Monitoring mental health and suicide prevention reform

National Report 2019

Australian Government
National Mental Health Commission

About this Report

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Message from Lucy Brogden

Chair of the NMHC Advisory Board

The National Mental Health Commission (NMHC) Advisory Board is proud to continue contributing to the important work of the NMHC. During the year we welcomed Ms Niharika Hiremath, Dr Elizabeth-Ann Schroeder and Mr Alan Woodward as Commissioners.

The Advisory Board farewelled Professor Wendy Cross, whose appointment as Commissioner ended in July. With over 35 years of experience as a mental health nurse, and in academia, Professor Cross brought extensive expertise and a unique perspective in her role as Commissioner. Professor Cross' passion was evident through her hard work in the role and the NMHC is grateful for her service and contribution.

In November 2018, the Advisory Board also farewelled Professor Harvey Whiteford, who was appointed as an Associate Commissioner to the Productivity Commission inquiry into the social and economic benefits of improving mental health. Harvey has a wealth of experience in the mental health field and will be a tremendous asset to the Productivity Commission inquiry.

The Advisory Board were pleased to welcome Ms Christine Morgan as the new CEO of the NMHC. Having worked as CEO of the Butterfly Foundation – Australia's leading foundation for eating disorders – Christine brings a wealth of expertise and leadership experience to the NMHC. We are pleased to work with Christine as part of a strong team supporting the significant reforms being undertaken to improve mental health and suicide prevention in Australia.

A number of significant inquiries are being held this year, including the Royal Commission into Victoria's Mental Health System, and the Productivity Commission's inquiry into the social and economic benefits of improving mental health. In addition, inquiries in the aged care and disability sectors are being undertaken – all of which are intended to examine the performance and effectiveness of the broader healthcare systems in Australia.

These inquiries have the potential to transform the way we approach mental health and suicide prevention in Australia. Indeed, the NMHC supports their work as part of our agenda to raise awareness, prioritise mental health, and reduce stigma and discrimination. In particular, the Productivity Commission's focus on factors such as housing, education, employment and social justice in the development and treatment of mental illness is an approach welcomed by the NMHC.

This year, we celebrated the graduation of the first two cohorts of the NMHC's Australian Mental Health Leaders Fellowship – a professional development program for emerging leaders in mental health. The first program of its kind in Australia, the fellowship incorporates a mix of experiential learning, reflective practice and group activities, with the aim of progressing the next generation of mental health sector leadership. The NMHC is proud to contribute to the development of emerging and future agents of change in Australia's mental health sector. We were particularly pleased to honour our former Commissioner, the late Jackie Crowe, awarding a prize in her name.

We are encouraged by the increasing profile and priority of suicide prevention. The Australian Government announced our newly appointed CEO, Christine Morgan, as the National Suicide Prevention Adviser to the Prime Minister. This direct reporting line is critical for ensuring that suicide prevention is embedded as a priority across government.

In addition, the Australian Government's investment into the mentally healthy workplace initiative, as announced in the 2019 Budget, will allow the NMHC to work with the Mentally Healthy Workplace Alliance to create a nationally consistent framework to support employers create mentally healthy workplaces.

The NMHC welcomes the Australian Government's *Long Term National Health Plan* which prioritises mental health and suicide prevention. This includes investing in better understanding and innovation through national surveys and research, as well as Australia's first mental health and wellbeing strategy for children.

The commitment shown by governments through inquiries and additional investments into mental health and suicide prevention speaks to the importance of addressing these issues in Australia. Thank you to the Minister for Health the Honourable Greg Hunt MP, the Australian Government, state and territory governments, state mental health commissions and the consumers and carers and other stakeholders who inform all we do. Together we will continue to advocate for, and prioritise, the ongoing reform of our mental health system.

Lucy Brogden, AM
Chair of the NMHC Advisory Board

Message from Christine Morgan

CEO of the NMHC

I am honoured to have been appointed as CEO of the National Mental Health Commission (NMHC). Since joining the NMHC in March 2019, I have travelled the country meeting with representatives across the full breadth of the mental health sector. I have been humbled listening to the experiences of consumers and carers, and by the significant challenges faced by service providers in mental health. However, I feel confident that reforms such as the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), activities in suicide prevention, and the National Disability Insurance Scheme will lead to significant improvements in the mental health system in Australia. Although system reform takes time, I look forward to working with the Commissioners and the NMHC team as we strive towards ensuring that mental health and wellbeing is a primary focus of all governments, allowing all Australians to lead contributing lives.

I would like to thank Maureen Lewis for her hard work as Interim CEO from July 2018 to March 2019. Under Maureen's leadership, the NMHC delivered the first report on the implementation progress of the Fifth Plan, the National Report 2018, and the very successful leadership program – the first mental health-specific development program of its kind. These significant achievements have set the tone for the future of the NMHC.

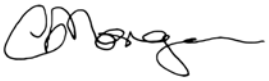
To support mental health system reform now and into the future, we need research and innovation. Research is critical in providing the evidence base to support future reforms and to help us understand the progress of existing reforms.

This year, the NMHC released the results of economic modelling that further contributes to the evidence base for investment in prevention and early intervention. This work is key to demonstrating the economic gains that can be achieved from investment upstream, and the importance of maintaining such investment as part of Australia's mental health and wellbeing agenda.

Central to reforms such as the Fifth Plan are the experiences of mental health consumers and carers. Earlier this year, the NMHC undertook a consumer and carer survey to understand how implementation of the Fifth Plan is affecting their experiences of care. Results from the survey were published in the *Fifth National Mental Health and Suicide Prevention Plan 2019: The consumer and carer perspective*, the first report of its kind. The report confirms that lack of availability and accessibility of services, and stigma and discrimination are still significant issues for consumers and carers. The NMHC is grateful to all who shared their stories and participated in the survey. These are a critical contribution to the NMHC's work towards sustainable reform of the mental health system.

There has been significant investment by the Australian Government in mental health this year, including funding for a national workplace initiative through the Mentally Healthy Workplace Alliance and the development of a national suicide information system led by the Australian Institute of Health and Welfare. The NMHC welcomes the investment in mental health and wellbeing in our workplaces, and in suicide prevention, and is proud to work with its partners in the Mentally Healthy Workplace Alliance and with the Australian Institute of Health and Welfare on these important initiatives.

Reform is the outcome of the collective efforts from many. I thank all who have contributed this year and will continue to contribute in the future – our dedicated Commissioners, the whole team at the NMHC and all our colleagues across the mental health and suicide prevention sector.



Christine Morgan
CEO

About us

The National Mental Health Commission (NMHC) was established in 2012 and provides insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention system and acts as a catalyst for change to achieve these improvements. This includes increasing accountability and transparency in mental health by providing independent reports and advice to the Australian Government and the community.

An Advisory Board of Commissioners helps set the NMHC's strategic directions and priorities. The NMHC's current Commissioners are Mrs Lucinda Brogden AM, Professor Ngiare Brown, Professor Helen Milroy, Ms Kerry Hawkins, Rabbi Mendel Kastel OAM, Ms Christina McGuffie, Professor Maree Teesson AC, Dr Elizabeth-Ann Schroeder, Ms Niharika Hiremath, Mr Alan Woodward, and Ms Christine Morgan. Ms Christine Morgan is also the CEO of the NMHC.

Our vision

Our vision is that all people in Australia are enabled to lead contributing lives in socially and economically thriving communities. We strive to achieve our vision by:

- ensuring mental health and wellbeing is a national priority
- increasing accountability and transparency through credible and useful public reporting and advice informed by collaboration
- providing leadership and information that helps to empower mental health consumers and carers
- working with others to influence decision-making, set goals and transform systems and supports to improve people's lives.

Executive summary

The mental health system in Australia is undergoing significant change. Reforms such as the National Disability Insurance Scheme (NDIS), the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), Primary Health Networks (PHNs) and activities in suicide prevention are all occurring simultaneously. These reforms are ambitious in their scope. They are also interrelated which adds to the complexity of their implementation, and it will take time before their implementation leads to sustained change for consumers and carers.

The combined efforts of all governments and the commitment to deliver these reforms have been critical to their progress. Although there is still a way to go, the changes being continually made under these reforms have started to lead to improvements in the way mental health services are planned and delivered.

The National Mental Health Commission (NMHC) commenced its Connections tour in July 2019 to consult and engage with communities across Australia on the *2030 Vision for Mental Health and Suicide Prevention.* The Connections tour provided an opportunity to hear directly from consumers, carers, families, and organisations that provide support and care, about their experience of the current mental health system.

The performance of the mental health system is also being closely examined through numerous inquiries. These include the Royal Commission into Victoria's Mental Health System and the Productivity Commission's inquiry into the social and economic benefits of improving mental health. The NMHC particularly welcomes the broad scope of the Productivity Commission inquiry and its inclusion of the social determinants of mental health.

These inquiries are valuable for identifying and understanding deficiencies in the mental health system. They also provide a unique opportunity for action, and it is critical that governments use the recommendations of these inquiries as the basis for system improvements.

The current focus on mental health and suicide prevention in Australia marks a significant turning point in our history. There is an increased awareness of the impacts of mental health and suicide – not only from a health and wellbeing perspective, but also from a social and economic one. There is also a sense of urgency to improve mental health and reduce suicide.

However, solutions that improve mental health and prevent suicide are never simple. Implementing reforms requires significant investment of time and money. To achieve real change we need real commitment to integrate services and increase accessibility, make more data available for effective service planning and measuring improved outcomes for consumers and carers, reduced stigma and discrimination, and improved mental health outcomes for Aboriginal and Torres Strait Islander people.

Part of the NMHC's remit is to monitor and report on Australia's mental health system.

