

The 2017 National Report

on Mental Health and
Suicide Prevention



Australian Government

National Mental Health Commission

About this Report

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A tribute to Commissioner Jackie Crowe

18 July 1968 – 21 October 2017



The Commission was deeply saddened by the untimely passing of Commissioner Jackie Crowe on Saturday, 21 October 2017 at the age of 49.

Jackie was appointed as a Commissioner at the time the

National Mental Health Commission was established in 2012, and had been reappointed this year for a further two years.

She was an extraordinary individual, charismatic, intelligent and larger than life. She brought expertise, tenacity, personal insights and compassion to her role as Commissioner. With great clarity, she was able to quickly get to the essence of any issue under discussion and powerfully presented the voice of lived experience in all that she did. She was a

champion for the development of person-centred care and ensuring that it was embedded in current mental health reforms.

Jackie was central to many key initiatives of the Commission, including supporting the development of the peer workforce, driving the elimination of seclusion and restraint practices, and greatly enhancing engagement and participation and effective care for people with lived experience. She made an exceptional contribution to mental health reform over many years.

Jackie encouraged greater understanding, compassion and respect for people affected by mental illness and suicide, and the families, friends and carers who journey with them.

Jackie left an indelible legacy of achievements, including some projects that were nearing completion before she passed away which the Commission will continue working on.

In loving memory of our endearing and irreplaceable colleague, Jackie Crowe.

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About us

The National Mental Health Commission (the Commission) was established on 1 January 2012 to report independently on what's working and what's not. It reports directly to the Minister for Health and will provide six-monthly updates to the Prime Minister on the government's mental health reform agenda.

Our role involves three main functions:

- Monitoring and reporting on the performance of the mental health system and playing a key role in reform.
- Advising governments, health services and community, particularly about evidence-based ways to improve outcomes for people with lived experience.
- Acting as a catalyst for change by engaging, collaborating, facilitating, influencing and leading.

Our Commissioners

The Commissioners are appointed by the Minister for Health to help the Commission achieve our objectives by providing expert and independent advice. The CEO is also a Commissioner.

Commissioner	Appointment term
Professor Allan Fels AO (Chair)	1/1/12 – 31/1/18
Mrs Lucinda Brogden (incoming Chair)	9/4/14 – 31/7/21
Dr Peggy Brown (CEO)	1/10/16 – 30/9/21
Ms Jackie Crowe	1/1/12 – 31/7/19
Professor Harvey Whiteford	1 /8/17 – 31/7/19
Professor Wendy Cross	1 /8/17 – 31/7/19
Professor Helen Milroy	1 /8/17 – 31/7/19
Professor Ian Hickie AM	1/1/12 – 31/7/18
Professor Ngiare Brown	1 /8/17 – 31/7/18
Mr Samuel Hockey	1 /8/17 – 31/7/18
Professor Pat Dudgeon	1/1/12 – 31/7/17
Mr Rob Knowles AO	1/1/12 – 31/7/17
Ms Nicole Gibson	24/9/14 – 31/7/17

Our staff

The work of the Commission is supported by 14 staff. We are a diverse organisation, with a wide range of skills and experience gained from working in clinical, health promotion, research, and project management roles in primary and acute health care settings, the community and private mental health sectors, academia, as well as government and non-government sectors.

Our vision

That all people in Australia are enabled to lead contributing lives in socially and economically thriving communities.

Our mission

To promote understanding of the outcomes that matter and drive transformational change across service systems for people with lived experience of mental ill health.

Our values

Excellence

- We believe everyone is capable of great things in a great environment.
- We strive for success and celebrate it when we achieve it.
- We know and use evidence to inform our decisions.
- We support innovation and continuous improvement, and are committed to helping to build the evidence base.
- We are credible and trusted.

Integrity

- We are honest and trustworthy in all that we do.
- We stand up for what we believe in.
- We respect each other's differences.
- We value human rights and social justice.
- We believe in equity and opportunity for all.

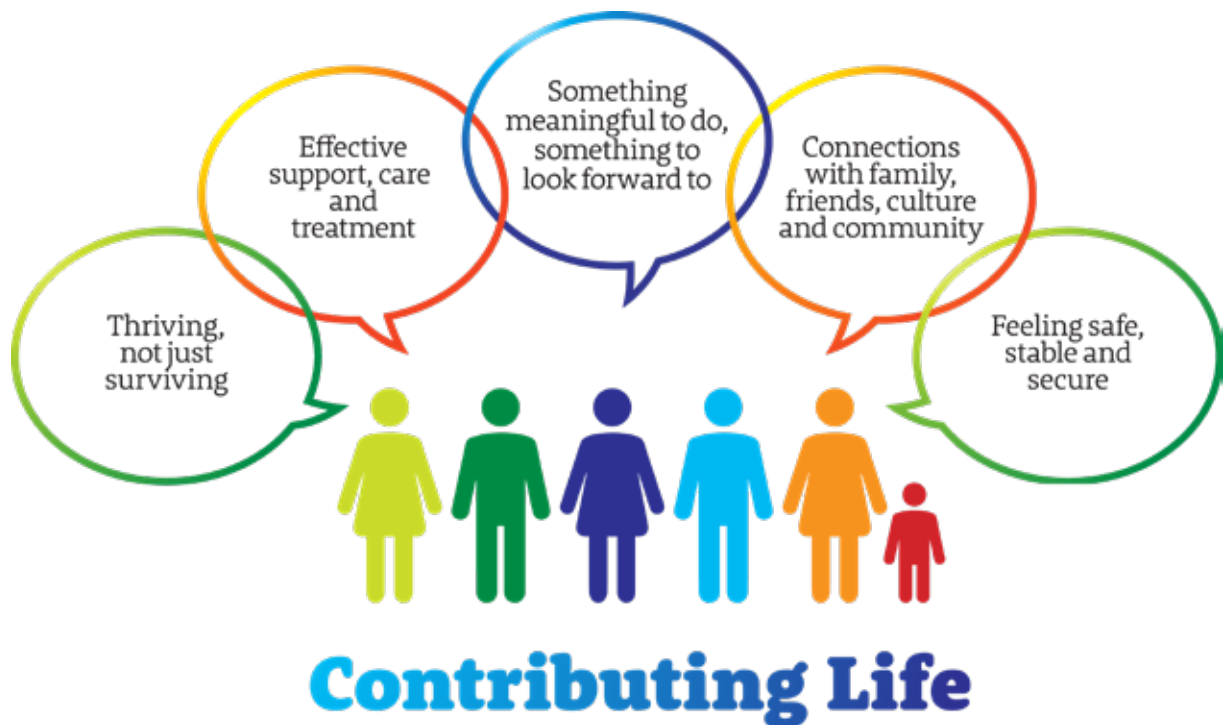
Collaboration

- We value individuals, interactions and connectedness.
- We respect and acknowledge everyone's input, skills and experience.
- We believe in working together.
- We acknowledge the importance of effective communication.
- We support engagement and participation at all levels to enhance our outcomes.

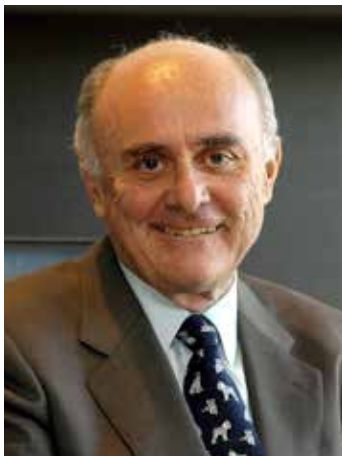
Accountability

- We value our independence and transparency.
- We take accountability for our commitments and actions and expect no less of others.
- We are reflective and open to feedback.
- We ensure correct information.
- We bring light to opportunities, challenges, and gaps.

At the Commission we believe that everyone has the right to lead a Contributing Life.



Message from Professor Allan Fels



This has been a highly productive year for the National Mental Health Commission. We have seen many of our recommendations taken up by Government, underpinning some of the most significant mental health reforms

in Australia's history. In addition, several key priority areas of the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) have reflected recommendations we have made previously. We have also advised Government on mental health aspects in the National Disability Insurance Scheme (NDIS).

The Commission keenly monitors the Government's mental health reforms, and will look forward to reporting on the implementation of the Fifth Plan and the NDIS roll-out as it progresses. To strengthen our accountability, we now report directly to the Minister for Health and the Prime Minister every six months on the Government's mental health reform agenda, and in future, will report to the Council of

Australian Governments (COAG) Health Council on progress on the implementation of the Fifth Plan.

Our achievements in 2017

There have been many achievements this year but to mention a few: we examined consumer and carer engagement and participation; considered the economics of mental health and promoted the development of 'best buys' in Australian mental health; explored ways to advance achieving security and safety of accommodation for people with lived experience; championed the need for further reduction in the use of restrictive practices such as seclusion and restraint; launched Equally Well to improve the physical health of people living with mental illness; and continued to include a specific focus on Aboriginal and Torres Strait Islander peoples in all aspects of our work.

We've been strengthened

The Government made an election commitment in 2016 to strengthen the National Mental Health Commission and has made good on that promise. In addition to strengthening our accountability as outlined above, the Commission has been provided with additional funding and received approval to increase our staffing level which together provides us with additional capacity to continue our important work.



Front row: Prof Ngiare Brown, Prof Pat Dudgeon, Ms Nicole Gibson, Minister for Health the Hon. Greg Hunt MP, Mrs Lucy Brogden, Prof Helen Milroy. Back Row: Prof Wendy Cross, Prof Harvey Whiteford, Dr Peggy Brown, Mr Samuel Hockey, Mr Rob Knowles, Prof Ian Hickie, 7 August 2017.

We continued our program of regular visits to cities and towns across Australia where we meet with consumers and carers and a range of stakeholders. We have also strengthened our internal processes and revised our Corporate Plan which includes our ambitious work plan.

In October 2016, I was delighted to welcome Dr Peggy Brown to the position of Chief Executive Officer. Dr Brown has extensive experience in the mental health sector and brings a long-term commitment to person-centred and whole-of-life approaches to mental health.

The Commission has also expanded its Advisory Board. In August, we welcomed five new Commissioners – Professor Harvey Whiteford, Professor Wendy Cross, Professor Helen Milroy, Professor Ngiare Brown and Samuel Hockey to join Lucy Brogden, Professor Ian Hickie and Jackie Crowe. Sadly we said farewell to Commissioners Rob Knowles, Professor Pat Dudgeon and Nicole Gibson. I'd like to take this opportunity to thank the Commissioners for their enthusiastic support and leadership.

I also wish to acknowledge and reflect on the life of Commissioner Jackie Crowe, who sadly passed away in October 2017. Jackie was a long-time champion for the rights of people with lived experience of mental ill health and her commitment to improving outcomes in suicide prevention and mental health was tireless.

This year I announced I will stand down as Chair of the Commission, and in February 2018, I will hand over the role of Chair to Lucy Brogden who I highly admire and respect. Until the changeover, from August 2017 the Government assigned us both as Co-Chairs.

Thank you!

I would like to take this opportunity to sincerely thank all organisations, individuals, consumers and carers for sharing their insights and experiences with the Commission throughout the year. Our efforts to support reforms designed to create a world leading, person-centred mental health system would be poorer without your contribution.

A handwritten signature in blue ink that reads "Allan Fels". The signature is written in a cursive, flowing style.

**Professor Allan Fels
Chair**

Message from Dr Peggy Brown



It has been an honour to lead the National Mental Health Commission over the past twelve months. The Commission consulted widely with many stakeholders in 2017 to inform our efforts to continually improve Australia's

mental health system and is pleased to detail the outcomes of our work in this national report.

