate remuneration to provide effective and quality care.
- Access to video conferencing and telehealth services should be widened and should improve access to Accredited Practising Dietitians and other members of the treatment team. In some cases, this will also be relevant to people living in urban areas who are unable to leave their home on account of physical disability or mental illness. Medicare should be expanded to fund video conferencing and telehealth services.

High intensity and complex care (step 4)

- Screening for physical comorbidity should be included in this stage.
- Dietary intervention, facilitated by an Accredited Practising Dietitian, should be provided where an individual is at risk of physical comorbidity or is nutritionally compromised.
- Referral pathways to Accredited Practising Dietitians and other allied health professionals should be well-established, and practitioners should have enough hours, with adequate remuneration, to provide effective and quality care. As per moderate intensity care (step 3), access to dietitians should be enhanced by inclusion of Accredited Practising Dietitians in the Better Access program and through improvements to the Medicare program.

All steps should emphasise better use of data to inform service design and delivery, and this should include monitoring and analysis of referral practices of GPs to allied health professionals including Accredited Practising Dietitians.

Part II: Re-orienting health services to consumers

Chapter 5 - Primary Mental Healthcare

Draft recommendations 5.2 - Assessment and referral practices in line with consumer treatment needs

In the short term (next 2 years): To ensure that assessment and referral practices are in line with consumer treatment needs, commissioning agencies (Primary Health Networks and Regional Commissioning Authorities) should establish referral pathways to allied health professionals including Accredited Practising Dietitians, as described in DAA's proposed adapted stepped care model.

In the medium term (over 2 – 5 years): Commissioning agencies should engage with peak bodies and service providers in the codesign of monitoring and evaluation frameworks to monitor the use of services, including dietetic services.

Draft recommendations 5.9 - Ensure access to the right level of care

DAA agree that the Australian, State and Territory Governments should reconfigure the mental health system to give all Australians access to mental healthcare, at a level of care that most suits their treatment needs, is timely and culturally appropriate.

To ensure consumers have 'access to the right level of care', referral pathways to allied health professionals including Accredited Practising Dietitians should be established across the continuum of primary-tertiary care, and at each stage of the stepped model of care, as discussed above.

Chapter 6 - Supported online treatment

Draft recommendation 6.1 - Supported online treatment options should be integrated and expanded

DAA agrees that clinician-supported online treatment options should be integrated and expanded. Accredited Practising Dietitians and other allied health professionals, who are qualified and credentialled to provide online treatment, should be accessible through supported online treatment facilities, and there should be appropriate time and remuneration for professionals to deliver their services.

Major providers of supported online treatment (MindSpot, Mental Health Online and THIS WAY UP) should be encouraged to build food and nutrition education into their programs and this should be codesigned by appropriately qualified dietetic professionals.

Draft recommendation 6.2 – Information campaign to promote supported online treatment

DAA agrees that the Australian Government should instigate an information campaign to increase awareness of the effectiveness, quality and safety of government funded clinician supported online therapy for treatment of mental ill-health for consumers and health professionals.

Chapter 7 – Specialist community mental health services

Draft recommendation 7.1 – Planning regional hospital and community mental health services

DAA agrees there is a need for specialist community mental health services, particularly those that meet the needs of the growing 'missing middle' population. Responsibility for the development and delivery of these services will primarily lie with State and Territory governments that have responsibility to identify services gaps within a region and then to develop and deliver services.(3)(p 288) In terms of Australian Government funding, Primary Health Networks also have a potential role in facilitating identification of gaps, and implementation of solutions in proportion to community needs.

Integrated models of care should be developed, and States and Territories should be supported to implement these models, with flexibility to adapt at the local level to meet regional needs. Integrated models of care should include funded positions for dedicated mental health dietitians, at appropriate patient to staff ratios and established referral pathways to all relevant members of the mental health workforce including Accredited Practising Dietitians.

DAA would like to see funding for dietitians in positions dedicated to mental health. We would also like to see dietetic services incorporated into the profile of services within community mental health services, hospitals and other practice settings, to ensure adequate resourcing for medical nutrition therapy.

Chapter 8 – Emergency and acute inpatient services

DAA noted in its first submission the necessity for adequate inpatient staffing to ensure Accredited Practising Dietitians are available for individual therapy and to work with food service staff and other stakeholders, to meet the needs of people admitted to health services for acute illness. This should consider the needs of people who may be frequently admitted for care, or who experience extended length of stay.