This report is the result of this monitoring over the past 12 months. It presents a snapshot of some of the issues faced by the mental health system as a whole, as well as the current progress of reforms in mental health and suicide prevention.

The report also identifies the need for improvements in specific areas and makes recommendations on how governments can begin to address these issues. These recommendations attempt to address systemic issues in mental health and suicide prevention – they do not focus on gaps between, or within, mental health and suicide prevention services.

The mental health system

Prevalence and burden of poor mental health, mental illness and suicide in Australia

Almost half of Australians aged between 16 and 85 years will experience a common mental illness, such as an anxiety, affective or substance use disorder in their lifetime. One in five Australians experience a common mental illness each year.

The available data suggest that Aboriginal and Torres Strait Islander people are at increased risk of poor mental health and mental illness. However, high quality data on the prevalence of mental illness in Aboriginal and Torres Strait Islander people is not available.

In 2017, 3,128 people died by suicide in Australia. This was an increase of 9% from the previous year. Suicide was the leading cause of death of children aged 5 to 17 years, with 98 deaths occurring in this age group in 2017. The suicide rate of the Aboriginal and Torres Strait Islander community is over twice that of non-Indigenous Australians. In July 2019, the Australian Bureau of Statistics published a once-off pilot study on the psychosocial risk factors associated with suicide deaths in 2017 that, if integrated into the routinely published deaths data collection, would provide valuable guidance for ongoing suicide prevention planning and funding.

Available data shows that Australians continue to have an ongoing need for mental health and suicide prevention supports and services, and different groups and communities require tailored responses. However, current prevalence data is more than 10 years old and there are key gaps in Australia's population data, including data for some disorder types and high risk community groups.

The NMHC welcomes the Australian Government's commitment to fund an updated National Survey of Mental Health and Wellbeing adult survey. However, an ongoing program of prevalence data collection, including for Aboriginal and Torres Strait Islander people should be conducted at regular intervals. To provide a more comprehensive picture of mental illness prevalence in Australia, the feasibility of expanding the National Survey of Mental Health and Wellbeing to include a broader set of disorder types and high risk community groups, should be investigated. This will ensure that contemporary prevalence data remains available to assist with service planning and funding decisions, and better outcomes can be achieved for consumers and carers.

The NMHC recommends that the Australian Government supports an ongoing program of prevalence data collection, conducted at regular intervals, and commits to a feasibility study to investigate options for expanding the scope of disorders and high risk community groups included in the prevalence data collection program.

The NMHC also recommends that the Australian Government supports the development of a culturally appropriate version of the National Survey of Mental Health and Wellbeing, to collect high quality data on the prevalence of mental illness in Aboriginal and Torres Strait Islander communities, and supports the ongoing inclusion and further development of psychosocial risk factor analysis in the routinely published deaths data collection.

Australia's mental health system

The mental health system in Australia is complex and fragmented, with roles and responsibilities spread across governments, as well as the non-government and private sectors.

Available data show that the number of people accessing clinical mental health services is increasing. The data does not quantify people who are turned away from services or the length of time that people are waiting to access services. However, the continued increase in the use of emergency departments to manage acute episodes of mental illness suggests that not all people with a mental illness are getting the care they need in the community.

Planning tools are available to help mental health service providers, governments and PHNs plan the provision of appropriate services for their local community. However, there are gaps in the available national mental health services data collections. These gaps limit the ability of governments and mental health service providers to compare the existing level and mix of mental health services with the optimal level recommended by planning tools. The NMHC recommends that, subject to the findings of the Productivity Commission inquiry into mental health, governments support a national mental health service gaps analysis.

For the mental health system to be responsive to changing needs and deliver quality services for consumers, the mental health workforce must grow and develop. The need to address workforce issues is not new. The issues impacting the mental health workforce have consistently been identified over a long period of time.

These issues include an ageing workforce, staff turnover, the challenges of working in rural and remote locations, the need for training and education to deal with a changing mental health system, and challenges affecting peer workers.

Workforce planning strategies and frameworks have been developed (or are in development) by the Australian Government, states, territories and professional peak bodies to try to address these issues.

At the national level, the Australian Government has committed to the development of a National Mental Health Workforce Strategy. The National Mental Health Workforce Strategy should build on the strategies and frameworks in place or in development and be developed in consultation with all stakeholders responsible for the mental health workforce. The NMHC recommends that the Australian Government produces a clear implementation plan to accompany the development and release of the National Mental Health Workforce Strategy.

Meeting the needs of consumers and carers

A mental health system that meets the needs of consumers and carers is accessible, acknowledges consumers' dignity, provides care that is both coordinated and relevant to the person's needs, and achieves the desired outcome for consumers.

Monitoring how well consumer and carer needs are being met by the mental health system is a key outcome measure. Much of the available data is from consumer and carer surveys that are collected at the time of service provision. The data that is available indicates that mental health services are not always meeting the needs and expectations of consumers. However, this data is not comprehensive and additional data is required to better understand the experience and outcomes of service use.

The Your Experience of Service (YES) survey aims to help mental health services and consumers work together to build better services, by identifying areas where consumers believe improvements can be made. Currently three states – New South Wales, Victoria and Queensland – publicly report data from the YES survey. The available data from the YES survey suggest that the majority of mental health care provided meets the needs of consumers, but a significant proportion (up to 49%) of consumers do not have a positive experience of care.

To create a nationally consistent picture of how mental health services are meeting the needs of consumers, the NMHC suggests that all state and territory governments offer the YES survey to consumers during every hospital stay or community health centre visit, and contribute to the national data collection on consumer perspectives of mental health care.

A measure of carer experience, the Mental Health Carer Experience Survey, has also been developed but has not yet been implemented by any state or territory. Currently, carers lack a way to easily and routinely contribute to the ongoing improvement of mental health services. The NMHC suggests that state and territory governments investigate the feasibility of implementing the Mental Health Carer Experience Survey.

The National Outcomes and Casemix Collection shows that there are positive clinical outcomes for the majority of consumers who attend state and territory specialised mental health services. However, there are still areas for improvement, as a consistent proportion of consumers display no significant improvement or significant deterioration in their clinical outcomes.

Improving social inclusion and meaning in life for consumers is a key priority of all governments. Currently there is no data available to report on progress towards achieving outcomes in these areas. The Australian Mental Health Outcomes and Classification Network, in collaboration with the Mental Health Information Strategy Standing Committee, is currently working to develop a measure, the Living in the Community Questionnaire Summary Form that aims to fill this data gap.

The NMHC recommends that the Australian Government supports the implementation of the Living in the Community Questionnaire Summary Form in the mental health services they fund. The NMHC suggests that state and territory governments implement the Living in the Community Questionnaire Summary Form in mental health services they fund. All resulting data should be publicly reported.

Everyone accessing the mental health system deserves to receive safe care and has the right to be treated with dignity and respect. The use of restrictive practices such as seclusion and restraint affects consumers' right to dignity, therefore monitoring the frequency of restrictive practices over time can provide an indication of the performance of mental health services. The continual reduction in restrictive practices is encouraging. The NMHC encourages governments to continue their efforts towards eliminating the use of seclusion and restraint.

Social determinants of mental health and suicide

The relationship between social determinants and mental health is dynamic and complex. As a result, the effects of social determinants on mental health and wellbeing should not, and cannot, be addressed by mental health interventions alone.

Although mental health interventions are critical, they are not sufficient to counter the significant influence of social determinants of mental health and suicide.

Mental health policy and program development in Australia needs to move to a coordinated approach that addresses whole-of-life needs. Part of this approach is to invest in early intervention and prevention policies, which are key to preventing mental illness later in life. Currently, responsibility for mental health-related policies and programs is dispersed across different government departments.

Addressing social determinants through a whole-of-government approach to mental health

The NMHC welcomes the Productivity Commission inquiry into the social and economic benefits of improving mental health, which looks beyond the health system and at the social determinants of mental health. The inquiry presents a significant opportunity to comprehensively review expenditure on mental health and suicide prevention in Australia.

The NMHC considers that a more coordinated approach is needed across government in relation to policy and investment in mental health.

The NMHC recommends that subject to the findings of the Productivity Commission inquiry into mental health, the Australian Government considers the role of a central government agency to coordinate a whole-of-government approach to mental health policy.

In addition, the NMHC recommends that subject to the findings of the Productivity Commission inquiry into mental health, governments consider the role of an independent statutory body to monitor and evaluate mental health policy outcomes. This includes the current levels of expenditure on mental health, and whether investment in mental health is effective, efficient and informed by evidence-based policy.

Monitoring and reporting on mental health expenditure

Current reporting of mental health expenditure is limited due to data gaps and different methods for calculating expenditure. In 2016–17, $9.1 billion was spent on mental health-related services in Australia. This figure does not include all spending in Australia on mental health, due to gaps in data. This figure does not include mental health expenditure which occurs outside the health system.

To ensure that mental health investment is effective and appropriately targeted, governments need to better understand current levels of expenditure including how much is spent, what it is spent on, and how well it is working.

Monitoring and reporting are essential to evaluate the outcomes of mental health expenditure, and to ensure that future investments are evidence based. The NMHC supports a broad approach to estimating mental health expenditure that goes beyond the health system and includes mental health-related expenditure in other systems (for example, disability, education, justice, child protection, and employment).

Investing in childhood and early intervention and prevention

Early intervention is key to preventing mental illness later in life. Investing in early intervention and prevention strategies will reduce the likelihood of consumers needing costly supports, services and systems, including the child protection and justice systems, acute hospital care, and social support payments.

To assist in building the evidence base for the economic value of investing in early intervention and prevention, the NMHC has completed work modelling the return on investment from 10 interventions. Overall, the results showed that there is good evidence for investing in a range of preventative interventions, both on the grounds of cost-effectiveness and cost savings.