Influencing system improvements

We know you cannot deliver reform and a person-centred system without consumers and carers playing a pivotal role in the co-design of policy and services. With that goal in mind, we commenced our Consumer and Carer Engagement Project, informed by a diverse Lived Experience Project Steering Group. Our online Engage and Participate in Mental Health consultation attracted over 800 submissions.

It is particularly pleasing to see our advice and recommendations led to additional funding and system improvements in 2017.

In June 2017, the Government released its response to the Commission's Review of services available to veterans and members of the Australian Defence Force (ADF) in relation to prevention of self-harm and suicide. Our recommendations gained an additional \$58.6 million in mental health funding; \$9.8 million to pilot new approaches to suicide prevention and improve care and the support available to veterans; and funding to increase support for those discharged from hospital and at risk.

We were also pleased to see the provision of \$80 million in the Federal Budget to support psychosocial disability services for people who do not qualify for the National Disability Insurance Scheme (NDIS), as earlier this year, the Commission had raised significant concerns with the Government about the level of psychosocial disability supports available to all who need it. We are aware that this funding is contingent on matched contributions from states and territories that have not yet been finalised and will continue to monitor this closely.

Monitoring and reporting

You may notice that our 2017 Report is different in format to our previous reports. This year, we are reporting on the outcomes of our engagement with stakeholders and the work of the Commission to help shape a mental health system that can respond to peoples' needs more effectively.

We are currently in the process of developing a new monitoring and reporting framework which will guide our future reports. We have been investing time and effort to develop a framework which will provide a consistent foundation to structure and guide us over the next five years and into the future. We look forward to bringing you a new approach to our reporting in 2018 as we will have established a framework that will:

- consider the impact of reforms such as the Fifth National Mental Health and Suicide Prevention Plan and the NDIS;
- bring a national perspective to mental health and suicide prevention, by drawing together information that provides insight on longer-term outcomes;
- consider the reform through the lens of consumers and carers, and their experiences; and
- deliver an independent, consistent, and comprehensive account of reform progress.

The Commission is committed to its role of monitoring and reporting on the mental health and suicide prevention systems and this year we welcomed the added responsibility of monitoring the implementation of the Fifth National Mental Health and Suicide Prevention Plan.

Vale Jackie Crowe

I would like to acknowledge the work of Commissioner Jackie Crowe whose commitment and contribution to mental health reform was exceptional. The mental health sector has lost a great champion through her untimely death but the Commission will seek to continue her legacy by prioritising and embedding the voice of lived experience in all that we do.

Thank you for our partnerships

I wish to express my sincere gratitude to all of the people who have contributed to our projects and activities in 2017; our success depends on you! We are grateful for our stakeholders' genuine commitment and passion to improving Australia's mental health system and look forward to working with you in 2018.

Finally, I would like to thank my colleagues at the Commission. Our small team consistently produces valuable results and I wish to acknowledge their dedication and passion for making a difference as well.



Dr Peggy Brown
Chief Executive Officer
Commissioner

1. Embedding consumer and carer engagement and participation

With a noticeable shift in policy to putting people first, successful reform requires engagement and participation of people with lived experience, families, and support people. Chapter 1 reflects on some of the challenges, key principles and learnings to support meaningful, genuine and active participation and engagement.

Working with consumers, carers, families, and other support people, helps to ensure that the design and delivery of programs, policy, and services effectively address what matters. The importance of this approach has been reaffirmed in the Fifth National Mental Health and Suicide Prevention Plan.

These voices are embedded in the work of the National Mental Health Commission, so we can shine a light on the mental health and suicide prevention systems and the areas which need improvement to influence change and achieve better outcomes. We believe all Australians have the right to lead a contributing life and we are committed to pursuing system wide change to achieve this goal.

Just as a one size fits all approach to service delivery is not desirable, a uniform approach to consumer and carer participation will not pick up the different types of needs and the most appropriate way of targeting services. Consumer and carer participation strategies should recognise the variation in consumers and their needs and target input accordingly.

Jackie Crowe, Commissioner

<p>Participation and Engagement are frequently used interchangeably, however they are not the same thing.¹</p>	<p>Participation is a practice that involves consumers and carers directly as equal partners and with equity in the decision making process.</p>	<p>Engagement refers to methods used to involve consumers and carers more generally, and is necessary for a shared decision making process to be undertaken.</p>
<p>Co-design, co-production and co-creation are terms used to describe approaches to enabling engagement and participation which recognise the centrality of consumers and carers in the development, implementation and evaluation of any initiative. It is underpinned by genuine and meaningful partnerships, shared power, transparent processes and continuous feedback with consumers, carers, families, support people, service providers and key stakeholders.²</p>		

What we heard

Through our broad engagement across the nation, we heard that there is much variability in the level of commitment to, and the actual practice of ensuring meaningful engagement and participation with consumers, carers, families and support people. Genuine engagement and participation is required at all levels – in the planning, design and delivery of services, and in policy development, training and education, research and evaluation. The critical influence of language and discrimination must also be considered.

Concerns people have raised with us show:³⁻⁵

- engagement and participation is often a token effort;
- assessment under the *National Standards for Mental Health Services – Standard 3 Consumer and Carer Participation* is not rigorously applied;
- payment for participation is inconsistent; and
- human rights and a recovery orientation are not reflected well in policies.

Of note, as part of the Government's mental health reform, Primary Health Networks (PHNs) are expected to collaborate⁶ and to establish Community Advisory Committees. Some PHNs have gone further and employed staff with lived experience to coordinate consumer and carer engagement.⁷

We have a consumer consultant who is an employed staff member... to ensure we bring that consumer voice to everything we're doing.⁷

PHN

Surveys such as *Your Experience of Service (YES)* and the *Mental Health Carer Experience Survey* provide insight into people's outcomes and experiences, and give consumers and carers other ways to inform improvements. To date, there is only limited information available on how this important input is shaping service delivery. The Commission invites services to share their learnings on how this information is being used.

We also heard that the community want more information on the range, quality and outcomes of engagement and participation in the mental health sector, particularly with diverse population groups such as:

- Aboriginal and Torres Strait Islander peoples;
- culturally and linguistically diverse people;
- lesbian, gay, bisexual, transgender, intersex and queer people (LGBTIQ);
- immigrant, refugee and asylum seeking background people;
- people with disability; and
- people subject to the criminal justice system.

Engage and Participate in Mental Health Project

The Government asked us to develop a consumer and carer engagement and participation framework. Co-designed with our Lived Experience Steering Group, we established the *Engage and Participate in Mental Health* project. As we were aware that many services and organisations already have participation and engagement frameworks, we wanted to understand what exists and what are the principles of best practice, to determine what more is needed.

The Lived Experience Steering Group for the *Engage and Participate in Mental Health Project* reviewed the state of engagement and participation and examined how consumer and carer engagement can be improved, identified new avenues for engagement and new ways of working, and considered research priorities.

We asked people to share their views on:

- the meaning of engagement and participation in mental health;
- ways in which they were engaging and participating in mental health care, support or treatment;
- how they would like to engage and participate in mental health policy and service development;
- benefits and outcomes from engagement and participation in mental health; and
- the future vision for engagement and participation in mental health.

More than 1,000 people participated and shared how they engage and participate in mental health.

Engagement means being able to be part of something bigger than myself and being part of something where I can contribute from our family's experience. Being able to use what has been a painful and distressing journey and to help others. I also draw hope from being able to contribute to service development and reform in this service.

Participant, Engage and Participate in Mental Health

We also collected different policies and frameworks for consumer and carer engagement and participation across key parts of the system and will make this information available in a searchable database at the completion of the project.

What we learnt

Collaboration is essential, as is a focus on putting people first. A key challenge is embracing a more systematic approach to embedding consumer and carer voices in the design and delivery of services. We need to ensure policy makers and service providers understand and address the diversity of need. There is also an opportunity for innovation and the application of technology. Digital innovation is essential to contemporary engagement and participation of consumers, families and communities.⁸



Connections Inc., Caboolture holding a community conversation for the Engage and Participate in Mental Health Project, 2017.

There are many excellent examples where the employment of people with lived experience informs the development and delivery of mental health and suicide prevention care and services. Collaboration through co-design of services, policies and infrastructure means consumers and carers are essential partners in decision making.

Some of our learnings from our co-design experience show that:

- expectations and responsibilities need to be agreed and clearly articulated, supported by terms of reference;
- establishing shared understanding and meaning of concepts is important to lay the foundation for the direction of any work;
- allowing adequate time to define the problem, creativity, and ensuring every voice has the opportunity to be heard are all essential;
- diversity fosters creativity and innovation;
- face-to-face contact is vital and needs to be balanced with project requirements and budget;
- capacity building and networking opportunities are important for future collaboration;
- contributions must be duly recognised and paid participation made available; and
- it is important people are given advanced notice for meetings and there is flexibility to accommodate needs.

2. Promoting access through digital mental health

Digital technology is an important, accessible part of a stepped-care approach to supporting people with lived experience of mental ill health. In Chapter 2 we consider the opportunities and potential for enhancing support and information, and reducing stigma and discrimination through digital mental health.

Digital mental health is a key part of the Government's response to the National Mental Health Commission's 2014 Review in which we described how innovative technologies could transform access to services and support.⁹ With the potential to transform Australia's mental health system, digital technologies create new opportunities for person-centred and self-managed services, and enable stronger connections between sectors. In particular, digital mental health can help address regional and remote inequity where there are high levels of unmet mental health need in rural and regional communities.



Harrison, Lived Experience Participant: Thriving Communities, 2016.

Living remotely challenges the provision of solid mental health services. With the ability to employ digital resources and services, we are able to begin to bridge the existing gaps between the services in major cities and those in rural and remote centres around Australia. Digital services also mean mental health services can be available for those who need it when they need it, at varying hours of the day or night.

Samuel Hockey, Commissioner

What we heard

Digital mental health can help us reach more people. We heard that:

- less than one in two (46 per cent) people seek help for mental ill health from a mental health service provider;¹⁰
- people less likely to seek conventional support include children and youth, middle-aged men, older people, geographically isolated groups and socio-economically disadvantaged groups;⁹ and
- concerns about privacy, stigma and discrimination can act as a barrier to receiving help and this is even greater for those living in regional, rural and remote areas and for people who identify as LGBTIQ.

People told us discrimination due to mental illness is a factor which affects whether a person seeks services in their town. Some people travel to the next town or regional centre for support (if available).

Young people, in particular, told us that technology and access to support out-of-hours in an anonymous way is critical.^{11,12} We still have barriers to overcome, such as:

- while 88 per cent of households in Australia's major cities have internet access, this falls to 79 per cent for those in outer regional or remote areas;¹³ and
- the cost of internet access is out of reach for some people. Of the 1.3 million Australian households in 2014-15 without internet access at home, 16 per cent reported cost was a reason. Further, cost was the most common reason (43 per cent) for not having internet access at home for households with children under 15 years of age.¹³

Equally important is the need for connection and community among people who are isolated and/or stigmatised for a range of reasons, especially due to poverty, illness, social isolation and unemployment.