Chapter 9 – Physical and substance use comorbidity

DAA support the focus on the link between physical and mental health, wellbeing and productivity. 80% of the gap in life expectancy is related to physical illness.(7) Much of the burden of physical disease here is related to dietary and physical activity patterns.(4) Proportional investment is needed to address the health and life expectancy gap through commitment to delivering on the objectives of the Equally Well National Consensus Statement(8) and the Fifth National Mental Health and Suicide Prevention Plan.(9)

Chapter 10 - Towards integrated care: linking consumers and services

Draft recommendation 10.1 – Consumer assistance phone lines

Consumer assistance phone lines should link consumers with evidence-based nutrition information and referral pathways to Accredited Practising Dietitians should be established and readily available.

Draft recommendation 10.2 - Online platforms to support better referral pathways

DAA agrees that service providers should have access to online navigation platforms offering information on pathways in the mental health system. Online platforms should include referral pathways to Accredited Practising Dietitians and other allied health professionals.

Draft recommendation 10.3 - Single care plans for consumers

DAA agrees that single care plans have the potential to promote integration in service delivery. DAA also agrees that single care plans should be comprehensive and promote integrated care. This means addressing nutrition care in addition to cultural, spiritual and psychosocial needs, as detailed on pg 26 of the Draft Report.

Providers, including allied health professionals, should be remunerated for the administration of care plans given that "a wide range of care providers may need to contribute to the single care plan or update it with new information — either by accessing a digital health record, or in a face-to-face discussion".(3)(p 352)

Remuneration for providers should reflect the high-level skills and experience required by allied health professionals to meet the needs of consumers with complex (social, physical and psychological) needs.

Draft recommendation 10.4 - Care coordination services

Care coordinators will play a critical role in linking people with severe and persistent mental illness to mental health services and ensuring individuals do not 'fall through the cracks' in the system. To ensure the delivery of effective, integrated care, care coordinators should be trained on the role of allied health professionals in addressing the mental healthcare needs of consumers.

Care coordinators should also be educated on the connection between physical and mental health and the relationship between lifestyle, food and nutrition and mental health and productivity. This education will ensure that the role of lifestyle in mental health is not overlooked and consumers are provided with encouragement and support to access dietitians and allied health services to address both physical and mental health needs.

Care coordinators should be trained to achieve competencies in basic food and nutrition to support consumers, to identify when referral is needed and to use appropriate referral pathways to Accredited Practising Dietitians.

Chapter 11 – Mental health workforce

The workforce section of the draft report(3)(p 367-376) recognises the role of Accredited Practising Dietitians as healthcare providers but greater emphasis should be placed on the role of dietitians in mental healthcare (see DAA submission 232 for details).(1)

DAA would like to see acknowledgement of Accredited Practising Dietitians as a routine part of the mental health workforce, with investment from the Australian, States and Territory governments to ensure the workforce is available in numbers and location to meet community needs.

Feedback from members working in South Australia indicates that recent initiatives in Eating Disorders for new inpatient or outpatient/ambulatory services include provision of additional medical, nursing and other staff but neglect to include Accredited Practising Dietitians in staffing estimates. Health service administrators ignore the need or erroneously assume new Eating Disorder services can draw on existing dietetic services. Those services are in fact already struggling to meet inpatient and outpatient demand across all service areas and must be funded to meet consumer needs.

<u>Box 11.1 – Health professions most relevant to people with mental ill-health</u>

Accredited Practising Dietitians provide consumer-focused, evidence-based nutrition services to address the mental and physical health needs of individuals and population groups. Dietitians are core members of the mental health workforce and should be recognised as such.

DAA requests that Accredited Practising Dietitians are listed in Box 11.1 as 'health professionals most relevant to people with mental ill-health',(3)(p 368) along with the other allied health professionals.

<u>Draft recommendation 11.1 – The National Mental Health Workforce Strategy</u>

The development of a new National Mental Health Workforce Strategy provides an important opportunity to estimate future mental health workforce needs and identify approaches to attract and train a workforce, to meet future demand.(10) Accredited

Practising Dietitians are core members of the mental health workforce and it is imperative that this is explicitly acknowledged in the National Mental Health Workforce Strategy, along with efforts to plan for the development of the dietetic workforce.