Despite the growing evidence of the benefit and economic value of early intervention initiatives, Australia lacks a coordinated approach to their implementation. A coordinated approach to early intervention and prevention for mental health is needed to ensure that investments in intervention and prevention strategies are sustainable and effective. The NMHC welcomes the recent announcement by the Australian Government for a National Children's Mental Health and Wellbeing Strategy, to be delivered by the NMHC and led by child mental health experts, Professor Frank Oberklaid and Professor Christel Middeldorp.

Key mental health and suicide prevention reforms

Primary Health Networks

PHNs are funded by the Australian Government to plan and commission medical and health services based on the local needs of their regions. They are required to undertake targeted work in several priority areas, including mental health. Their program objectives of improving the efficiency and effectiveness of services, and improving the coordination of care, mean that they are well positioned to support regionally driven approaches to mental health and suicide prevention.

The significant public funding provided to PHNs to contribute to key mental health and suicide prevention reforms highlights their important role in improving the mental health of Australians. However, PHNs are faced with tight timeframes, high expectations and a rapidly expanding scope of work.

Two separate evaluations of PHNs have been undertaken in the past 12 months to determine their effectiveness. This included the Evaluation of the PHN Program, commissioned by the Australian Government, and a report prepared by the PHN Advisory Panel on Mental Health (PHN Advisory Panel Report). In addition, the PHN Advisory Panel released a strategic document, the *Reform and System Transformation: A Five Year Horizon for PHNs* (Five Year Horizon), which outlines enablers for the progress of the PHN Program. The NMHC recommends that the Australian Government responds fully to the 17 recommendations in the PHN Advisory Panel Report, endorses the implementation of the Five Year Horizon and details how it will publicly report on its implementation.

To address the increasing expectations placed on PHNs as the PHN Program expands, there is an ongoing need for appropriate PHN supports and guidance. The role of the Australian Government is to provide funding and contract oversight, and to act as a capacity builder for the PHNs. Multiple reports, however, have found that guidance and support for PHNs lag behind announced changes to PHN areas of responsibility. This has affected the ability of PHNs to progress work in these areas. Stakeholders have also suggested that the Australian Government's role as funder is not compatible with its role as a capacity builder for PHNs. The NMHC recommends that, in consultation with PHNs, the Australian Government establishes an overarching entity to govern, support and build PHN capacity on a national scale.

The NMHC is encouraged by the release of a new PHN Performance and Quality Framework, which provides a mechanism to measure the performance of PHNs under all funding schedules of the program. The NMHC is aware that the Australian Government will release a report on the performance of the PHN Program in late 2019 under the new PHN Performance and Quality Framework. To measure performance of the PHN Program over time, the NMHC recommends that this report includes baseline data about how the PHN Program is meeting outcomes under the PHN Performance and Quality Framework.

The NMHC welcomes the introduction of a longer-term funding model for PHNs in response to the challenges created by short-term funding cycles. The increased length of the funding model will allow PHNs to undertake longer-term local planning and enter into longer contracts with service providers. Provided PHNs enter into contracts with service providers that are more than 12 months in length, this will increase the capacity of PHNs to develop the stakeholder relationships necessary for regional planning and commissioning, as well as allowing service providers to effectively meet the needs of the local community and demonstrate outcomes. The NMHC recommends that the Australian Government encourages PHNs to extend contracts with existing service providers who can demonstrate efficacy and suitability in providing services in their region; and, where feasible, enter into longer-term contracts when commissioning services with new providers.

Working to improve the health of Aboriginal and Torres Strait Islander people is a priority area for PHNs. The PHN Advisory Panel Report recommended that PHN funds for mental health and suicide prevention for Aboriginal and Torres Strait Islander people should be provided directly to Aboriginal Community Controlled Health Services (ACCHS) as a priority, unless a better arrangement can be demonstrated. The Senate Inquiry into the accessibility and quality of mental health services in rural and remote Australia also made a similar recommendation. PHNs should continue to work on formalising partnerships with ACCHS. The NMHC supports the recommendations made by both these reports and recommends that the Australian Government encourages PHNs to position ACCHS as preferred providers for mental health and suicide prevention services for Aboriginal and Torres Strait Islander people.

National Disability Insurance Scheme

As at 30 June 2019, 25,192 people with psychosocial disability (9% of all NDIS participants) were accessing and receiving support through the NDIS. It was expected that by full scheme, 64,000 participants (or 14% of all NDIS participants) would be people with a psychosocial disability as their primary disability.

People with a psychosocial disability need to be able to access the support they need to live a contributing life, regardless of whether or not they are participating in the NDIS.

The NMHC welcomes the effort made by the National Disability Insurance Agency (NDIA), governments and stakeholders to improve the experiences of NDIS participants and ensure continued support for those not accessing the scheme. The NDIS is working for many, especially those participants who are experiencing support for the first time. There is still work that needs to be done to improve participants' experiences, and to ensure that the NDIS and mental health systems are equipped to assess and address the needs of people with a psychosocial disability.

The NDIA is implementing several initiatives to improve the experience of people with a psychosocial disability accessing the scheme. These initiatives include implementing psychosocial disability training for NDIA staff, training for health professionals including general practitioners and psychiatrists, streamlined access process for clients in existing programs transitioning to the NDIS, rolling out the complex support needs pathway and implementing service improvements to the psychosocial disability service stream. However, concerns remain for people with a psychosocial disability around consistencies in eligibility and planning outcomes, lack of understanding of psychosocial disability and how the episodic nature of mental illness and the recovery approach aligns with the NDIS assessment process.

In order to understand how key learnings from current initiatives will be used to improve participant experiences, the NMHC recommends that the NDIA publishes information about the outcomes of the complex support needs pathway and the psychosocial disability service stream, and the evaluation outcomes of streamlined access for people with psychosocial disability.

The NDIA is currently considering a number of improvements to the psychosocial disability pathway including the inclusion of recovery-orientated practice into the scheme, a stronger focus on an episodic approach to psychosocial disability, working with states and territories on an outreach and more connected-up approach, and linking people who are unsuccessful in their access requests on grounds of primary psychosocial disability to other sources of psychosocial and clinical support. The NMHC welcomes this work and looks forward to seeing the details on how support and guidance will be provided to people with a psychosocial disability.

There is growing concern about the transition rates of Commonwealth community mental health program clients into the NDIS, as they are lower than expected. The NMHC welcomes the additional funding under the National Psychosocial Support Measure to support the transition of existing clients of Commonwealth community mental health programs. Based on existing knowledge of the transition process, it is likely that current clients will need more than an additional 12 months to transition into the NDIS. The NMHC recommends that the Australian Government: extends support for Commonwealth community mental health program clients to at least June 2021; considers whether the funding available under the National Psychosocial Support and Continuity of Support measures matches the needs of people who are ineligible for the NDIS; and considers how funding and access to services for people ineligible for the NDIS can be simplified.

People with psychosocial disability who are ineligible for the NDIS will also be able to access support through state or territory funded programs. Future decisions about the funding and services provided under state and territory programs depend on how many people transition from these programs into the NDIS.

All governments have a role in ensuring that people who are ineligible for the NDIS have access to appropriate psychosocial supports.

The NMHC recommends that the Australian Government, with state and territory governments, ensure that people who are ineligible for the NDIS have access to adequate psychosocial support services.

The support required for people with psychosocial disability requires a stable and accessible market. The NDIA and the Australian Government have been working to address key market issues, but further work is required to ensure continued support for participants with a psychosocial disability who cannot access services as a result of insufficient market supply or because providers have failed to provide care. The NDIA has been working with states and territories to develop a provider of last resort policy, now known as the Maintain Critical Supports policy. The NMHC is concerned by the continued lack of clarity and progress on this policy and recommends that the NDIA work with state and territory governments to progress the Maintain Critical Supports policy and release detail on what is happening with the policy.

Consumers must be able to make informed choices to participate in the NDIS. Participants with psychosocial disability need help to navigate the NDIS, engage providers and navigate other systems.

Participants need a single point of contact when something goes wrong – which includes when a provider decides to no longer provide them with a service.

Support coordination for NDIS participants with psychosocial disability has the potential to drive improvements in case management and coordination for this cohort. However, the current inclusion of support coordination in NDIA plans is low for people with psychosocial disability.

The NMHC recommends that the NDIA includes support coordination as a standard item in all plans for people with a psychosocial disability.

The NDIS is having an impact on the mental health system. The NMHC has heard that participants are not always getting the support they need, and this is leading to a deterioration of individuals' mental health and a greater reliance on clinical mental health services, including increased presentations at emergency departments. The NMHC has also heard that delays in participants getting their plan or having a plan review completed are resulting in delayed discharges from hospitals.

Addressing system impacts of the NDIS begins with understanding how people with psychosocial disability engage with the scheme. Data is an important part of building this knowledge and will enable jurisdictions to monitor participant outcomes and experiences and address system issues to ensure adequate support for people with psychosocial disability. The NMHC recommends the NDIA routinely publish data about participants with psychosocial disability including information about application, access and planning outcomes by population groups, eligible/ineligible status, plan utilisation, the extent of support coordination in plans, and current rates of access and expenditure on supports in plans.

Suicide prevention

Suicide has a significant impact on families, communities and society. This has prompted multiple governments to commit themselves to specific reduction targets and others to working towards a target of zero suicides.

Unfortunately, there is a long way to go to reach this goal. Australia's suicide rate has increased during the past 10 years. In 2017, 3,128 people died by suicide in Australia, this was an increase of 9% from the previous year.

The NMHC is encouraged by the current developments in Australia's suicide prevention sector, including the move towards coordinated prevention initiatives, committing to the regular production of detailed data on suicide attempts and deaths, and trialling alternatives to emergency departments for people in suicidal crisis. However, governments must work together to strengthen Australia's suicide prevention infrastructure in a number of areas.