Participant, Engage and Participate in Mental Health

We are also aware:¹⁴⁻¹⁶

- the transition to digital platforms is not occurring in a structured way;
- there is a lack of visibility of what is being funded in digital mental health;
- there is a need for an integrated approach to prevent duplication and unnecessary spending on product development;
- workforce adaptation is needed;
- community awareness of digital mental health needs to be improved;
- lack of confidence or knowledge to use the internet can be a barrier to using digital technology (22 per cent of Australian households in 2014-15 who did not have internet access at home, did not have it because of this);
- there is a lack of agreed measurements of accessibility, quality and safety of digital mental health services; and
- there is a need to ensure evidence-based online care is accessible.

What we did

We partnered with SANE Australia for the Building Thriving Communities through Social Connection initiative (*Thriving Communities*). It was a nationwide campaign to raise awareness of the benefits of online peer support and social connection for people affected by complex mental illness, particularly those in rural and regional areas.

The *Thriving Communities* project involved:

- a national campaign about the online SANE Forums using social media, radio, television and print;
- creation of authentic, helpful and inspirational content for the campaign, drawing on the lived experience of people with complex mental illness <https://www.sane.org/livingstories>;
- collaboration with community mental health organisations to promote the peer support forums; and
- evaluation of the effectiveness, impact and relevance of online peer support forums for people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander backgrounds.

SANE Forums

SANE Australia's Lived Experience and Carers Forums are thriving online peer support communities that are anonymous and professionally moderated 24 hours/7 days a week. The Forums allow people to interact by posting supportive messages to each other about their mental health concerns to help themselves and others.

A family member of mine, who is usually very quiet and shy, saw my story on TV and all of a sudden disclosed his own battle with mental illness – to the shock of his children. This then started a family ‘around the table discussion’, which was probably the proudest moment for me as I was part of starting that discussion! I’ve also had so many Facebook messages from people, including a couple from Indigenous women, thanking me for telling my story and for being a strong Indigenous role model.

Denielle, Lived Experience Participant: Thriving Communities



Denielle, Lived Experience Participant: Thriving Communities, 2016.

What we learnt

The *Thriving Communities* campaign confirmed that the online peer support model offered by the SANE Forums increased access to support, information, and opportunities for social connection via peer-to-peer contact.

Using television, radio and social media to promote the stories of people with lived experience of mental illness was very successful.

Future work is needed to ensure cultural inclusivity and extend the reach of the forums to people from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds.

The Commission's strong support for continued work in the digital realm is reflected by the Government's *Head to Health* consumer-friendly digital mental health gateway. This new website aims to provide tools and information to help improve mental health awareness and access to evidence-based information, advice and treatment options.¹⁸ The Government also provided \$9 million funding over four years from 2017-18 for telehealth so people in rural and regional locations can access psychological services by videoconferencing for seven of their 10 (Better Access) sessions.^{19,20}

The *Thriving Communities* campaign:¹⁷

- reached 155 communities – 97 per cent were from regional and remote areas;
- increased new forum members by 256 per cent;
- increased regional and remote forum membership by 103 per cent;
- increased unique visitors to the forums by 119 per cent;
- significantly increased traffic and activity on the SANE website and SANE Forums with the highest engagement among women and people aged 25 years and over;
- involved members accessing a significant number of pages for 1–2 hours at a time; and
- frequently started new discussions amongst members.

Participants said:

- SANE Forums provided social connection allowing them to reframe the often-difficult experiences of mental illness and provided a space to step out of the stigmatisation and loneliness they experienced in everyday life; and
- SANE Forums enabled them to speak more openly about their mental health, to seek additional help, understand where to get help, and activate strategies to better manage mental health.

3. Improving physical health to promote wellbeing

It is unacceptable that people with lived experience receive less and lower quality healthcare, and die younger than the rest of the population from preventable diseases. Chapter 3 presents *Equally Well: the national consensus statement for improving the physical health and wellbeing of people living with mental illness* and discusses how these disparities are being addressed.

People with mental illness experience worse health outcomes than the rest of the population, including a significant reduction in life expectancy. Whilst this issue has been known for many years, there has been a lack of coordinated action to address it. The National Mental Health Commission made it a priority to partner with a range of key stakeholders to develop a national consensus statement to affect real change and improve the physical health of people living with mental illness in Australia.

Often the physical health needs of people with a mental illness are 'overshadowed', leading to physical conditions going undiagnosed and untreated, sometimes proving fatal.

Some evidence suggests there is a life expectancy gap of 14-23 years between those living with severe mental illness and the general population,²¹ and that for some mental illnesses the gap is widening.²²

There can be no greater illustration of how the health system has failed people with mental illness than the life expectancy gap, mostly caused by preventable, and treatable, diseases.

**Professor Harvey Whiteford,
Commissioner**

What we heard

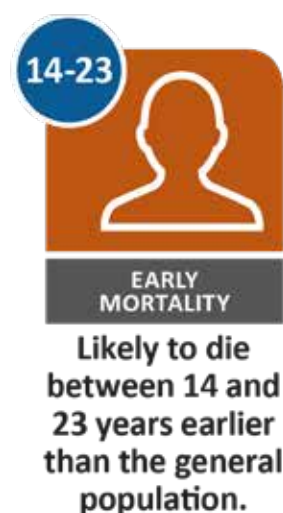
Our online and face-to-face consultations helped us better understand the physical health problems that people living with mental illness in Australia face.

We heard that people living with a chronic mental illness are dying from largely preventable physical health conditions, including respiratory disease,

metabolic syndrome and cardiovascular disease.

There is a need for improvements to the way physical health conditions are diagnosed and treated to place the health of people living with a mental illness on equal footing with everyone else.

People living with severe mental illness are particularly at risk. They are:



Source: Equally Well Consensus Statement. National Mental Health Commission, 2016.

What we did

Building on our previous work, we collaborated with both the health and mental health sectors to develop *Equally Well: the national consensus statement for improving the physical health and wellbeing of people living with mental illness*.²¹

Equally Well outlines six essential elements that provide guidance to ensure health services have the capacity to safely, collaboratively and effectively recognise and respond to the health needs of people living with mental illness.²⁵

We approached each state and territory government in Australia as well as a range of organisations in the sector to encourage their support for *Equally Well* and its principles.

In March 2017, we held a workshop to update stakeholders on the progress of *Equally Well*. Following a recommendation from participants, we established the Equally Well Implementation Committee (EWIC) which provides leadership and governance to implement and promote *Equally Well* nationally.

...smoking is a major factor in this life expectancy gap. For this reason, working with mental health organisations has become a priority. Over the past 12 months, we have been working with a range of clinical and community mental health services to embed smoking cessation into routine care using an organisational change framework that addresses smoking policies, assessment tools (e.g. intake forms), training in delivering brief interventions and systematic data collection and monitoring.

Equally Well partner, Quit Victoria

These are the essential elements of Equally Well



Source: *Equally Well Consensus Statement. National Mental Health Commission, 2016.*

People with lived experience, their families and support people have been involved every step of the way. Elida Meadows, the Carer Co-Chair of the National Mental Health Consumer and Carer Forum (NMHCCF) and Associate Professor Russell Roberts (Charles Sturt University) were appointed as Co-Chairs of the EWIC. The Commission also partnered with Mental Health Australia and built relationships with our colleagues in New Zealand who established *Equally Well* in 2014.

What we learnt

In order to create change and improve the life expectancy of people living with both mental illness and physical health conditions, there needs to be significant cultural change, community buy-in, and shared ownership and responsibility for action.

We want consumers, carers, families and the community to know how they can work with health care workers to support people living with mental illness to successfully manage their physical health. We want health professionals in both physical and mental health services to work together and with consumers to provide better treatment for people with mental illness.

The importance of *Equally Well* was confirmed through the inclusion of physical health in the Fifth National Mental Health and Suicide Prevention Plan

as a priority area of action. One of the actions in the Fifth Plan has already been met: all state and territory governments confirmed their support for *Equally Well* in July 2017.

To date, 71 organisations, including state and territory governments and professional colleges, have signed up to support *Equally Well*, endorsing its principles and the message it stands for. We continue to monitor the progress of this initiative.

The *Equally Well* consensus statement reminds us that we can make a huge difference to the overall wellbeing of people with mental ill health by adopting actions that address the whole person. To ignore this is to risk continuing down the path of the current appalling situation of people with mental ill health experiencing a significantly reduced life expectancy and persistent poor physical health. In the mental health sector, we talk about recovery and helping people to live the best life they can. This will only truly happen if people are given the chance to optimise their physical as well as their mental health and wellbeing. This is an opportunity for us all to become part of the solution by making a commitment to the fair, equitable and holistic treatment of people with mental ill health.

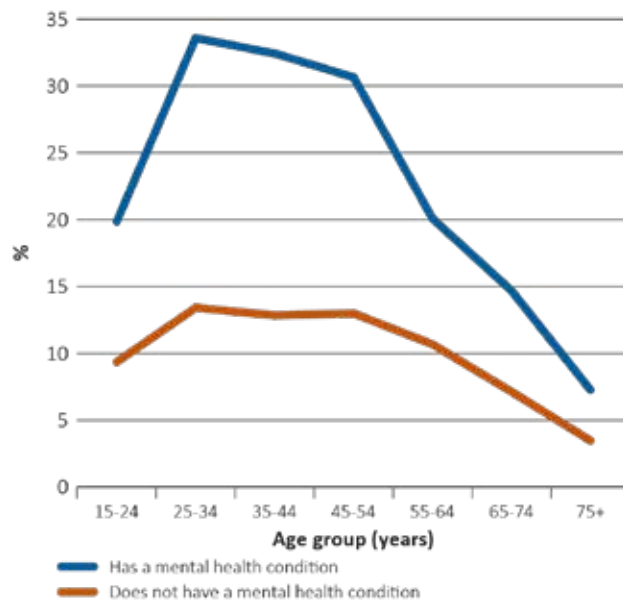
Elida Meadows – Co-Chair, *Equally Well* Implementation Committee

4. Linking housing, homelessness and mental health

Feeling 'safe, stable and secure' is one of the five domains in our Contributing Life Framework. Chapter 4 provides insight into the complex relationship between housing and mental health, and identifies research needed to drive change across the health and housing sectors.

In Australia, people with lived experience of mental ill health experience greater housing instability, poorer quality of housing and less choice over living conditions than people without mental illness.²³ The National Mental Health Commission is aware that the factors contributing to this are complex. We are committed to developing relevant expertise and advice to identify the policy levers to influence change and ensure this issue remains at the forefront of governments and funders.

Figure 1: Proportion of people who had ever experienced homelessness, age and mental health status, 2014



Source data: General Social Survey, 2014²⁴

Insecure housing contributes to adverse mental health outcomes for everyone, and more so for those living with mental illness. A fundamental human need is that of safe and secure shelter. If we cannot meet this most basic of human living requirements, we will never achieve other fundamental needs such as a sense of belonging, self-esteem and achievement.

Professor Wendy Cross, Commissioner

What we heard

Since the start of the Commission in 2012, housing has been repeatedly raised as a concern for families, carers and those with lived experience of mental ill health.²⁶

Homelessness is expensive living day to day and week to week...when you couch surf you are everyone's friend on pay day and once pay day has gone you are asked to go until next pay day... Sometimes you have to choose between eating on that day or where you are going to stay.

Consumer participant, Housing and Homelessness Consultation

We heard reports about people being discharged from hospital, custodial care, or public mental health and drug and alcohol services into homelessness. Aboriginal and Torres Strait Islander peoples with a current mental illness access specialist housing assistance at a rate of more than six times that of non-Indigenous Australians.²⁷ It has also been estimated that 50 per cent of homeless youth in Australia experience mental illness, based on self-reported rates of diagnosis.²⁸ A decrease in family functioning and lived experience of mental illness are key markers for increased time spent away from home.²⁹

People also told us about gaps in monitoring exit pathways into homelessness when people leave hospitals, the justice system, out-of-home care,

mental health, and drug and alcohol services without a safety net in place.