Draft recommendation 11.5 – Improved mental health training for doctors

DAA recommends improving mental health training for medical practitioners and allied health professionals including Accredited Practising Dietitians.

Draft recommendation 11.6 – Mental health specialisation as a career option

DAA agrees there is a need to reduce negative perception of, and to promote, mental health as a career option. More focus is also needed on promoting mental health as a specialty area among allied health professionals and career pathways implemented to support service delivery for individuals and populations, along with teaching and training and research within and across professions.

To deliver integrated care, efforts are needed to build the workforce across all professions involved in mental healthcare. Failure to do so will result in gaps in service provision and poorer health outcomes.

Draft recommendation 11.7 – Attracting a rural health workforce

More investment is needed from Australian, State and Territory Governments to support recruitment and retention of allied health practitioners in rural locations.

Funding should also ensure greater use of teleconferencing and expanded initiatives to fund access to health professionals where delivery of services in place is challenging. The new MBS Eating Disorder items for dietitians can be delivered face to face or through telehealth but not MBS Chronic Disease Management items. MBS items should be expanded to include telehealth to increase access to services.

Training of the mental health workforce

There should be core mental health training for all staff and health professionals involved in mental healthcare.

All mental health clinicians should have an understanding of the connection between physical and mental health, and the role of food and nutrition in the treatment and prevention of mental illness and the promotion of wellbeing and productivity. Training should also cover the role of members of the mental health workforce including Accredited Practising Dietitians, to build better coordination and integration of care.

Education on physical health comorbidities and nutrition care should be included in all mental health professional courses, undergraduate courses and post-graduate courses where applicable. Information on nutrition care, dietetic services and referral pathways should be readily available online for all mental health clinicians to refer to. Such education and information should be developed and provided by qualified dietitians.

Much of the training of dietitians and other allied health practitioners occurs in hospital settings or community health services. Student placement programs must be expanded to improve the exposure of students to various practice settings, including private practice and aged care. DAA advocates that Medicare and Department of Veterans' Affairs should allow students to work under supervision with allied health practitioners to build the allied health workforce, including in the area of mental health.

Part III: Re-orienting surrounding services to consumers

Chapter 12 – Psychosocial support

Draft recommendation 12.3 - NDIS support for people with psychosocial disability

The NDIA should continue to improve its approach to people with psychosocial disability including providing more consistency and enhanced access to Accredited Practising Dietitian services and nutrition support products. During the implementation of the NDIS, inconsistency in the inclusion of dietetic services in NDIS plans has resulted in people with disability being denied access to services and nutrition support products that are both reasonable and necessary. There are reports of poorer nutrition-related health outcomes for consumers as a result.(11-13)

The NDIA should do more to ensure that participants in the scheme have access to nutrition-related health supports including dietitian services. NDIS plans should include adequate consultation hours for dietitians and appropriate remuneration for travel to enable sustainable service delivery.

Evaluations of the psychosocial disability stream trial sites in Tasmania and South Australia should examine the methods, outcomes and decisions of NDIS Planners in relation to the provision of dietitian services and nutrition support products.

Chapter 15 – Housing and homelessness & Chapter 16 - Justice

Draft recommendation 15.2 (Support people to find and maintain housing) and draft recommendation 16.2 (Mental healthcare standards in correctional facilities)

DAA is still concerned about issues of food security, which includes accessibility and affordability of a nutritious diet. Adequate food and nutrition should be provided to supported housing, sub-acute residential facilities, aged care facilities, prisons and schools.

Draft recommendation 16.3 - Mental health in correctional facilities and on release

Combined physical and mental health screening should be conducted for prisoners within correctional facilities and on release, and referral pathways should include allied health professionals and Accredited Practising Dietitians. This is particularly relevant to forensic

mental health services given the prominence of severe mental illness and lengthy engagement with services in this sector.

Part IV: Early intervention and prevention

Chapter 17 - Interventions in early childhood and school education

Draft recommendation 17.1 - Perinatal mental health

Research demonstrates that a nutritionally adequate maternal diet reduces the risk of perinatal and childhood mental illness including depression and anxiety.(14) Diet during childhood is also important, with a growing body of evidence linking healthy diets to better mental health outcomes(15) and poor diet to poorer mental health in children and adolescents.(16)

Given the link between poor diet and negative mental health outcomes, it is alarming that discretionary food choices comprise over 35% of the total energy intake in the diet of Australian children.(17) More needs to be done to support families to choose healthy foods and to reduce the intake of discretionary foods, to protect the physical and mental health of children, young people and adults across the life course.