Under the Fifth Plan health ministers committed to developing a National Suicide Prevention Implementation Strategy that embodies a systems approach to suicide prevention. The draft strategy requires all health ministers to attempt to collaborate with non-health portfolios, but focuses on the actions of the health system. To facilitate cross-portfolio and cross-government collaboration and acknowledgement of their shared responsibility in preventing suicide, the NMHC recommends that any future national suicide prevention strategies be co-designed and co-governed by all relevant portfolios under the Australian Government, including health, education, justice, social services and employment.

Aboriginal and Torres Strait Islander people die by suicide at a rate twice that of non-Indigenous people. To reduce this disparity, an appropriately resourced, comprehensive, whole-of-government Aboriginal and Torres Strait Islander suicide prevention plan is required. The NMHC recommends that the Australian Government work with the state and territory governments to commit to a national Aboriginal and Torres Strait Islander suicide prevention plan, that is led by the knowledge and expertise of Indigenous people.

Each year, more than a quarter of a million Australians present to emergency departments seeking help for acute mental and behavioural conditions, including people who are experiencing a suicidal crisis. Yet the evidence suggests that emergency departments are not adequately resourced or positioned to be a timely and accessible entry point to the mental health system.

In response, in addition to the activities of the local area suicide prevention trial sites, governments have implemented strategies aimed at improving the management of mental health and suicidal crisis within emergency departments. However, published evaluations of these initiatives do not analyse the impact of the initiatives on outcomes for consumers.

Attempts to improve emergency department care are welcome, but will be limited in their impact if they are not systematically evaluated for their effect on consumer care and outcomes.

To ensure that future government funding can be invested in initiatives that produce meaningful outcomes for the community, the NMHC recommends that the Australian Government work with state and territory governments to ensure that all evaluations of initiatives to improve emergency department care extend beyond measures of process and impact on hospital staff, to include impact on meaningful outcomes for consumers and carers as a primary outcome measure.

The NMHC has heard that there is significant variation in the quality of care received by consumers when they present to health or mental health services in suicidal crisis. To establish a national regulatory framework that ensures a consistent minimum standard of care is achieved across all public and private hospitals, and community services provided by Local Health Networks, the NMHC recommends that the Australian Government work with the Safety and Quality Partnership Standing Committee to ensure that the mental health supplement to the National Safety and Quality Health Service Standards (NSQHS Standards) includes detailed requirements and guidance on the care required by people at risk of suicide.

Other suicide prevention service types and settings, including educational programs and other non-clinical supports, do not have existing mandatory regulatory processes through which to implement consistent care standards. The NMHC recommends that the Australian Government work with the Mental Health Principal Committee, to oversee the development of suicide prevention service best practice guidelines that cover the full range of suicide prevention activities, from primary prevention to postvention, in all settings. These guidelines should consider and complement existing NSQHS Standards and the mental health supplement to the NSQHS Standards.

Significant improvements have been made in the collection and reporting of Australia's suicide rates, including the recent commitment for more timely and detailed information about suicide attempts and deaths. However, data on suicide prevention expenditure, workforce and program and service activity are not currently systematically collected and publicly reported at the national or state and territory levels. This reduces transparency, which negatively impacts on attempts to monitor the systemic effectiveness of suicide prevention strategies, plans, policies and services in Australia.

The NMHC recommends that the Australian Government work with the state and territory governments on the development of routinely collected data on suicide prevention expenditure, workforce and program and service activity. This would allow more detailed monitoring of what is working well and what needs to be improved in the sector, and may ultimately lead to better care for those at risk of suicide and a reduction in the suicide rate.

Evidence of the effectiveness of Australian suicide prevention activities is needed to ensure that governments and others who commission services can make informed funding decisions.

Methodological problems commonly associated with suicide prevention evaluations, such as the statistically small number of suicide deaths in any given year, small program size and short program duration, can diminish the statistical power of evaluations and thus limit the ability to determine the effects of the program. To overcome these methodological issues and ensure that future investments can be informed by robust evidence, the NMHC recommends that the Australian Government, with the state and territory governments commits to longer-term funding for suicide prevention activities and evaluations of these activities to better assess outcomes over a longer period of time. For the local area suicide prevention trials, the NMHC recommends the Australian Government commit to the timely public release of the evaluation of the National Suicide Prevention Trial. The Australian Government should also work with the Victorian Government, Australian Capital Territory Government and the Black Dog Institute to encourage the timely public release of their evaluations of their local area suicide prevention trials. This will allow governments to determine whether expansion or revision of the place-based suicide prevention trial sites is required.

Fifth National Mental Health and Suicide Prevention Plan

Reporting on the progress of mental health reform is fundamental to understanding whether the commitments made in the Fifth Plan are being honoured and are making a difference.

By monitoring the progress of the stakeholders responsible for implementing the Fifth Plan, as well as consumers and carers across Australia, the NMHC will gain a broader understanding of whether the reform is successfully meeting its objectives. Monitoring the implementation progress of the Fifth Plan is also essential for identifying barriers, challenges or significant system change that may impede progress.

The first report on the implementation progress of the Fifth Plan was presented to health ministers in October 2018. The report outlined the progress achieved against the implementation actions in the early stages of the Fifth Plan, and presented baseline data for the available performance indicators. To supplement this report, the NMHC conducted a national survey to capture the experience of consumers and carers. *Fifth National Mental Health and Suicide Prevention Plan 2019: The consumer and carer perspective* (2019 Consumer and Carer report) sought to establish a baseline against which the performance of the Fifth Plan reform can be measured.

Given that the Fifth Plan is still in the early stages of implementation, it is difficult to provide detailed commentary on progress of the reform to date. However, the issues reported by consumers and carers in the 2019 Consumer and Carer report, such as the availability and adequacy of mental health services, the availability and cultural appropriateness of services for Aboriginal and Torres Strait Islander communities, and experiences of stigma and discrimination, reinforce the intended direction of priority areas and subsequent actions under the Fifth Plan.

As implementation of the Fifth Plan progresses incrementally over the coming years, the NMHC expects to see changes in Australia's mental health system. The NMHC will continue to survey and report on the experiences of consumers and carers to ensure that these changes result in genuine improvements for people with mental illness.

The NMHC values the commitment demonstrated by all stakeholders named in the Fifth Plan in working towards the successful implementation of the actions under the eight priority areas, and expects to note further progress against these actions in its second progress report. The progress report for 2018–19 will be delivered to health ministers in early 2020.

Recommendations

The list of recommendations below compiles the recommendations made throughout the body of this report. The NMHC acknowledges that these recommendations are variable in both scale and scope, and many will require time to be implemented by stakeholders. As part of its monitoring and reporting role, the NMHC will work with stakeholders to identify how progress of the recommendations can be measured.

Addressing population data gaps

Recommendation 1: The Australian Government supports an ongoing program of prevalence data collection, conducted at regular intervals, and commits to a feasibility study to investigate options for expanding the scope of disorders and high risk community groups included in the prevalence data collection program.

Recommendation 2: The Australian Government supports the development of a culturally appropriate version of the National Survey of Mental Health and Wellbeing, to collect high quality data on the prevalence of mental illness in Aboriginal and Torres Strait Islander communities.

Recommendation 3: The Australian Government supports the ongoing inclusion and further development of psychosocial risk factor analysis in the routinely published deaths data collection.

Australia's mental health system

Recommendation 4: Subject to the findings of the Productivity Commission inquiry into the social and economic benefits of improving mental health, governments support a national mental health service gaps analysis.

Recommendation 5: The Australian Government produces a clear implementation plan to accompany the development and release of the National Mental Health Workforce Strategy.

Meeting the needs of consumers and carers

Recommendation 6: The NMHC suggests that state and territory governments offer the Your Experience of Service (YES) survey to consumers during every hospital stay or community health centre visit, and contribute to the national data collection on consumer perspectives of mental health care.

Recommendation 7: The NMHC suggests that state and territory governments investigate the feasibility of implementing the Mental Health Carer Experience Survey.

Recommendation 8: The Australian Government supports the implementation of the Living in the Community Questionnaire Summary Form in the mental health services they fund. The NMHC suggests that state and territory governments implement the Living in the Community Questionnaire Summary Form in mental health services they fund. All resulting data should be publicly reported.

Social determinants

Recommendation 9: Subject to the findings of the Productivity Commission inquiry into the social and economic benefits of improving mental health, the Australian Government considers the role of a central government agency to coordinate a whole-of-government approach to mental health policy.

Recommendation 10: Subject to the findings of the Productivity Commission inquiry into the social and economic benefits of improving mental health, the Australian Government considers the role of an independent statutory body to monitor and evaluate mental health policy outcomes. This includes the current levels of expenditure on mental health and whether investment in mental health is effective, efficient and informed by evidence-based policy.

Primary Health Networks

Recommendation 11: In consultation with PHNs, the Australian Government establishes an overarching entity to govern, support and build PHN capacity on a national scale.

Recommendation 12: The Australian Government responds fully to the 17 recommendations in the PHN Advisory Panel Final Report.

Recommendation 13: The Australian Government endorses the implementation of the Five Year Horizon for PHNs and details how it will publicly report on its implementation.

Recommendation 14: The report on the performance of the PHN Program to be released by the Australian Government includes baseline data about how the PHN Program is meeting outcomes under the PHN Performance and Quality Framework.

Recommendation 15: The Australian Government encourages PHNs to extend contracts with existing service providers who can demonstrate efficacy and suitability in providing services in their region; and where feasible, enter into longer-term contracts when commissioning services with new providers.

Recommendation 16: The Australian Government encourages PHNs to position Aboriginal Community Controlled Health Services as preferred providers for mental health and suicide prevention services for Aboriginal and Torres Strait Islander people.