What we did

'Feeling safe, stable and secure' is one of the five areas in our Contributing Life Framework. To better understand housing issues in relation to mental health we conducted a national online consultation with a range of stakeholders and also held workshops in each state and territory from March to May 2017. We heard from consumers, carers, their families and support people, and received written submissions about Aboriginal and Torres Strait Islander peoples' housing needs and experience of homelessness, especially in the Northern Territory.

We asked people to share their views on the following:

- success factors associated with existing policies and programs;
- options for increasing housing supply for people with a mental illness while simultaneously addressing consumer preference and choice;
- data that should be collected to monitor the effectiveness of systems and policies designed to improve housing outcomes for people with mental illness; and
- key policy issues and research which could be progressed at the national or jurisdictional level.

We are now working with the Australian Housing and Urban Research Institute (AHURI) to research opportunities and tools to leverage policy in the area of housing and mental health. This project is also consistent with targets under the Commission's Corporate Plan³⁰: to create momentum, within and outside of the health system. Consistent with the Commission's commitment to involve people with lived experience in all of its work, this project will directly consult with carers and consumers via an 'investigative panel' method. Outcomes of this work are due in mid-2018.



Participants at workshop held in Adelaide, April 2017.

What we learnt

The strong message we heard from the consultations has been the need for more and better mental health services and housing options.

Other key findings included:

- housing arrangements need to support recovery, not just provide ‘a roof over one’s head’;
- a need to engage with estate agents and landlords to educate, reduce stigma and improve access in the private rental market to reduce the risk of homelessness for people with mental illness;
- good examples of supported housing (and service integration) exist, noting there are challenges in scaling these up state and nation-wide;
- the importance of co-design and consumer choice in social and community housing development and models which support home ownership such as rent to buy, shared equity or co-operatively owned housing;
- a need for step-up-step down facilities and intensive support at discharge; and
- integrated mental health and housing support services, and peer worker assistance, are important to maintain tenancies and help people live independently.

A clear theme from our national consultation was the need for flexibility and adaptability in service delivery for specific populations, including Aboriginal and Torres Strait Islander peoples, youth, rural and remote, older people, and the LGBTIQ community.

Aboriginal and Torres Strait Islander perspectives – Northern Territory (NT)

Aboriginal and Torres Strait Islander peoples are over-represented in all homeless groups (28 per cent), relative to their proportional representation of the national population (3 per cent).³² The highest rates of homelessness are in the NT, with one in four NT residents considered to be homeless. Indigenous people experiencing homelessness are most often female, residing in a severely overcrowded dwelling, in a ‘very remote’ region.³² Fourteen per cent of state owned and managed Indigenous housing occupants accessed mental health services in 2016.³³

Waiting periods for public housing in the NT are currently between two and eight years depending on location, with the private rental market inaccessible and/or inappropriate for people receiving public assistance payments.³⁴ There are several reasons for over-crowding and poor standards of maintenance and management of public housing: overall decline in public housing quality and availability, fewer Aboriginal organisations involved in the management and maintenance of housing, and housing policies which failed to consider the social determinants of health.³⁵

Factors such as intergenerational trauma, have not always been considered in policy responses. The values, lifestyles, aspirations, and needs of Aboriginal and Torres Strait Islander peoples have generally not been considered in the delivery of mainstream programs delivered by mainstream providers.

There are examples we can learn from such as the ‘Health for Habitat’ framework, which closely collaborates with Aboriginal and Torres Strait Islander communities to inform housing, construction and management. The Aboriginal Peak Organisations Northern Territory (APONT) developed Partnership Principles for working with Aboriginal organisations and communities in the NT – the 11 principles relate to housing and mental health services including “ensure Aboriginal control, not just consultation”, “recognise existing capacity” and “seek partnerships not direct competition”.

Policy responses aimed at tackling issues of housing, homelessness and mental health must identify and build upon existing bodies of knowledge, experience and strength within Aboriginal and Torres Strait Islander communities and organisations. They should also be based on a trauma-informed, social and emotional wellbeing approach with delivery in a culturally safe way.

We have learnt of new legislation proposed by the Federal Treasury to increase the supply of affordable housing. The draft legislation proposes a capital gains discount of up to 60 per cent for investors who elect to provide affordable housing for at least three years, rather than the standard 50 per cent discount for private dwellings.³¹ The Commission submitted a response during the consultation period

in September 2017. We confirmed the need for the introduction of legal and policy instruments which leverage private investment to create more housing stock for those earning low to moderate incomes, and which create conditions favourable to security of tenure. We also reiterated the need for ongoing support from providers of health and social services.

5. Preventing suicide

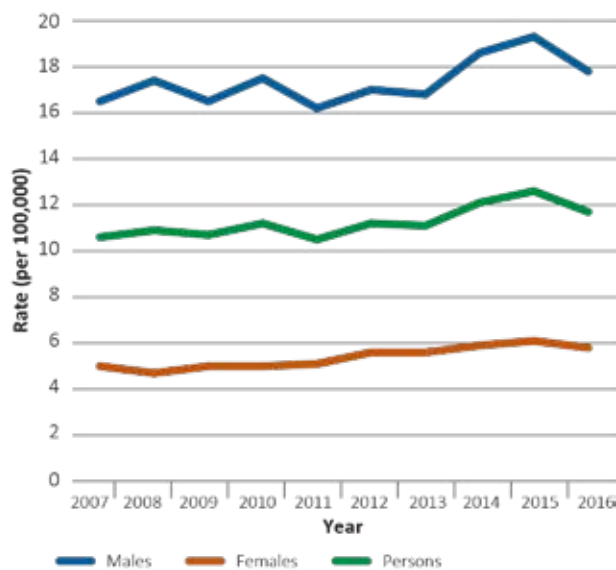
There is significant work underway across the nation addressing suicide prevention. Chapter 5 focuses on our efforts in facilitating approved approaches to suicide prevention, and presents the review of suicide prevention services for Australian Defence Force members and veterans.

Suicide affects many Australians, their families, support people, and communities each year.

In 2016, 2,866 people died by suicide in Australia. Suicide is the 15th leading cause of death in Australia.³⁶ The National Mental Health Commission previously reported on the fragmented approaches to suicide prevention in Australia and called for programs to be better coordinated and targeted, particularly to vulnerable groups and hot spots.⁹ Whilst we have seen some positive developments with an increased number of services, programs and trials commissioned at the national, state and local levels, more needs to be done.

In response to Australia's suicide rates and disparities amongst communities in their experience of suicide, the Commission is facilitating improved approaches to suicide prevention by encouraging sector-wide national collaboration.

Figure 2: Suicide rates per 100,000, 2007 to 2016



Source: Standardised death rates for Intentional self-harm, 2007-2016³⁶

Children and young people are our future. We need to be concerned for their wellbeing and focus on supporting this throughout their life, so they can live their story to its full potential.

Professor Helen Milroy, Commissioner

What we heard

People working in the sector told us much work in suicide prevention occurs in isolation and there is a call for better coordination – including in the funding of suicide prevention activities. Governments need to work together, whether their focus is on health, disability, education or families and communities.

Through the Australian Advisory Group on Suicide Prevention (AAGSP), we heard greater suicide prevention awareness, knowledge and skills among carers, families, friends and the community is needed for building more resilient communities. The AAGSP recommended better support through training, resources and tools to build strong cultural and community connections and enable equal participation in suicide prevention programs and initiatives.

The AAGSP also recommended workforce development as a priority area, with a greater investment in people – not just in systems. Whilst training and resources exist for various workforces on suicide prevention, the extent to which they are available, useful and put into practice is often unclear. They also vary, making it difficult for the sector to make informed decisions about which training to choose. The AAGSP called for an increased focus on developing a skilled, informed, and well supported workforce to prevent suicide and help those affected by suicide.

A key message the Commission heard from people working in suicide prevention is that it is difficult to access good quality data. Whilst there is suicide deaths data available, there is a lot of variation in the way it is collected and shared, and in the time it takes to receive it. This makes it difficult to draw an accurate national picture.

What we did

This year, a focus for the Commission was undertaking the review of self-harm and suicide prevention services available to current and former members of the defence forces.

The Australian Defence Force Review

In late 2016, the Government asked us to undertake a review of the services available to current and former serving members of the *Australian Defence Force (ADF) in relation to the prevention of self-harm and suicide (the ADF Review)*.

The ADF Review focused on the types of self-harm and suicide prevention services that are available to current and former serving members of the ADF, how useful they are, how often they are used and whether there were any barriers in accessing them.

We conducted a literature review, held workshops, conducted surveys and consultations both face-to-face and online. We heard from over 3,000 current and former ADF members, families and service providers, and received valuable insights about the recruitment process, life as a serving member, transition supports, and life after leaving the ADF.

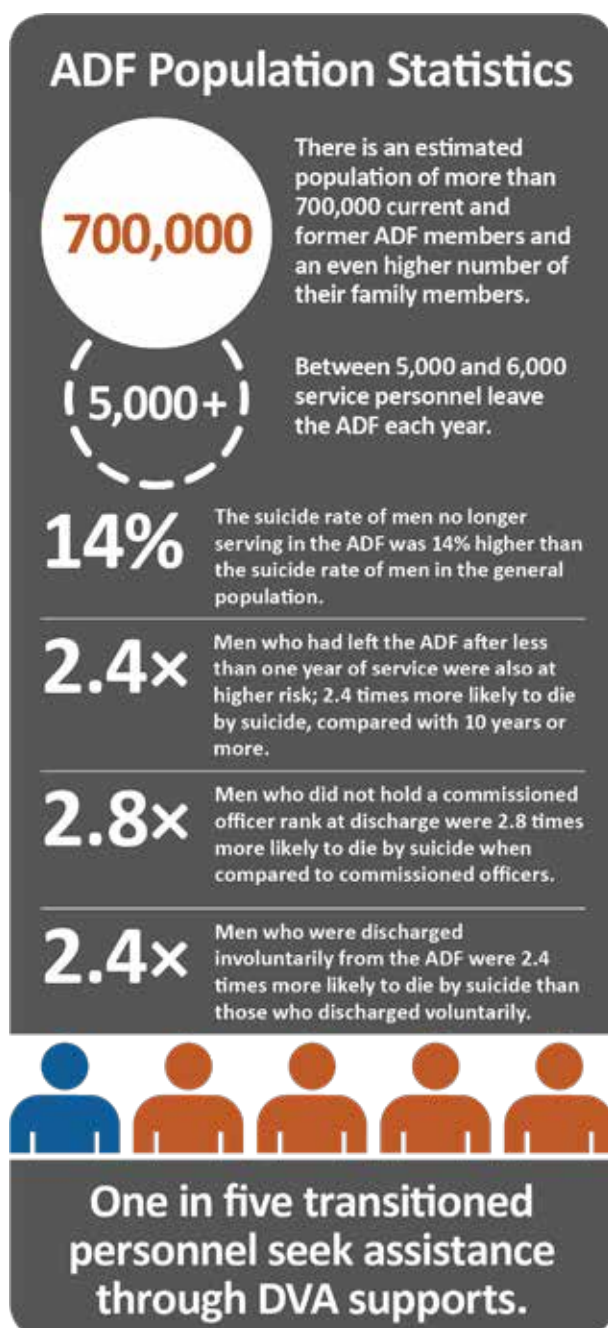
We learnt that the ADF population is recruited and trained to be strong, tough, resilient and perseverant in the face of adversity. These traits are essential in serving members of the ADF and a study has shown that men who were serving full-time or in the Defence reserves were considerably less likely to die by suicide than Australian men generally.³⁷

Serving members of the ADF have access to a range of medical services which, in many cases, are arguably better than those available to the general population. Within the ADF there is also a strong sense of camaraderie, purpose and belonging, which are all seen to be strong preventative factors against suicide.