Universal screening for perinatal mental illness should include assessment of food and nutritional intake and measures to identify and refer mothers at risk of poor nutrition and nutrition-related health outcomes.

Health professionals involved in perinatal care should be educated to provide basic nutrition information to new families and referral pathways to Accredited Practising Dietitians and allied health professionals should be established for parents and carers in need of professional support to address food and nutrition issues.

Draft recommendation 17.5 - Wellbeing leaders in schools

Wellbeing leaders will play a critical role in promoting the mental and physical health of children in schools. It is imperative that wellbeing leaders are educated on the various contributors to mental health including the physical-mental health connection and the role of diet in addressing the mental health needs of adolescents.(15) Also relevant to this age group is the growing body of evidence linking healthy diet to better academic performance(18) cognitive outcomes,(19) which may in turn contribute to the overall wellbeing of children and adolescents. Given that discretionary foods comprise 35% of the total energy intake of the diet of Australian children(17) and the known impact on these foods on both physical and mental health outcomes,(15, 16) strong advocates for nutrition are needed in the school setting. Wellbeing leaders are well-placed to play this role, but appropriate education of wellbeing leaders is needed to ensure students are provided with evidence-based lifestyle and nutrition information and support.

Wellbeing leaders and teachers should be competent to provide basic food and nutrition education in the school setting. School canteens should implement health food guidelines (e.g. NSW guidelines, Victorian guidelines), to support healthy food choices and to reinforce food and nutrition educational principles.

Draft recommendation 17.6 - Data on child social and emotional wellbeing

Data gathered in schools should include information on food, nutrition and physical activity. Data should be collected in a way that enables analysis and integration of data sets to enable future research, monitoring and evaluation.

Chapter 18 – Youth economic participation

Draft recommendation 18.1 - Training for educators in tertiary education institutions

As per recommendation 17.5 (wellbeing leaders), teaching staff should be provided with education on the interconnection between physical and mental health and role of lifestyle, food and nutrition in mental healthcare. Appropriate resources should be used in education such as those developed by the Australian Government Department of Health available on the eatforhealth.gov.au website.

Draft recommendation 18.2 - Student mental health and wellbeing strategy in tertiary education institutions

Student mental health and wellbeing strategies in tertiary education settings should include a food and nutrition policy and strategies to promote a healthy food environment. Referral pathways to allied health professionals should be made available as part of the 'links into the broader health system'.

Chapter 19 – Mentally healthy workplaces

Workplace health promotion interventions, including diet and physical activity intervention, have been shown to promote the physical and mental health of employees(20, 21) and boost productivity.(22) Mentally healthy workplaces should therefore support individuals to make healthy food choices and reduce exposure to discretionary foods within employer funded food outlets such as cafeterias and vending machines.

More needs to be done to promote healthy food environments as promoters of workplace wellbeing. DAA suggest that Box 19.1(3)(p 739) of the final report should list an unhealthy food environment as a risk factor to workplace mental health and Figure 19.1(3)(p 740) should include healthy food environment as a promoter of a mentally healthy workplace.

Draft recommendation 19.5 - Disseminating information on workplace interventions

Information about the benefits and features of multicomponent workplace health promotion interventions, including diet and physical activity intervention,(20-22) should be broadly disseminated.

Chapter 20 – Social participation and inclusion

Social exclusion and mental ill-health are exacerbated by physical comorbidity.(4) For instance, obesity may lead to social withdrawal(23) and sedentary behaviour(24) in individuals with mental illness and there is evidence that obesity and metabolic syndrome, conditions both addressed by dietary intervention, independently predict relapse and rehospitalisation in individuals with severe mental illness.(4) Hence, the importance of addressing the combined physical and mental healthcare needs of consumers cannot be understated and as outlined in this submission and previously (see DAA submission number 232),(1) nutrition intervention delivered by an Accredited Practising Dietitian has a key role to play in addressing the combined mental and physical healthcare needs of consumers, with subsequent benefits for social participation and inclusion.

Chapter 21 – Suicide prevention

Suicide prevention requires a multidisciplinary, integrated person-centred approach to treatment and prevention, with services that are well-funded to ensure continuity of care. However, there is a lack of specialist community mental health services to meet community needs including a lack of funded positions for dietitians within these services.