National Disability Insurance Scheme

Recommendation 17: The NDIA publishes information about the outcomes of the complex support needs pathway and the psychosocial disability service stream, and the evaluation outcomes of streamlined access for people with psychosocial disability.

Recommendation 18: The Australian Government: extends support for Commonwealth community mental health program clients to at least June 2021; considers whether the funding available under the National Psychosocial Support and Continuity of Support measures matches the needs of people who are ineligible for the NDIS; and considers how funding and access to services for people ineligible for the NDIS can be simplified.

Recommendation 19: The Australian Government, with state and territory governments ensure that people who are ineligible for the NDIS have access to adequate psychosocial support services.

Recommendation 20: The NDIA works with state and territory governments to progress the Maintain Critical Supports policy and release detail on what is happening with the policy.

Recommendation 21: The NDIA includes support coordination as a standard item in all plans for people with psychosocial disability.

Recommendation 22: The NDIA routinely publishes data about participants with psychosocial disability including information about application, access and planning outcomes by population groups, eligible/ineligible status, plan utilisation, the extent of support coordination in plans, and current rates of expenditure on supports in plans.

Suicide prevention

Recommendation 23: In acknowledgement of their shared responsibility for preventing suicide, any future national suicide prevention strategies be co-designed and co-governed by all relevant portfolios under the Australian Government, including health, education, justice, social services and employment.

Recommendation 24: The Australian Government work with the state and territory governments to commit to a national Aboriginal and Torres Strait Islander suicide prevention plan, that is led by the knowledge and expertise of Indigenous people.

Recommendation 25: The Australian Government work with state and territory governments to ensure that all evaluations of initiatives to improve emergency department care extend beyond measures of process and impact on hospital staff, to include impact on meaningful outcomes for consumers and carers as a primary outcome measure.

Recommendation 26: The Australian Government work with the Safety and Quality Partnership Standing Committee to ensure that the mental health supplement to the National Safety and Quality Health Service Standards includes detailed requirements and guidance on the care required by people at risk of suicide.

Recommendation 27: The Australian Government work with the Mental Health Principal Committee, to oversee the development of best practice suicide prevention guidelines that cover the full range of suicide prevention activities, from primary prevention to postvention, in all settings.

Recommendation 28: The Australian Government work with the state and territory governments on the development of routinely collected data on suicide prevention expenditure, workforce and program and service activity.

Recommendation 29: The Australian Government, with the state and territory governments commit to longer-term funding for suicide prevention activities and evaluations of these activities to better assess outcomes over a longer period of time.

Recommendation 30: The Australian Government commit to the timely public release of the evaluation of the National Suicide Prevention Trial. The Australian Government should also work with the Victorian Government, Australian Capital Territory Government and the Black Dog Institute to encourage the timely public release of their evaluations of the local area suicide prevention trials.

The mental health system

Section 1

Chapter 1:
Prevalence and burden of poor mental health, mental illness and suicide in Australia

Mental illness and suicide are significant public health issues, both in Australia and internationally. Although population data cannot represent the diversity of people's experiences, population estimates of poor mental health, mental illness and suicide can be used by governments, Primary Health Networks and Local Health Networks to assess and respond to the needs of their communities.

As such, having contemporary and comprehensive population data (including the prevalence and burden of disease of mental illness and suicide) is an essential component of evidence-based mental health and suicide prevention service planning.

Key terms relating to the prevalence and burden of poor mental health, mental illness and suicide are defined in Box 1.

Incidence of psychological distress

Psychological distress is one measure of poor mental health and can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness. A person experiencing high levels of psychological distress may not meet the criteria for a mental illness, but their distress may still have a negative impact on their life.[1]

Although the proportion of people who experience high or very high levels of psychological distress has remained relatively stable over time for most age groups, women have consistently experienced high and very high levels of psychological distress more commonly than men across all age groups (Figure 1).[2]

Prevalence of suicide and selected mental illness

Australia's mental illness prevalence data is collected by the National Survey of Mental Health and Wellbeing (NSMHWB). The NSMHWB has three components—a population-based survey of adults, a service-based survey of people with psychotic disorders, and a population-based survey of children and adolescents. In addition to prevalence estimates, the NSMHWB provides valuable information about the level of impairment associated with mental illness, use of mental health services and suicidality.

Box 1: Prevalence key terms

Burden of disease is the quantified years of healthy life lost, either through premature death or living with a disability, due to illness or injury. Burden of disease is a measure of the impact of a disease or injury on a population.

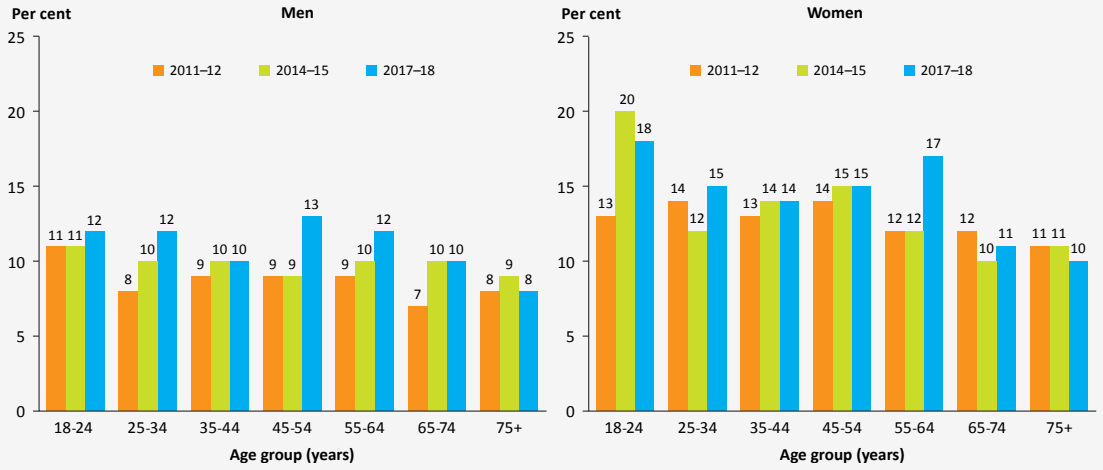
Mental health is defined by the World Health Organization as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community.

Mental illness is a wide spectrum of diagnosable health conditions that significantly affect how a person feels, thinks, behaves, and interacts with other people. Mental illness can vary in both severity and duration. In this report 'mental illness' is used in place of 'mental health problem', 'mental health disorder', 'mental ill-health' and 'mental health disease'.

Poor mental health is defined as low levels of mental health that are not diagnosable. Poor mental health may be associated with suicidality.

Suicidality is a term that covers suicidal thoughts, suicide plans, and suicide attempts.

Figure 1: High and very high levels of psychological distress in men and women, by age group, 2011–12 to 2017–18



Source: Australian Bureau of Statistics. National Health Survey: First results, 2017–18.

The NSMHWB of adults was first conducted in 1997 and was most recently repeated in 2007, making this data almost 12 years old. The lack of contemporary prevalence data hinders mental health service planning and attempts to evaluate the effectiveness of the mental health system. There are also key gaps in the NSMHWB, including data for some disorder types and high risk community groups. The scope of the 2007 survey was high prevalence disorders, such as affective, anxiety and substance use disorders. Low prevalence disorders such as eating disorders and personality disorders were not in scope, as these disorders require tailored survey methodology to produce robust prevalence estimates.[1]

The methodology used in the 2007 NSMHWB also limits the information available on some high risk groups, such as homeless people, people in residential aged care, non-English speaking Australians and Aboriginal and Torres Strait Islander people (Box 2).[3]

The NMHC welcomes the Australian Government's commitment to fund an updated NSMHWB adult survey. However, an ongoing program of prevalence data collection, conducted at regular intervals, is required to ensure that contemporary prevalence data remain available.

To provide a more comprehensive picture of mental illness prevalence in Australia, the feasibility of expanding the NSMHWB to include a broader set of disorder types and high risk community groups should be investigated.

The NMHC recommends that the Australian Government supports an ongoing program of prevalence data collection, conducted at regular intervals, and commits to a feasibility study to investigate options for expanding the scope of disorders and high risk community groups included in the prevalence data collection program. The NMHC also recommends that the Australian Government supports the development of a culturally appropriate version of the NSMHWB, to collect high quality data on the prevalence of mental illness in Aboriginal and Torres Strait Islander communities.