However, the same traits and arrangements that protect serving members can present challenges when they leave the ADF and transition into civilian life.

Some themes that emerged from our consultations are also reflected in the broader community. For example, the importance of social connection and meaningful participation for current and former serving members, as well as the protective nature of a strong sense of community and belonging, are important for the general population as well.

Figure 3: ADF Population Statistics



Source data: ADF Population data; ABS Population data; Defence Suicide Database; National Death Index; National Mortality Database; Personnel Management Key Solution data.³⁷

Soldiers are taught to ‘harden up’ and be aggressive. This is desirable in the situations they encounter. It is a way of coping that is effective only temporarily. Many soldiers post deployment and service have difficulty experiencing the normal gamut of human emotions and are troubled by this. It is an attitude that often translates poorly to civilian and family life.

Submission to the ADF Review consultation³⁸

What we learnt

The *ADF Review* released in March 2017, identified a number of areas for improvement, including the need to:

- provide whole-of-life transition supports starting from the point of recruitment, throughout ADF service then, post-service;
- better engage with families of current and former ADF members;
- use co-design and peer workers in mental health and suicide prevention; and
- better align the Department of Veteran Affairs and ADF services and processes.

We were pleased that the Government responded to the *ADF Review* by providing additional funding to support veterans, including expanded access to services and new suicide prevention initiatives. This is a vital step towards ensuring that they can access mental health services when they require them.

The Hon. Dan Tehan MP, the Minister for Veteran Affairs and Defence Personnel, gave the first annual Ministerial Statement on Veterans and Their Families in August 2017. In this speech, he outlined that a key focus of the Government is on the men and women who transition out of the ADF, which is one of the key recommendations the Commission made in its *ADF Review*.³⁹

We know there is still more required to adequately support current and former serving members, their families and their communities. We will continue to monitor developments in this space.

The Fifth National Mental Health and Suicide Prevention Plan endorsed a national approach to address suicide prevention. By acknowledging that suicide prevention is the responsibility of all levels of government – Commonwealth, state and local – and by emphasising the importance of collaboration in all suicide prevention efforts, we hope the Fifth Plan can drive cohesive planning and action to respond to this major public health issue.

Transitions and turning points in lives are the times when people are most vulnerable, even when they are anticipated. Adequate and multifaceted services for those in occupations such as the ADF are needed to safeguard people whose lives are often in a state of flux. Importantly, the cultures, the personal connections and the ways of working must be taken in account when developing services.

Professor Wendy Cross, Commissioner

6. Reducing seclusion and restraint

Seclusion rates have declined since 2011, but data on restraint was released for the first time this year. More action is needed to eliminate seclusion and restraint practices. In Chapter 6, we consider factors influencing restraint use and the need for greater collaboration and national approaches to drive consistent monitoring and reporting.

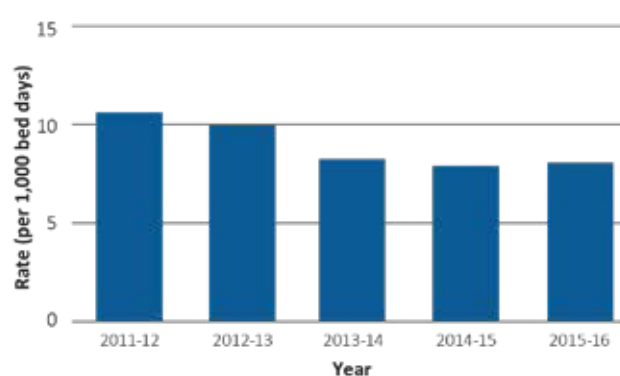
Seclusion and restraint in mental health settings are employed to manage risk of harm to consumers and mental health staff. Despite intended use as a last resort, the use of seclusion and restraint is known to be distressing for all people involved, raises concerns for the human rights of the consumer, compromises the therapeutic relationship, and remains inconsistent with recovery-oriented and trauma-informed practices.

In Australia, alongside international efforts, a commitment has been made to reduce the use of seclusion and restraint and to work towards its elimination where possible. In 2007, the Australian Health Ministers' Advisory Council's Safety and Quality Partnership Standing Committee (SQPSC) implemented the National Mental Health Seclusion and Restraint Project (known as the 'Beacon project'), with the intent to minimise the use of seclusion and restraint. Through the work of the SQPSC, collection and publication of data on seclusion and restraint events is now becoming publicly available.

Additionally, since 2012, the National Mental Health Commission has been working to reduce, and where possible eliminate the use of seclusion and restraint and to make available data that monitors restrictive practices as outlined in our 2015 position paper.⁴⁰

Whilst more needs to be done, national seclusion rates have fallen over time and in 2017, restraint data was presented for the first time which showed there were 9.2 physical restraint events per 1,000 bed days and 1.7 mechanical restraint events per 1,000 bed days.

Figure 4: Rate of seclusion events per 1,000 bed days for public sector acute mental health hospital services, national total: 2011-12 to 2015-16



Source data: Restrictive Practices Table RP.2⁴¹

Human rights are a significant factor in shaping Australia's commitment to the reduction and elimination of seclusion and restraint.

Jackie Crowe, Commissioner

What we heard

We heard about commitment to changing practices, opportunities for sharing experiences and successes, closer scrutiny of the health system, and increased progress in monitoring and reporting on the use of seclusion and restraint.

At the 'Towards Elimination of Restrictive Practices' forum in May 2017, we heard from consumers, carers, clinicians and others about alternatives to restrictive practices. We welcomed their endorsement of clear principles that support best practice approaches to eliminate the use of mechanical and physical restraint.

We acknowledge the Royal Australian and New Zealand College of Psychiatrists and the Australian College of Mental Health Nurses (ACMHN) who have released position papers that convey that seclusion or restraint should only ever be used as a measure of last resort and must be used strictly in line with formal policies in a safe, dignified and respectful way.

What we did

In July 2017, we made a submission to the Human Rights Commission highlighting the need for seclusion and restraint to be considered in the process of ratifying the [Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment \(OPCAT\)](#). Sustained attention is required to reduce the use of seclusion and restraint within mental health services, including physical, mechanical and chemical restraint. Other forms of restrictive practice, such as involuntary detention, also warrant continued attention, noting that in February 2017, the Government announced its intention to ratify OPCAT by December 2017.

In 2017, we partnered with the ACMHN to better understand the decision making processes of mental health nurses around using seclusion and restraint.

This project included a literature review, a national survey and focus groups which looked at:

- perspectives, experiences and attitudes of mental health nurses towards the use of seclusion and restraint;
- barriers experienced by mental health nurses to reducing seclusion and restraint;
- training received around de-escalation techniques and approaches;
- commitment of services and service leaders to recovery-oriented practice and a trauma-informed approach;
- processes required to support attitudinal and practice change; and
- cultural aspects that impact attitudes, experience, and practice.

What we learnt

The final report from this project outlined that a number of factors influence the use of restraint:⁴² While mental health nurses were aware of the potential harm of seclusion and restraint, and agreed on its use as a last resort, they saw them as necessary methods to ensure safety, and identified the following barriers to reducing seclusion and restraint:

- insufficient resources (inadequate physical environment and equipment);
- inadequate staffing levels (high staff turnover, inadequate skill mix particularly on weekends, casualisation of nursing staff positions, and an ageing workforce);
- the changing role of the nurse, with nurses being time poor and having high workloads;
- concerns about safety and duty of care;
- inadequate skills/practice development opportunities for staff and limited to no education for families about alternatives;

- consumers being drug-affected and violent;
- inappropriate environment (including a lack of space, and high stimulation);
- conflicts between staff approaches, specific approaches for individual consumers and policies; and
- understanding and empathy with consumers, and communication difficulties.

Similarly, people with lived experience of mental illness highlighted two key areas to progress the reduction and where possible the elimination of seclusion and restraint:

1. Addressing problems with staffing, skill mix and capability as a high priority; and
2. Improving training and staff education around trauma-informed care, as well as building skillsets in de-escalation and early-intervention strategies where a person is distressed. It was acknowledged that increasing staff knowledge may assist in changing attitudes and workplace culture.

We support the ongoing work of the SQPSC to continue to develop a high standard for data collection and publication on the use of seclusion and restraint in the mental health system. The intent is to promote a national approach to monitor and report on seclusion and restraint across jurisdictions and services, and to provide transparency and accountability to the public about these practices. Monitoring and reporting on seclusion and restraint is a legal requirement for jurisdictions, however complexities exist in this space. Whilst new seclusion and restraint data was reported this year, differences in legislation and reporting requirements by states and territories means there is variation in what is reported. For example, data is not available for all states and territories for physical and mechanical restraint.

Overall, more collaboration is needed. Positive change requires leadership and shared ownership, by clinicians, people with lived experience of mental ill health, their families and carers, and advocacy groups. It also needs to extend beyond mental health services to emergency departments and other health providers, schools, the justice sector and police and ambulance services.

The Commission calls for increased efforts to protect mental health consumers and staff from the harms associated with the use of seclusion and restraint. Collectively we need to:

- support the continued implementation of a national approach to the regulation of seclusion and restraint with nationally consistent standards and guidelines;
- report and monitor restrictive practice across all jurisdictions, working towards more effective data collection and use;
- continue to involve consumers and carers in strategies to reduce seclusion and restraint;
- further educate and train clinicians to embed human rights and the principles of recovery-oriented practice and trauma-informed care along with de-escalation and debriefing strategies to reduce and where possible eliminate seclusion and restraint; and
- focus efforts on reducing rates of seclusion and restraint for more vulnerable groups, especially children and adolescents.