It is notable that rates of suicide and all-cause mortality are particularly high among individuals with anorexia nervosa and eating disorders.(25) Nutrition interventions delivered by an Accredited Practising Dietitian are an essential component of the treatment of eating disorders and should be built into models of service delivery for this population group.(26) The new MBS items for Eating Disorders goes some way to filling current service gaps but DAA is concerned that the use of items might be limited by the short duration of the items, rebated at the equivalent of 20 minutes.

A holistic approach to suicidality is needed including educating the community and the workforce on how to address suicide ideation/suicidality.

Part V: Pulling the reforms together

Chapter 22 - Governance

Draft recommendation 22.1 – A national mental health and suicide prevention agreement

DAA agrees that COAG should develop a National Mental Health and Suicide Prevention Agreement between Australian, States and Territory Governments. As recommended, consumers and carers should be key partners in the development of the agreement.

Peak bodies and services providers should also be consulted regarding implementation of the agreement including the development of performance and reporting requirements.

Draft recommendation 22.4 – Establishing targets for outcomes

DAA agrees that performance targets should be developed with input from consumers and carers. Peak bodies, academic institutions and service providers should also be consulted in the process of developing targets and data collection standards.

Draft recommendation 22.5 – Building a stronger evaluation culture

A strong evaluation culture requires standards for data management and collection, as well as efficient and affordable IT infrastructure and data collection systems. A priority in data collection should be identification of community needs and service gaps.

Peak bodies, academic institutions and service providers will all benefit from data to enable evaluation and monitoring activities and should be consulted in the process of developing evaluation systems.

Chapter 24 – Funding arrangements

As outlined in our previous submission to the Mental Health Inquiry (see submission number 232)(1) and in detail in DAA's submission to the Medicare Benefits Schedule (MBS) Review,(27) there is a lack of funding to support community need for dietetic services. Some of the key funding issues include:

- Not enough funded positions for dedicated mental health Accredited Practising Dietitians and dietitians in community-based positions
- Insufficient duration and number of MBS rebated sessions available for dietitians and other allied health services. Current funding only entitles eligible people to 5 sessions per year, across all allied health professionals. This makes it impossible to deliver evidence-based care for people with chronic and complex needs such as individuals with conditions such as autism, pervasive developmental disorder, disability and mental illness. Items of sufficient number and duration are needed

to support building of relationships, communication, and incremental behaviour change

- Items for Accredited Practising Dietitians not available in the Better Access program
- Exclusion of telehealth services under the MBS Chronic Disease Management program for allied health providers.

An effective mental health system cannot operate without appropriate funding of allied health and dietetic services. Improvements to the MBS are needed but additional sources of secure funding are also required to support community needs.

Draft recommendation – Toward more innovative payment models

DAA agree new funding models are needed. Peak bodies should be involved in the design and implementation of these models.

Chapter 25 – A framework for monitoring, evaluation and research

Draft recommendation 25.2 – Routine national surveys of mental health

DAA agrees that the Australian Government should fund the ABS to conduct a National Survey of Mental Health and Wellbeing at least every 10 years. This survey should be linked to future ABS Australian Health Survey datasets including the National Health Survey and National Nutrition and Physical Activity Survey, to enable evaluation of mental health, physical health and lifestyle trends.

Draft recommendation 25.3 – Strategies to fill data gaps

Broad consultation with consumers, peak bodies, mental health service providers, including allied health professionals, and Australian, State and Territory governments, is needed to identify data gaps and strategies to ensure the collection of high-quality and fit-for-purpose data.

Additional comments

The importance of a National Nutrition Policy

Many of the recommendations in this submission could be tied together with the development and implementation of a National Nutrition Policy. Such a policy would bring together evidence on the role of food and nutrition in mental and physical healthcare and provide a framework for translating evidence regarding food, nutrition and health, into action in prevention and treatment of combined physical and mental health disorders.

Further detail regarding the rationale and recommendations for a National Nutrition Policy are outlined in the '*Joint Policy Statement: Towards a National Nutrition Policy for Australia*',(28) endorsed by the DAA, Nutrition Australia, the Public Health Association of Australia and the Heart Foundation.

Mental health in Aboriginal and Torres Strait Islander communities

Aboriginal and Torres Strait Islander communities experience a greater burden of mental health disease and require additional measures to address the challenges in those communities.

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