Mental illness in adults

Almost half (45%) of Australians aged between 16 and 85 will experience a common mental illness, such as an anxiety, affective or substance use disorder, in their lifetime. One in five (20%) Australians experience a common mental illness each year. Of these, anxiety disorders are the most common, affecting one in seven (14%) people, followed by affective disorders (such as depression; 6%), and substance use disorders (such as alcohol dependence; 5%).[4]

On average, people with affective disorders experience greater levels of impairment due to their mental illness, compared to people with anxiety or substance use disorders.[1] It is estimated that, on average, people with a common mental illness were unable to perform their usual activities between 11% and 21% of the time due to their mental illness.[1]

Psychotic illness

Psychotic illnesses are characterised by distortions of thinking, perception, and emotional responses, and include schizophrenia, schizoaffective disorder, bipolar disorder, and delusional disorder. It is estimated that in 2010, 64,000 people between the ages of 18 and 64 (4.5 cases per 1,000 population) had a psychotic illness, and were in contact with public specialised mental health services, during the previous 12 months.[5] The prevalence of psychotic disorders was higher in males than females (5.4 cases per 1,000 compared to 3.5 per 1,000) and males aged 25-34 years had the highest rates of psychotic illness of any age group.[5]

Mental illness and suicidality in children and adolescents

It is estimated that 14% of children and adolescents aged 4-17 experience a mental illness each year. The most common mental illnesses in children and adolescents are attention deficit hyperactivity disorder (ADHD; 7%), anxiety disorders (7%), major depressive disorder (3%), and conduct disorder (2%). Mental illness is more common in males aged 4-17 than females (16% and 12% respectively), but the difference is likely to be due to the higher proportion of males who experience ADHD.[6]

Suicidal ideation is more common than suicide plans or attempts (Table 1). Around 8% of people aged 12-17 seriously consider attempting suicide every year. Females are twice as likely to seriously consider attempting suicide, compared to males (11% and 5% respectively).[6]

Table 1: Suicidal ideation, suicide plans and suicide attempts among 12-17 year-olds, by sex

Sex	Suicidal ideation in previous 12 months	Suicide plan in previous 12 months	Suicide attempt ever	Suicide attempt in previous 12 months
Males	5%	3%	2%	2%
Females	11%	8%	5%	3%
Persons	**8%**	**5%**	**3%**	**2%**

Source: Second Australian Child and Adolescent Survey of Mental Health and Wellbeing

In addition, 5% of males and 7% of females answered 'prefer not to say' to the question on suicidal ideation and were not asked subsequent questions about suicide plans or suicide attempts. As such, the results presented here may underestimate the full extent of suicidal behaviours in Australian young people.[6]

Suicide

In 2017, 3,128 people died by suicide in Australia, making suicide the 13th leading cause of death. This was an increase of 9% from the previous year. Suicide was the leading cause of death of children aged 5 to 17 years, with 98 deaths occurring in this age group in 2017. This represents a 10% increase in deaths from 2016.[7] Suicide rates in Aboriginal and Torres Strait Islander communities are over twice that of non-Indigenous Australians (Box 2).

In July 2019, the Australian Bureau of Statistics published a once-off pilot study on the psychosocial risk factors associated with suicide deaths in 2017.[8]

At the national level, the most frequently identified psychosocial risk factors for suicide deaths in 2017 were personal history of self-harm, followed by disruption of family by separation and divorce. However, the types of psychosocial risk factors most commonly identified for suicide deaths varied between demographic groups.

History of self-harm was the most common psychosocial risk factor identified for people aged under 65, while limitations of activities due to disability or chronic disease was the most common psychosocial risk factor for people aged over 65. Bullying was more commonly identified

Box 2: Aboriginal and Torres Strait Islander people

A strong cultural identity and connections to country, family and community can be protective factors for the mental health and wellbeing of Aboriginal and Torres Strait Islander people. Unfortunately, many Aboriginal and Torres Strait Islander people also experience disadvantage in the form of unemployment, poverty, isolation, trauma, discrimination, trouble with the law, and alcohol and substance abuse. For some people, this disadvantage contributes to the development of mental illness.

Mental illness

High quality data on the prevalence of mental illness in Aboriginal and Torres Strait Islander people is not available. However, in a 2014–15 national survey, 29% of Aboriginal and Torres Strait Islander people reported having been diagnosed with a mental illness at some point in their life.[9]

Psychological distress

Aboriginal and Torres Strait Islander people are nearly three times as likely as non-Indigenous people to experience high or very high levels of psychological distress. In 2014–15, 33% of Aboriginal and Torres Strait Islander people reported high or very high levels of psychological distress, compared to 12% of non-Indigenous people.[9]

Aboriginal and Torres Strait Islander women experience high or very high levels of psychological distress more commonly than Aboriginal and Torres Strait Islander men (39% and 26% respectively).[9]

Suicide

In 2017, 165 Aboriginal and Torres Strait Islander people died by suicide, accounting for 6% of Aboriginal and Torres Strait Islander people's deaths in 2017 (compared to 2% of deaths of non-Indigenous Australians). People aged 15-34 accounted for 67% of all Aboriginal and Torres Strait Islander suicide deaths in 2017.[7]

Burden of disease

In 2011, mental illness and substance use disorders were the leading cause of total burden of disease amongst Aboriginal and Torres Strait Islander people, accounting for 19% of the total burden. Suicide and self-inflicted injuries contributed 4.5% to the total burden of disease among Aboriginal and Torres Strait Islander people.[11]

as a psychosocial risk factor in suicides of people aged under 25 than any other cohort. Problems in relationships with a spouse or partner was the most commonly identified psychosocial risk factor in Aboriginal and Torres Strait Islander suicides.[8]

If integrated into the routinely published deaths data collection, analysis of psychosocial risk factors would provide valuable guidance for ongoing suicide prevention planning and funding, to improve the opportunities for intervention prior to someone's suicide.

The NMHC recommends that the Australian Government supports the ongoing inclusion and further development of psychosocial risk factor analysis in the routinely published deaths data collection.

Burden of disease

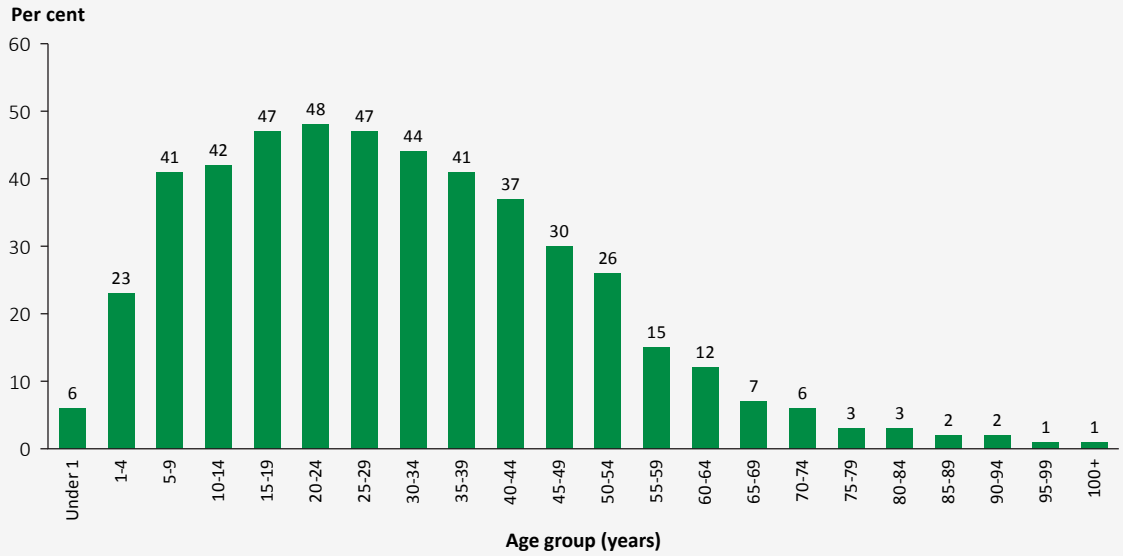
Burden of disease measures the impact of people dying from, and living with, different diseases, conditions, injuries and risk factors for poor health.

Mental illness and substance use disorders were responsible for 12% of the total burden of disease in Australia in 2015, making it the fourth biggest contributor to Australia's total burden of disease.[12]

Mental illness and substance use disorders were the second largest cause of non-fatal burden in Australia (23%), and accounted for almost half of the non-fatal burden in people aged between 15 and 30 years (Figure 2).[12]

Suicide causes 3% of the total burden of disease and is the second leading cause of total burden of disease in males.[12]

Figure 2: Non-fatal burden caused by mental illness and substance use disorders, by age group, 2015



Source: AIHW. Australian Burden of Disease Study: impact and causes of illness and death in Australia, 2015

Conclusion

Australians continue to have a significant need for mental health and suicide prevention supports and services and different groups and communities require tailored responses. However, current prevalence data is more than 10 years old and there are key gaps in Australia's population data. The NMHC welcomes the Australian Government's commitment to fund an updated NSMHWB adult survey. However, an ongoing program of prevalence data collection, including for Aboriginal and Torres Strait Islander people, should be conducted at regular intervals. This will ensure that contemporary prevalence data remains available to assist with service planning and funding decisions.

Recommendation 1: The Australian Government supports an ongoing program of prevalence data collection, conducted at regular intervals, and commits to a feasibility study to investigate options for expanding the scope of disorders and high risk community groups included in the prevalence data collection program.

Recommendation 2: The Australian Government supports the development of a culturally appropriate version of the National Survey of Mental Health and Wellbeing, to collect high quality data on the prevalence of mental illness in Aboriginal and Torres Strait Islander communities.

Recommendation 3: The Australian Government supports the ongoing inclusion and further development of psychosocial risk factor analysis in the routinely published deaths data collection.

Chapter 2:
Australia's mental health system

The mental health system exists to provide care for Australians who are affected by poor mental health, mental illness and suicide.

This system is complex and fragmented, with roles and responsibilities split across a wide range of government, non-government and private stakeholders. Issues persist within the mental health workforce, despite ongoing efforts to address them. Families and carers play a significant role in the care and support for people living with mental illness, and also face these complexities and issues.

The diversity of key stakeholders responsible for planning and delivering services presents challenges in collecting and sharing data. This has resulted in knowledge gaps throughout the sector, one of which is data on 'unmet need'. Although planning tools have been developed to assist with the appropriate provision of services to local populations, additional data is needed to understand how services can address the needs of the population that are not currently being met.

Roles and responsibilities

There is a division of roles and responsibilities for legislation, policy, funding, and service delivery across the mental health system in Australia. These roles and responsibilities are divided among the Australian Government, state and territory governments, Primary Health Networks (PHNs), Local Health Networks (LHNs), the private and non-government sectors (including Aboriginal Community Controlled Health Services; Box 3). In addition, the families and carers of people with mental illness contribute to the mental health and suicide prevention system by supporting consumers to recover and live in the community.

Many of these roles and responsibilities overlap with or impact each other. This can create uncertainty and complexity for service providers, as well as for the consumers and carers navigating the system.