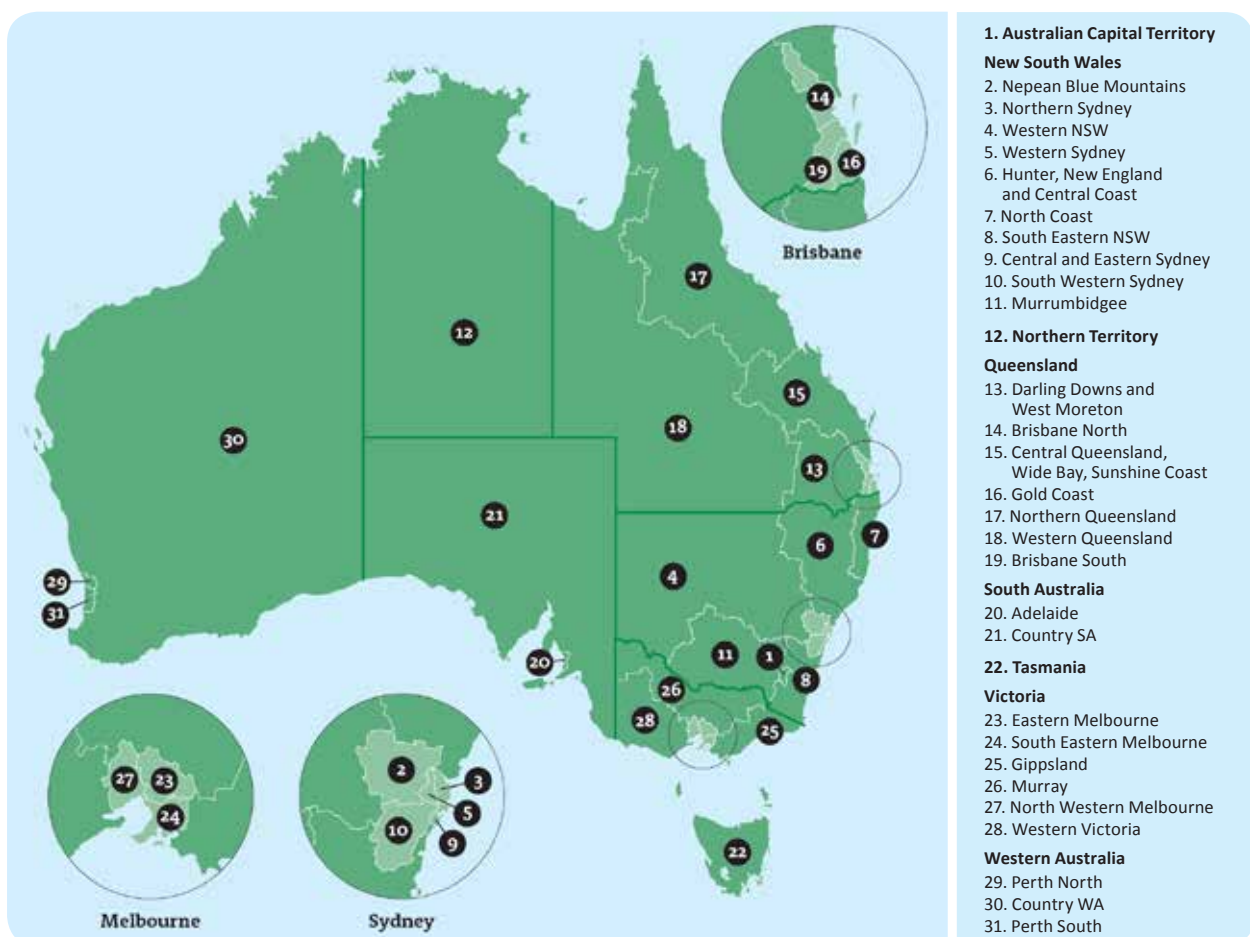
7. Supporting Primary Health Networks

PHNs are working toward embedding a regional approach to planning, commissioning and delivery of mental health and suicide prevention services with key local partners. Chapter 7 identifies key challenges for PHNs in developing a person-centred approach as they develop new ways of authentically collaborating with communities.

It is evident PHNs are at different stages of readiness in terms of their capacity and capability to take on mental health reform. On top of this, it is only one of the reform issues PHNs have to progress at the same time. The support for regional level approaches is strong and needs longer timeframes to implement and measure the impact of the changes.

Dr Peggy Brown, CEO and Commissioner

The 31 Primary Health Networks across Australia



Source: <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Locator#>

In the 2014 Review, the National Mental Health Commission proposed a more localised approach to delivering mental health services. The Government established 31 Primary Health Networks (PHNs) in July 2015 to plan and commission health programs, services and integrated care pathways in their local regions, to ensure people receive the right care in the right place at the right time.

What we heard

PHNs are working towards providing better mental health care to meet individual and population needs using a stepped-care approach. This is a new way of working together with people with lived experience of mental illness, their families and other support people, as well as front line services. Initial timeframes and requirements have meant some PHNs have needed to commission services quickly to offer continuity of care, until they can work out what is best for their communities. This has resulted in variation in the delivery of stepped-care services.⁴³ In addition, funding and accountability requirements have made it difficult for PHNs to commission services in a person-centred way that meets people's needs. For example, commissioning services for people with severe and complex needs (such as a person with mental illness, an alcohol use disorder, and diabetes) has been particularly challenging.

Another challenge raised by some PHNs is how to develop a person-centred approach, based on trust and mutual respect, with consumer and carer participation in the design of programs and services.⁴³ Whilst guidelines have been provided to PHNs by the Government, there is a need for further guidance on what is expected. Some PHNs told us they have struggled to get meaningful engagement and participation with consumers and carers even when they wanted to.

I think consumers and carers need to be involved much more. They'll see the roadblocks better, and where things need to be improved. They know where things get stuck and what needs to change. Sometimes the change needs to come the other way – bottom up rather than top down. It's not until you get to the other end to see it.

Carer, Victoria

Significant concerns about the mental health workforce capacity, capability and retention were noted, especially in relation to low intensity workers and the level of training or accreditation that is required. Suggestions have been made that digital mental health and peer workforce models can challenge traditional workforce models in a stepped-care approach.⁴³

To understand whether the reforms are having the intended effect in meeting the needs of consumers and carers, PHNs told us they need to monitor meaningful outcome measures. The minimum data set requirements for the Government do not necessarily measure the outcomes PHNs wish to know.

What we did

Throughout 2017 we met with PHNs to introduce the Commission and explore how we can help them improve the service experience and outcomes for people living with mental ill health in their regions. We discussed key challenges PHNs are facing implementing the current reforms, such as relationships with stakeholders in the region, change management, the level of red tape faced by PHNs, new ways of delivering a stepped-care approach, the need for a 'right touch' approach to accountability, contract management, timeframes, political overlays, and integration with the local hospital network.

We also worked with the Gippsland PHN to better understand how to measure outcomes of mental health care for consumers and the experiences of PHNs in implementing mental health reform.⁷ Our work explored the role of PHNs in the definition, design, measurement and reporting of mental health outcomes, and participation by consumers and carers in mental health and suicide prevention policy and practice.

In 2017, the PHN Mental Health Advisory Panel (the Panel) was established by the Minister for Health. Co-chaired by our CEO, Dr Peggy Brown and the CEO of Mental Health Australia, Frank Quinlan, the Panel will report on reform progress and make recommendations to continuously improve services and programs. The Panel's first meeting focused on the active involvement of people with lived experience, their families and other support people as being at the heart of the mental health reform agenda. It was discussed that the involvement of people with lived experience should be central to ensuring better outcomes, and should inform all policy development, implementation, and evaluation.⁴⁴

What we learnt

To implement stepped-care models, PHNs need robust data about the needs of their consumers and new planning tools like the National Mental Health Services Planning Framework.⁴⁵ Data provided through the Government's online portal for PHNs and Patterns of Use of Mental Health Services and Prescription Medications have provided a good foundation to assist this planning role.⁴⁶ However, it is important that PHNs also have access to longitudinal data to support their planning processes as trends and patterns need to be assessed over a long-term timeframe.

Our work with Gippsland PHN on mental health outcomes provided insight into how PHNs are approaching their role in promoting mental health outcomes alongside other stakeholders including people with lived experience, carers, service providers, and peak bodies.

Gippsland PHN mental health outcomes project⁷

We need an evidence-based outcomes framework with a variety of suggestions around monitoring – individual, organisation, client, provider, system, and having a set of guidelines that each PHN can draw on... the best ways to look at how to measure that and draw on research and expertise.⁷

PHN

Consultation with PHNs was supported by a review of literature and frameworks to examine outcomes measures that PHNs can routinely collect which enable performance monitoring of services.

The project confirmed there is strong stakeholder passion and interest in implementing mental health reforms.

The most important aspects of mental health outcomes for PHNs were consumers and carers, commissioning, frameworks and models, systems and data, and integration and partnership. The findings showed varied experiences by PHNs, and highlighted the value of learning from each other.

- PHNs viewed consumer and carer participation in the reform implementation as fundamental to success. Opportunities to improve engagement were identified as it was sometimes seen as inadequate or invisible.
- There was strong interest from PHNs in building expertise in outcomes based commissioning. There was a lot of variation across PHNs in their approach to stepped-care. Sharing commissioning resources and tools was identified as a way to avoid duplication and increase efficiencies.
- There were a number of existing recommended indicators, frameworks and models of care available to inform the development of mental health outcomes. Domains such as goal setting, quality of life, and functional recovery were suggestions to add value to how outcomes and experiences are measured.
- Mental health outcomes measurement, monitoring and reporting requires efficient and interconnected technology. Stakeholders recommended data access and sharing agreements at state/national levels to avoid duplicated effort by PHNs.
- PHNs are just one component supporting mental health reform. Stakeholders identified a need for greater integration and partnerships between levels of government and between public and private services.

We support further targeted research and evaluation to build on learnings from PHNs, so that improvements to the system may continue. This should include work to understand which incentives can be used to:

- shift the system's current focus from acute care towards community and primary health care;
- make better use of digital services and monitoring; and
- develop and implement step-up and step-down services.

PHNs must consider how to close the feedback loop when engaging with consumers and carers to assist in co-design, defining outcomes, or monitoring and evaluating outcomes and experiences.⁷

Gippsland PHN

8. Putting mental health on the economic agenda

Mental health and wellbeing is part of the mental wealth of Australia. Chapter 8 examines the ‘invest to save’ model of investment in prevention and early intervention in mental health, and the growing number of mental health policy issues that could benefit from the addition of an economic perspective.

Investing in mental health is not only morally and socially compelling, it is economically fundamental. Mental illness has significant personal impacts and broader implications for the Australian economy. When Australians do not get the support they need when they need it, there are substantial

financial and human costs for governments, and the community. The National Mental Health Commission recognises the need to put mental health on the economic agenda, and is pursuing evidence of cost-effective interventions to better support our case.

The estimated cost of mental illness^{9,47}



*an approximation based on current 2016-17 GDP data

Gross domestic product (GDP) is a measure of our economy – based on the total value of everything produced by all people and companies in Australia.

By investing in the mental health and broader wellbeing of the Australian people, there is an opportunity not only to reduce the costs that signify system failure but also to support the conditions that enable people to thrive and be productive, engaged and contributing members of the community. Such investment is critical to supporting the productivity, prosperity and overall mental wealth of our nation.

Professor Ian Hickie, Commissioner



Commissioner Jackie Crowe, Professor Martin Knapp, Dr Peggy Brown, Tim Marney, Professor Allan Fels, 2016.

What we heard

In seeking to put mental health on the broader economic agenda, we heard that:

- the evidence base around best value investments and interventions is still emerging but where robust evidence is available, it is not always effectively translated or applied;
- there is broad support for initiatives that will avoid longer term costs related to mental illness, but there is limited funding and few professional incentives (especially for early career researchers) to undertake work specifically in mental health, including in relation to economic research;
- a wide variety of research methods and ways of assessing evidence are used across health, mental health and other services to evaluate interventions; and
- it can be difficult to determine the effect (return) of investments, especially where benefits flow to other portfolio areas (e.g. housing and education) and other levels of governments (e.g. local and state government) over variable periods of time.

What we did

In December 2016, we hosted Professor Martin Knapp from the London School of Economics and Political Science (LSE). We led discussions with Commonwealth departments of Health, Social Services, Treasury, and Prime Minister and Cabinet, state and territory health departments and mental health commissions, consumers and carers, health researchers and economists and representatives from the private and community-managed sectors.

There are ways in which these mental health problems can be responded to or they can be prevented, and there's very strong evidence from lots of places, including from the UK, that makes a lot of economic sense.⁴⁸

Professor Martin Knapp

Participants considered the growing number of mental health policy issues that could benefit from the addition of an economic perspective. We noted that an economic lens would enrich the debate around public spending and return on investment, and better inform the evidence for policy development and implementation.