Box 3: Roles and responsibilities within the mental health system

Australian Government

The Australian Government has both policy and funding responsibilities, and provides policy direction for the delivery of primary mental health care services delivered by private psychiatrists, general practitioners, private psychologists, mental health nurses and other allied health professionals. The Australian Government funds a range of mental health-related services through the Medicare Benefits Schedule, and the Pharmaceutical Benefits Scheme/Repatriation Pharmaceutical Benefits Scheme. The Australian Government also provides core funding to Aboriginal Community Controlled Health Services (ACCHS) and contributes funds to the non-government sector, both directly and via grants to Primary Health Networks (PHNs).

State and territory governments

State and territory governments are responsible for enacting mental health legislation, setting policy frameworks and funding, and delivering public mental health services that provide specialist care for people with illness. These services include specialised mental health care delivered in public acute and psychiatric hospital settings, state and territory specialised community mental health care services, and state and territory specialised residential mental health care services.

Primary Health Networks

PHNs were established by the Australian Government to plan and commission health services, including mental health services, in their region. The key objectives for PHNs have been to increase the efficiency and effectiveness of clinical services for patients, particularly those at risk of poor health outcomes, and improve coordination of care to ensure that patients receive the right care, at the right place, at the right time, through a stepped care approach. Local Health Networks (LHNs) were established by states and territories to manage public hospital services. LHNs may also manage other community-based mental health services funded by state and territory governments. PHNs and LHNs both support service integration at the regional level.

Private sector

Private sector services include admitted patient care in private psychiatric hospitals, and private services provided by psychiatrists, psychologists and other allied health professionals. These services can include primary care, acute management, rehabilitation, psychological interventions and other allied health supports. Private sector services are funded by a mix of patient fees, Australian Government rebates and private health insurance funds.

Non-government sector

The mental health non-government sector is made up of private organisations (both not-for-profit and for-profit). Mental health non-government organisations may receive funding from the Australian Government, state or territory governments, PHNs, LHNs or private entities. Generally, these services focus on providing non-clinical support, advocacy and assistance to people who live with a mental illness, rather than the assessment, diagnostic and treatment tasks undertaken by clinical services.

Aboriginal Community Controlled Health Services

ACCHS are organisations that are established and operate under an Aboriginal and Torres Strait Islander community controlled model. These not-for-profit organisations may deliver the same type of services as private providers and the community sector, using culturally appropriate models of care. ACCHS play a critical role in the provision of mental health services for Aboriginal and Torres Strait Islander communities, with a workforce that includes Aboriginal and Torres Strait Islander health workers.

Unmet need for mental health services

A mental health system that meets the needs of consumers and carers is one that can respond to the increasing demand for mental health services. People with mental illness require varying degrees of support across a variety of settings. Available data shows that the number of people accessing clinical mental health services is increasing. For example:

- The proportion of general practitioner encounters due to mental health issues increased from 10% in 2006–07 to 12% in 2015–16. More than half (62%) of these encounters were managed by prescribing, supplying or recommending medication.[13]
- The number of people who received community treatment services increased from 328,000 in 2007–08 to 420,000 in 2016–17.[14]
- The proportion of emergency department presentations that related to mental health increased from 3% in 2011–12 to 4% in 2017–18. This equates to over 98,000 more presentations now compared to six years ago.[15]

These data do not quantify people who are turned away from services or the length of time that people are waiting to access services. However, the continued increase in the use of emergency departments to manage acute episodes of mental illness suggests that people with a moderate to severe mental illness are not getting the care they need in the community.

People with moderate mental illness may require more support than what is provided by public mental health services. Alternative options such as private services can be inaccessible due to cost, even when subsidised by private health insurance. Understanding the number and type of mental health services that are needed is essential for ensuring that people with moderate mental illness can access appropriate support.

National mental health service data collections provide some information about the availability, access and use of existing mental health services. Governments, PHNs and LHNs can also use the National Mental Health Service Planning Framework Planning Support Tool and other similar tools to estimate the need and predicted demand for mental health care, including the level and mix of mental health services that may be required in their region. By comparing existing mental health services with optimal services, governments, PHNs and LHNs can identify what is needed to meet their community's mental health service requirements.

Unfortunately, current gaps in the available national mental health service data collections limit the ability of all jurisdictions to routinely compare the existing level and mix of mental health services with the optimal levels estimated by planning tools.

These comparisons would provide invaluable knowledge to better inform effective mental health service planning, as well as enabling regular monitoring of progress towards eliminating unmet need.

The NMHC recommends that, subject to the findings of the Productivity Commission inquiry into the social and economic benefits of improving mental health, governments support a national mental health service gaps analysis.

Mental health workforce

For the mental health system to be responsive to changing needs of consumers and to deliver high quality services, the mental health workforce must grow and develop.

The need to address mental health workforce issues has been consistently identified over a long period of time and there are a number of issues which continue to negatively impact the mental health workforce (Box 4).[16, 17]

Box 4: Key issues impacting the mental health workforce

Ageing workforce

Current trends show that the mental health workforce is facing a shortage due to an ageing population. In 2017, about 3 in 5 mental health nurses (58%) were aged 45 and over, and one-third (33%) were aged 55 and over.[18] Other clinical specialities, including psychiatry and psychology, show similar patterns. In 2017, half of psychologists were aged 45 and over, and more than one-quarter were aged 55 and over. While more than 70% of psychiatrists were aged 45 and over, and more than 40% were aged 55 and over.[18,19]

Staff turnover

One of the biggest issues in relation to the mental health workforce across professional streams and geographical areas is staff turnover. There is a well-known range of contributing factors including stress and burnout, an ageing workforce, excessive workloads, insecure tenure, limited career paths, and reduced time for training, mentoring and supervision.[17,20,21] Mental health professionals operating in rural and remote areas, and those operating in private practice may also experience isolation.

Movement of mental health professions from public to private settings

Another trend impacting the workforce is the movement of mental health professionals from public to private settings. Mental health professionals in the public sector are under increased pressure. A lack of resources and an over-stretched public system are some of the factors contributing to the shift from the public to the private work setting,[22] particularly amongst psychiatrists.[20,21]

Training and education to deal with a changing mental health system

Training is needed to ensure that the workforce has the knowledge to deliver trauma informed care, help prevent suicide, adapt to new ways of service delivery (such as through digital mental health platforms) and provide culturally appropriate care to Aboriginal and Torres Strait Islander people.[23]

Challenges for peer workers

Peer workers play an important role in building recovery oriented approaches to care. Peer workers face challenges including stigma, discrimination, lack of resources to meet demand, lack of peer supervision and professional development, and complex remuneration structures.[23]

Attempts have been made to address these issues through workforce policy and planning at both the national[17] and jurisdictional levels.[24-30] Despite this, workforce issues continue to be raised in the context of mental health reform requirements.[31,32] New South Wales, Queensland and Victoria all have dedicated mental health workforce strategies, while Western Australia's is currently under development.[24-26,28] All other states and territories refer to mental health workforce within broader mental health strategic plans.[27,29,33,34]

At the national level, the following actions are occurring:

- Development of the Workforce Development Program under the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan). The Workforce Development Program will guide strategies to address future workforce supply requirements and drive recruitment and retention of skilled staff. It is to be completed by 2022.[35]

- The development of the Peer Workforce Development Guidelines under the Fifth Plan which is to be completed by 2021 (Section 3, Chapter 4).
- Development of the National Medical Workforce Strategy, which will guide long-term collaborative medical workforce planning across Australia. The National Medical Workforce Strategy is being led by the Australian Government Department of Health in collaboration with a range of stakeholders and is expected to be finalised in late 2020.[36]
- Development of the National Mental Health Workforce Strategy by the Australian Government, which will provide options to attract, train and retain mental health workers to support the provision of mental health services.[19,35]

Professional peak bodies are also taking steps to address known workforce issues, such as supply shortages. Key priorities that stakeholders are seeking to address include:

- support for new practitioners, including clearer pathways into mental health, mental health placements and scholarships[24,28,29,37]
- upskilling of existing mainstream workforces, including general practitioners, general nursing staff and midwifery staff[25,28,30,37-40]
- ongoing development of the existing mental health workforce, including professional development and supervision, cultural competence, trauma competence and leadership development[23,24,26,28,30,33,39-41]
- development and planning for specific workforces, including the Aboriginal and Torres Strait Islander workforce, peer workers, and workers in rural and remote areas[42,43]
- addressing concerns regarding the community-based mental health workforce, including low pay and poor working conditions, leading to turnover and instability [29,41]
- workforce planning that is informed by evidence of what is needed and supported by tools such as the National Mental Health Service Planning Framework[24-28,37,41]
- improving the safety and wellbeing of the mental health workforce.[26,28,37]

The National Mental Health Workforce Strategy should build on the strategies and frameworks in place or in development, and be developed in consultation with all stakeholders responsible for the mental health workforce. The NMHC recommends that the Australian Government produces a clear implementation plan to accompany the development and release of the National Mental Health Workforce Strategy.

Conclusion

The mental health system in Australia is complex and fragmented, with roles and responsibilities spread across governments, as well as the non-government and private sectors. To ensure that the system meets the needs of consumers and carers, governments and mental health service providers need to coordinate and integrate mental health and suicide prevention policy, planning and service delivery.

Current data gaps in available national mental health services data collections limit the ability of governments and mental health service providers to effectively plan for and deliver services, particularly for high risk population groups. Effective delivery of services also depends on a mental health workforce that is adequately resourced, skilled and responsive to the changing needs of the community.

Recommendation 4: Subject to the findings of the Productivity Commission inquiry into the social and economic benefits of improving mental health, governments support a national mental health service gaps analysis.