Examples of topics considered included:

- how greater social and economic participation by people with lived experience could help to improve both national productivity and wellbeing;
- NDIS personal budgets and choice and control on the demand side, and the development of provider markets on the supply side;
- consideration of choice and competition in the design, development and commissioning of public sector, private sector and not-for-profit services; and
- current considerations around health and welfare reform, using established actuarial methods to quantify and manage long-term risks through an investment approach.

In 2017, we progressed debate on why mental health must be an essential part of the national social reform and economic agenda in Australia. Professor Allan Fels, Chair of the Commission, advanced the argument for ‘good’ debt in the context of investment in mental health.⁴⁹ Professor Fels argued for the potential of mental health related costs to enhance productivity and deliver long-term economic gains, similar to investment in road, rail and telecommunications infrastructure.⁴⁹

We commenced investigation into economic ‘best buys’ for effective interventions in mental health, working with Australian academics with assistance from Professor Knapp and colleagues. This project aims to apply new and previously tested economic models to interventions that have good evidence for their success, and which are a priority for consumers and carers, researchers, and clinicians.

What we learnt

Through our work, we learned of:

- the need to link lived experience of mental illness and other practical issues with the economic and analytical frameworks used by policy makers;
- how economics can help shape our understanding of systems, policies and interventions in mental health, to help support contributing lives for all Australians;
- the limited understanding of expenditure and resources, across all portfolios and jurisdictions, that have the potential to improve mental health outcomes;
- the importance of data and research to inform policy decisions and economic analyses with plans to explore these issues in further detail; and
- improving funding allocation through better data and communication about pressures in supply, demand, and outcomes in the system.

Central to our learning has been the need to inject consumer and carer perspectives; this is especially important in areas such as housing, where long-term stability of accommodation in a safe place delivers a better chance of a meaningful job which in turn promotes social and economic participation. Mental health is an invest-to-save issue. Better allocation of resources, and meeting individual and community preferences will be the key to improving efficiency, national productivity and better mental health and wellbeing.

Under the Fifth Plan, we have been asked to undertake the development of a mental health research strategy in collaboration with key stakeholders. This work provides the opportunity to improve the breadth and depth of research into the economics of mental health, and to identify the barriers preventing its uptake into policy and practice.

9. Transitioning to the National Disability Insurance Scheme: understanding the challenges ahead

The NDIS promotes individualised care and choice for people with disability. Chapter 9 describes our work to understand and promote the challenges experienced by people with psychosocial disability during the transition to full implementation of the scheme.

Serious concern was raised in the *Engage and Participate in Mental Health* Project, not just about the current state of mental health service provision, but about a potential narrowing of service focus incumbent upon the implementation of NDIS, its perceived restrictive access criteria, and the decommissioning of existing programs which are viewed as being more inclusive.

Leanne Craze (consultant), Engage and Participate in Mental Health

The NDIS has been described as the largest social reform since the introduction of Medicare over 40 years ago. The Commission considers the NDIS as an important initiative which will promote individualised care and choice. As a market-style system, government funding will now go directly to people with disability, their families, and carers, instead of disability service providers.

The NDIS brings together two large and complex systems which have much in common. Mental health and disability involve some of the most vulnerable people in the community who continue to experience under-resourcing, stigma, discrimination, and barriers to living a contributing life. However, there are specific challenges for people with psychosocial disability which impact on the implementation of the NDIS. The sector and community are experiencing significant uncertainty and disruption as existing mental health funding is redirected to the NDIS. Other challenges include the highly variable nature and severity of mental ill health which requires flexible service provision and non-clinical supports; and the lack of reliable and consistent data about the prevalence of mental ill health and psychosocial disability or the effectiveness of the interventions provided.

What we heard

The Commission heard that for many people with severe and persistent psychosocial disability, participation in the NDIS is resulting in more effective services and supports, better tailored to the diverse and specific needs of individual consumers.

However, the Commission also heard of the following challenges which impact on people with psychosocial disability and providers of NDIS support services:

- the lack of an agreed functional assessment tool for psychosocial disability;
- the absence of a psychosocial disability reference package;
- disparities in outcomes for people with psychosocial disability compared to other types of disability;
- disparities in outcomes for people with psychosocial disability due to inconsistencies in the application of eligibility criteria and the planning process, with different outcomes for people in broadly similar circumstances; and
- undefined outcomes for psychosocial disability in the NDIS Outcomes Framework.

Access to registration with the NDIS was declined for me (twice) even though I have Bipolar (I don't meet the lifetime criteria). Therefore all my supports are through my social circle of lived experience peers and the Bipolar Support Group I attend... The depth of explanation required to a lay person on what I am experiencing is taxing and I often cannot find the words to adequately describe my symptoms/experiences.

Participant, Engage and Participate in Mental Health

What we did

In March 2017, the Commission undertook a targeted desktop review and analysis of available research to improve our understanding of the complexities associated with the transition to the NDIS, with a focus on psychosocial disability.⁵⁰

We found that:

- the accelerated implementation of the NDIS and the lack of systematic outreach by the National Disability Insurance Agency (NDIA) puts at risk the anticipated outcomes of the NDIS;
 - the lack of eligibility assessment tools and delays in developing a reference package for psychosocial disability put at risk the consistency and efficacy of the NDIS;
 - interface issues between the NDIS and the mental health system need to be addressed, through the National Disability Strategy and the Fifth Plan; and
 - there is a risk estimates or forecasts are becoming de facto 'targets' for the NDIS, undermining the fair and consistent implementation of access and eligibility processes.
- Joint Standing Committee on the NDIS – the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition;
 - Department of Social Services – NDIS Code of Conduct;
 - Productivity Commission – Review of the NDIS Costs; and
 - Senate Standing Committee on Community Affairs – NDIS Quality and Safeguards Amendment Bill 2017.

We appeared before the Senate Standing Committee on Community Affairs in September 2017 in response to our submission about the impact of the NDIS Amendment (Quality and Safeguards Commission and Other Measures) Bill 2017 on people with psychosocial disability. The NDIS Quality and Safeguards Commission will involve the creation of a provider registration system including national practice standards and a code of conduct, a complaints and incident management system, and a compliance monitoring and enforcement process. The Commission welcomed the creation of a national Senior Practitioner responsible for providing leadership in behaviour support, and in the reduction and elimination of the use of restrictive practices by NDIS providers through a range of activities. In our submission we also highlighted that the establishment of the NDIS Quality and Safeguards Commission must account for the existing challenges which impact on access to the scheme noting the current underestimation of potential NDIS consumers with psychosocial disability. The Committee tabled its final report of the inquiry in the Senate on 8 November 2017 recommending that the Bill be passed. We envisage that the proposed legislative changes will improve services for people receiving support through the NDIS.

What we learnt

In considering the currently available evidence and data, we note that:

- There are challenges in estimating the number of people with psychosocial disability (including secondary psychosocial disability) eligible for the NDIS due to the lack of a transparent, single database and different methodologies.
- The transition phase has focused largely on meeting participant intake estimates (i.e. quantity) and not enough on planning processes, supporting infrastructure, and market development (i.e. quality).
- Continuity of service and program interfaces and bilateral agreements are critical to ensuring that people with (any) disability do not 'fall between the cracks' when services are split between NDIS and non-NDIS provision.
- A specialised gateway for people with psychosocial disability, provided by experienced clinicians, would facilitate greater access especially for hard-to-reach people and groups.

The Commission is committed to monitoring the level of service provision during the transition to the full implementation of the NDIS and to seeking further information where necessary in order to do so. There are both emerging and sustained concerns regarding the interface between the NDIS and the mental health system, and the potentially negative impacts for people with mental illness and psychosocial disability as full implementation progresses.

The Commission will continue to build our relationship with the NDIA to understand current and new data collections which will enable the monitoring of support received by people with mental illness and psychosocial disability.

10. Supporting mental health reform implementation

Mental health is a national issue, but improving outcomes requires collaborative action at all levels. Monitoring and reporting will enable the Commission to demonstrate if reform is making a real difference, ensure accountability, and provide information to support change. Measurement and monitoring issues are the focus of Chapter 10 together with other Commission activity supporting reform implementation.

The National Mental Health Commission's role as a catalyst for change involves delivery of a robust monitoring and reporting framework which focuses on mental health outcomes. This year, we proactively engaged with stakeholders with renewed energy. This involved national consultations, new partnerships, participation in workshops, meetings and conferences and preparation of 18 submissions to better understand the needs of the sector and of people with lived experience of mental illness and suicidality, families, friends and support people. This activity is critical to informing our work and providing a national perspective.

This concluding chapter provides an overview of some current issues in monitoring and reporting, activities we have undertaken to support reform implementation, and identifies future directions where we believe action is needed.

Monitoring and reporting framework

This year, a core area of focus for the Commission has been to develop a long-term monitoring and reporting framework (the Framework). The Framework, guided by an Advisory Committee, will bring a national perspective to mental health and suicide prevention and consider the current reforms through the lens of consumers and carers, and their experiences. This will enable the Commission to deliver an independent, consistent and comprehensive account of reform progress.

To determine the current state of mental health monitoring and reporting, we consulted with stakeholders, completed an environmental scan, and undertook a national consultation on the components of a draft Framework.

Our Framework will be released in 2018 in time to commence reporting for the Fifth Plan and our next national report on mental health and suicide prevention.

Fifth National Mental Health and Suicide Prevention Plan

In August 2017, the Council of Australian Governments (COAG) Health Council confirmed the Commission's new responsibility to monitor and report on the implementation of the Fifth National Mental Health and Suicide Prevention Plan. To ensure strengthened accountability, the Commission will report directly to the COAG Health Council on an annual basis.

As set out in the Fifth Plan, the Commission will:

- monitor and report on the progress in implementing the Fifth Plan and on specific indicators within the Plan;
- monitor and report on implementation of the *Equally Well* National Consensus Statement across jurisdictions;
- lead the development of a National Mental Health Research Strategy in collaboration with the National Health and Medical Research Centre (NHMRC), consumers and carers, states and territories, research funding bodies and prominent researchers;
- progress the development of a consumer and carer guide that outlines how they can participate in all aspects of what is undertaken within a mental health service so that their role in ongoing safety and quality initiatives is strengthened; and
- lead the development of peer workforce development guidelines.

Exploration, collaboration and partnerships

Our exploratory work and partnerships have included:

- **Levers for change** – we identified levers to help shift the focus of mental health service provision towards prevention and early intervention initiatives and community based care.
- **Marriage equality** – we highlighted the negative mental health impacts that discrimination on the basis of gender and sexuality have on individuals, couples, and families.
- **Multicultural mental health** – we engaged with key stakeholder and leading experts in the field to discuss the alignment of multicultural mental health and suicide prevention with the Fifth Plan, and engaged people with lived experience from a culturally and linguistically diverse background in our committees and consultations.
- **Borderline personality disorder** – we worked with the Australian Borderline Personality Disorder Foundation to develop materials and facilitate professional networks to reduce stigma and increase understanding of treatment options noting its low prevalence yet high severity and impact on consumers, carers, families, support people, and service providers.
- **Peer workforce** – we partnered with the Private Mental Health Consumer and Carer Network, and the National Mental Health Consumer and Carer Forum to investigate the feasibility of establishing a national member based organisation to support peer workers, in order to promote professional connections and national networks for this emerging workforce, valuing their shared personal experiences of recovery, and need for support, supervision, and mentorship.
- **Private health insurance** – we engaged with the Australian Private Hospitals Association and Private Health Care Australia to better understand the role of health insurance in delivering mental health services noting that private health insurance should be able to provide a spectrum of interventions, particularly focusing on maintaining wellbeing or intervening early as well as inpatient care/day patient programs.
- **Intergenerational trauma** – we supported Lowitja Institute to better understand areas of focus and actions to support good mental health amongst Aboriginal and Torres Strait Islander peoples on their own terms.
- **Collaboration with mental health commissions** – we renewed our shared commitment in March 2017 to working with New Zealand to improve the mental health and wellbeing of our populations together with our partners in New South Wales, Queensland, Western Australia, Victoria and South Australia mental health/ mental health complaints commissions.
- **Submissions to various public inquiries** – we made several submissions to provide a big picture view on a range of issues that impact people with lived experience – See Appendix C.
- **Mentally Healthy Workplace Alliance** – we established the Mentally Healthy Workplace Alliance in 2012 and continue as a member, meeting with other national organisations from the business, union, community and government sectors, leading change to promote and create mentally healthy workplaces.

Future Directions

We are excited to bring you an updated approach to our reporting next year, with the expected finalisation of our monitoring and reporting framework. In our future work program we will continue to interrogate what is working and what is not so we can better understand the experiences and impact of the reform changes on people with lived experience of mental ill health, their families and support people.

We invite you to engage and participate with the Commission to help improve outcomes or identify areas of need or concern in Australia's mental health system.

People are at the centre of mental health reform in Australia: consumers, carers and service providers. Collectively we are working to ensure all Australians are afforded their human right to live and lead a contributing life. We recognise those that have gone before us in this important work, their legacy lives on as we focus on the future.

Co-Chair, Lucy Brogden

Appendices

Appendix A Abbreviations

Abbreviation	Meaning
2014 Review	<i>Contributing Lives, Thriving Communities – report of the national review of mental health programmes and service (2014)</i>
AAGSP	Australian Advisory Group on Suicide Prevention
ADF	Australian Defence Force
ADF Review	<i>Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families</i>
APONT	Australian Peak Organisations Northern Territory
EWIC	<i>Equally Well</i> Implementation Committee
Fifth Plan	Fifth National Mental Health and Suicide Prevention Plan
Government	The Australian Government
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
LHN	Local Hospital Network
NDIS	National Disability Insurance Scheme
NMHCCF	National Mental Health Consumer and Carer Forum
OPCAT	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
PHN	Primary Health Network
The Commission	National Mental Health Commission

Appendix B Glossary

Term	Meaning
Better Access Program	The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access) commenced in November 2006. Under Better Access, psychiatrists, general practitioners, psychologists (and appropriately trained social workers and occupational therapists) provide mental health services on a fee-for-service basis subsidised through Medicare. These services offer access to short term psychological therapies through private providers.
Cardiovascular disease	Cardiovascular disease refers to all diseases and conditions involving the heart and blood vessels. The main types include coronary heart disease, stroke and heart failure/cardiomyopathy.
Carer	A carer is someone who voluntarily provides ongoing care and assistance to another person who, because of mental ill health or psychosocial disability, requires support.
Co-design	An approach to design that includes all stakeholders e.g. consumers, carers, researchers, health workers, clinicians, funders, policy makers.
Consumer	A person with mental illness who has used a mental health service.
Co-operatively owned housing	Unlike social housing or privately owned low-income housing, co-operatively owned housing is owned under a single title by all members of the co-operative.
Contributing Life Framework	<p>A term first used in the Commission's 2012 <i>National Report Card on Mental Health and Suicide Prevention</i>, which means:</p> <p>A fulfilling life where people with lived experience of mental ill health can expect the same rights, opportunities and health as the wider community. It is a life enriched with close connections to family and friends, supported by good health, wellbeing and health care. It means having a safe stable and secure home and having something to do each day that provides meaning and purpose, whether this is a job, supporting others, or volunteering.</p>
Intergenerational trauma	The experience of trauma that is passed from one generation to their offspring, and to further generations in the absence of treatment.
Jurisdiction	The geographical area over which an authority extends. In the report this is used to refer to states, territories and the Commonwealth.
Lived experience	In this report, lived experience is used to refer to people who have experience of mental ill health either as a consumer or a carer/family member/support person.

Term	Meaning
Local Hospital Network (LHN)	A LHN is an organisation that provides public hospital services in accordance with the National Health Reform Agreement. A LHN can contain one or more hospitals, and is usually defined as a business group, geographical area or community. Every Australian public hospital is part of a LHN. LHNs have different names in each state and territory. ⁵¹
Mental capital/ mental wealth	Mental capital refers to the cognitive and emotional resources available to individuals. Mental wealth is the collective mental capital of individuals in a society.
Metabolic syndrome	A collection of disorders including high blood pressure, obesity, high cholesterol and insulin resistance – that together increase the risk of stroke, heart disease and type 2 diabetes.
My Health Record	<p>The My Health Record system previously known as Personally Controlled Electronic Health Record (PCEHR) was rolled out nationally in July 2012.</p> <p>Having a My Health Record means your important health information like allergies, current conditions and treatments, medicine details, pathology reports or diagnostic imaging scan reports can be digitally stored in one place. Healthcare providers like doctors, specialists and hospital staff can see these details online from anywhere at any time when they need to, such as in an accident or emergency.</p>
National Disability Insurance Scheme (NDIS)	The NDIS provides individualised support for eligible people with permanent and significant disability, their families and carers. Roll out commenced 1 July 2016 and full coverage is expected by 2020.
Peer Workforce	Peer workers, sometimes called consumer workers, carer workers or lived experience workers, deliver recovery oriented support, facilitate group work and provide advocacy.
Person-centred	Where services are designed, funded and delivered to match the needs of individuals and particular population groups, in a way that enables them to lead contributing lives. A person-centred mental health system features more clearly defined pathways between health, mental health and other supports, recognising whole-of-person needs.
Primary Health Network (PHN)	PHNs have been established by the Australian Government with the key objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time. Roll out commenced 1 July 2016.

Term	Meaning
Psychosocial disability	Describes the functional impairment created for a person living with mental ill health that is sufficiently severe and disruptive as to impede their ability to lead a contributing life, participating in the social and economic life of the community.
Recovery	The National Framework for Recovery-oriented Mental Health Services: Policy and Theory (2013) states “There is no single definition or description of recovery. Starting with the initial assumption that personal recovery is different for everyone, it is defined within this framework as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’”.
Rent to buy	A non-traditional financing arrangement where property is purchased in instalments, while the property is subject to standard leasing conditions.
Respiratory disease	Disease or conditions that affect the airways, including the lungs as well as the passages that transfer air from the mouth and nose into the lungs. Includes chronic obstructive pulmonary disease (COPD – which includes emphysema and chronic bronchitis), and asthma.
Restraint	When somebody’s movements are restricted by the use of straps or belts (physical restraint) or sedation (chemical restraint).
Seclusion	When someone is confined in a specific room from which that they cannot freely leave.
Shared equity	Shared equity schemes are designed to permit home buyers to share the capital (initial) cost of purchasing a home with an ‘equity partner’, usually a public sector or philanthropic organisation.
Social and Emotional Wellbeing (SEWB)	A broad and holistic concept that reflects the Aboriginal and Torres Strait Islander holistic understanding of life and health. It includes mental health, but also considers other factors such as cultural, spiritual and social wellbeing.
Socio-economic disadvantage	Reduced access to material and social resources, and subsequent capacity to participate in society, relative to others in the community.
Stepped-Care	A care model that sees people receive varying levels of primary care treatment and support depending on their level of need as determined by a health professional, whether that be ‘at risk’, mild, moderate or severe/complex. Stepped-care helps shape the delivery of primary mental health services towards a more modern, flexible and nimble model of care, rather than the current ‘one-size-fits-all’ approach.

Appendix C Submissions

The Commission made several submissions to provide a big picture view on the following:

Department/Agency	Submission title	Publication date
Digital Health Agency	National Strategy for Digital Health	January 2017
Cooperative Research Centres Priorities Consultation	Research collaboration	February 2017
Department of Health	Review of Australia's Health System Performance Information and Reporting Framework	February 2017
Joint Standing Committee on the National Disability Insurance Scheme (NDIS)	The provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition	February 2017
Department of Health	Regional Planning for Mental Health and Suicide Prevention – a Guide for PHNs	May 2017
Royal Commission into Institutional Responses to Child Sexual Assault	Consensus Statement by the Mental Health Commissions of Australia	June 2017
Department of Social Services	NDIS Code of Conduct	June 2017
Productivity Commission	NDIS Costs	July 2017
Productivity Commission	Draft report on Introducing Competition and Informed User Choice into Human Service: Reforms to Human Services	July 2017
Senate Standing Committee on Community Affairs	NDIS Quality and Safeguards Amendment Bill 2017	July 2017
NSW Government	Review of Seclusion and Restraint and observation of consumers with mental illness in NSW mental health facilities	July 2017
Federal Treasury	Increasing the Supply of Affordable Housing. Tax Amendments Bills 2017	September 2017
Senate inquiry	Cyberbullying Laws	October 2017

Department/Agency	Submission title	Publication date
Department of Health	Development of a Framework for Secondary Use of My Health Record System Data	November 2017
National Health and Medical Research Council	NHMRC Peer Review Consultation Paper	December 2017
Department Industry, Innovation and Science	National digital economy strategy – public consultation	December 2017
National Health and Medical Research Council	NHMRC Draft Road Map 3: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health through Research	December 2017
Australian Prudential Regulation Authority	Response to Submissions: Review of the role of the Appointed Actuary and actuarial advice within insurers	December 2017

Appendix D Accessible graph data

Figure 1: Proportion of people who had ever experienced homelessness, age and mental health status, 2014

Age groups (years)	Has a mental health condition	Does not have a mental health condition
15–24	19.86%	9.36%
25–34	33.55%	13.41%
35–44	32.40%	12.85%
45–54	30.62%	12.99%
55–64	20.07%	10.68%
65–74	14.68%	7.14%
75+	7.27%	3.49%

Figure 2: Suicide rates per 100,000, 2007 to 2016

Year	Males	Females	Persons
2007	16.5	5	10.6
2008	17.4	4.7	10.9
2009	16.5	5	10.7
2010	17.5	5	11.2
2011	16.2	5.1	10.5
2012	17	5.6	11.2
2013	16.8	5.6	11.1
2014	18.6	5.9	12.1
2015	19.3	6.1	12.6
2016	17.8	5.8	11.7

Figure 3: ADF Population Statistics

- There is an estimated population of more than 700,000 current and former ADF members and an even higher number of their family members.
- Between 5,000 and 6,000 service personnel leave the ADF each year.
- The suicide rate of men no longer serving in the ADF was 14% higher than the suicide rate of men in the general population.
- Men who had left the ADF after less than one year of service were also at higher risk; 2.4 times more likely to die by suicide, compared with 10 years or more.
- Men who did not hold a commissioned officer rank at discharge were 2.8 times more likely to die by suicide when compared to commissioned officers.
- Men who were discharged involuntarily from the ADF were 2.4 times more likely to die by suicide than those who discharged voluntarily.
- One in five transitioned personnel seek assistance through DVA supports.

Figure 4: Rate of seclusion events per 1,000 bed days for public sector acute mental health hospital services, national total: 2011-12 to 2015-16

Year	Rate (per 1,000 bed days)
2011-12	10.6
2012-13	9.8
2013-14	8.2
2014-15	7.9
2015-16	8.1

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