Recommendation 5: The Australian Government produces a clear implementation plan to accompany the development and release of the National Mental Health Workforce Strategy.

Chapter 3:
Meeting the needs of consumers and carers

The goal of Australia's mental health system is to meet the needs of consumers and carers.

To achieve this, the mental health system needs to:

- be accessible at the right place and right time, regardless of the individual's income, geography and cultural background
- provide care that is relevant to the person's needs and based on established standards
- provide uninterrupted, coordinated care and services across programs, practitioners and organisations over time
- provide care that achieves desired outcomes, with the most cost-effective use of resources
- show respect for the consumer's dignity, confidentiality and right to actively participate in deciding their own care
- provide an appropriate and sustainable workforce
- respond to emerging needs.[44]

Monitoring how well consumer and carer needs are being met is a key component of monitoring the performance of the mental health system.

Data is essential to monitoring and understanding whether the mental health system is addressing consumers' and carers' needs.

Ongoing monitoring and reporting also contributes to service improvements and improved future outcomes for consumers and carers.

Consumer perspectives of mental health care

Mental health consumers' and carers' experiences of health care have long been identified by services, consumers, carers and families as being important in understanding how health services are performing and to driving the quality improvement of services.45 The Your Experience of Service (YES) survey aims to help mental health services and consumers to work together to build better services, by helping to identify specific areas where consumers believe quality improvements can be made.[46] The survey asks respondents to rate their experience of care, as well as a range of questions about how often the service showed respect for their dignity and privacy, and actively included them in deciding their own care. The detailed results can be used by services to inform ongoing improvement efforts, and can also be aggregated to provide an overall picture of the performance of mental health services.

Currently three states—New South Wales, Victoria and Queensland—have implemented the YES survey in mental health-related hospital and community mental health settings and are contributing to a publicly reported data collection. There are differences in how each state uses the YES survey. In New South Wales, consumers are offered the YES survey during every hospital stay or community health centre visit. In Victoria and Queensland, consumers are offered the YES survey in a particular week or month of the year.[47]

While each state has chosen the survey delivery method that best suits their local needs, differences in collection practices makes comparison difficult and reduces opportunities for jurisdictions to learn from each other about how best to meet consumer needs.

The differences in data collection methods, and the absence of data from multiple states and territories also hinders the ability to provide a national perspective on the performance of mental health services.

The available data from the YES survey suggests that the majority of mental health care provided meets the needs of consumers, but a significant proportion of consumers (between 19% and 49%) do not have a positive experience of care. In all three states that publish their YES survey data, over 70% of consumers rated their admitted patient mental health care as 'good', 'very good' or 'excellent', and over 85% of consumers rated their community-based care as 'good', 'very good' or 'excellent'.

However, between 8% and 27% of consumers report a 'fair' or 'poor' experience of their admitted patient or community-based mental health care (Figure 3).[47]

To create a nationally consistent picture of how well mental health services are meeting the needs of consumers, the NMHC suggests that states and territories offer the YES survey to consumers during every hospital stay or community health centre visit, and contribute to the national data collection on consumer perspectives of mental health care.

A measure of carer experience, the Mental Health Carer Experience Survey, has also been developed but has not yet been implemented by any state or territory government. As a result, carers lack a way to easily and routinely contribute to the ongoing improvement of mental health services.[47,49] The NMHC suggests that states and territories investigate the feasibility of implementing the Mental Health Carer Experience Survey.

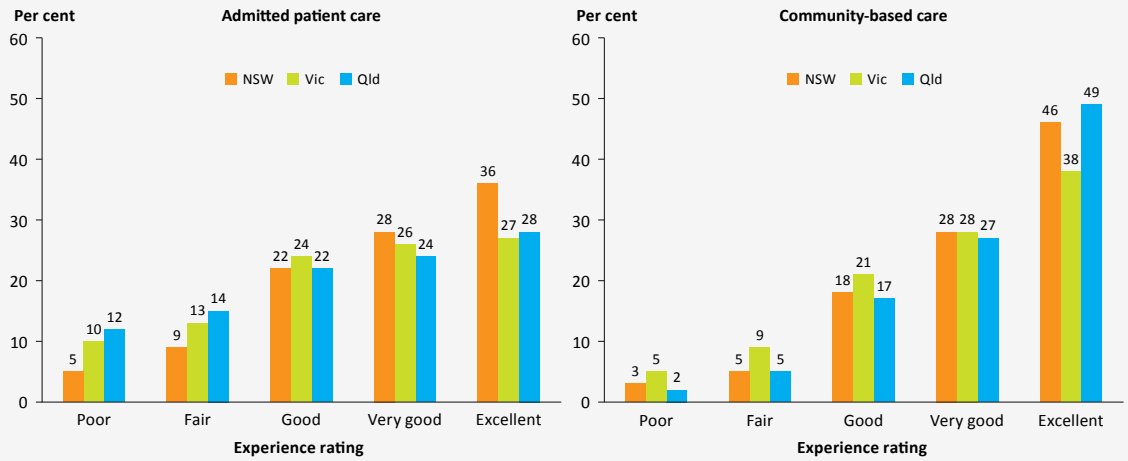
Restrictive practices

Everyone accessing the mental health system deserves to receive safe care, and has the right to be treated with dignity and respect.[50]

The use of restrictive practices, such as seclusion and restraint (Box 5), impacts on consumers' right to dignity, so monitoring the frequency of restrictive practices over time can provide an indication of the performance of mental health services.[51]

Governments have committed to a policy priority of working towards eliminating restrictive practices in Australian mental health care.

Figure 3: Consumer's experience of care ratings, admitted patient care and community-based care, by state, 2016–17



Source: AIHW. Mental Health Services in Australia. Consumer perspectives of mental health care.

Box 5: Restrictive practices key terms

Seclusion and restraint are interventions used in mental health facilities and other settings to manage or control a person's behaviour.

Seclusion is the confinement of an individual at any time of the day or night alone in a room or area from which free exit is prevented.

Restraint is the restriction of an individual's freedom of movement by physical or mechanical means.

Mechanical restraint is the application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict their movement to prevent the person from harming themselves or endangering others, or to ensure the provision of essential medical treatment.

Physical restraint is the application by health care staff of 'hands-on' immobilisation or the physical restriction of a person to prevent the person from harming themselves or endangering others or to ensure the provision of essential medical treatment.

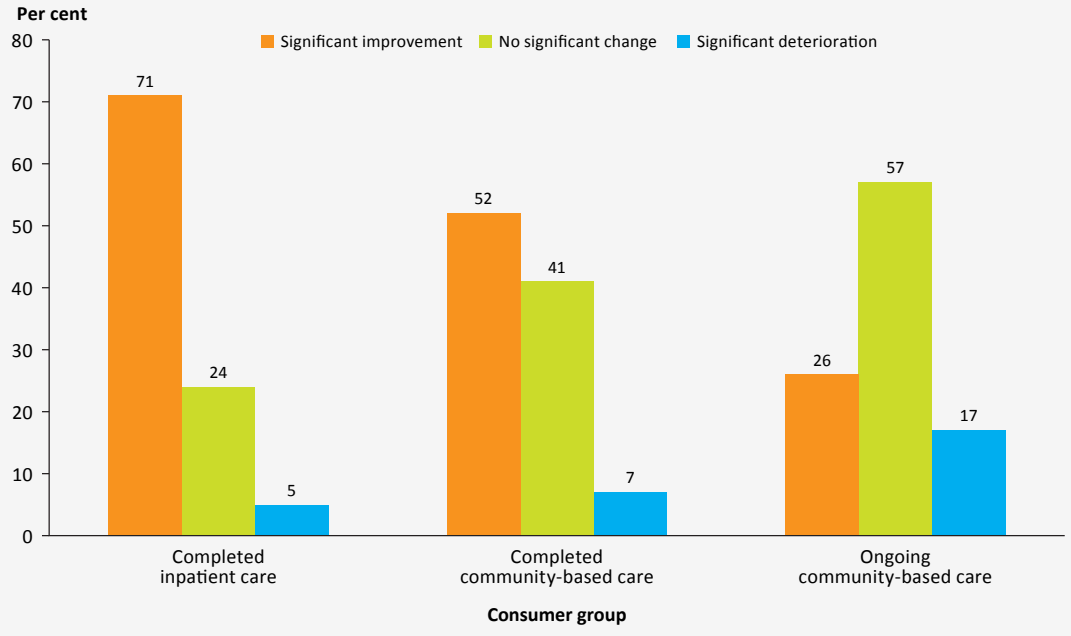
Changes in legislation, policy and clinical practice have affected the frequency and duration of seclusion events in Australia's public sector acute mental health hospital services.

In 2017–18, there were 6.9 seclusion events per 1,000 bed days in acute specialised mental health hospital services, a reduction from 13.9 in 2009–10. The average duration of seclusion declined from 6 hours in 2013–14 to 5 hours in 2017–18.[53]

The frequency of restraint in Australia's public sector acute mental health hospital services is also declining. There were 0.5 mechanical restraint events per 1,000 bed days in 2017–18, compared to 0.9 in 2016–17, and 10.3 physical restraint events per 1,000 bed days in 2017–18 compared to 11.2 in 2015–16.[54]

The continued reduction in restrictive practices is encouraging. The NMHC encourages all governments to continue their efforts towards eliminating the use of seclusion and restraint.

Figure 4: Mental health consumer's clinical outcomes, by consumer group, 2016–17



Source: AIHW. Mental Health Services in Australia. Key performance indicators for Australian public mental health services.

Clinical outcomes for consumers

State and territory specialised mental health services aim to reduce the symptoms of mental illness and improve consumer functioning. The National Outcomes and Casemix Collection uses clinician and consumer-rated measures of consumer symptoms and functioning at key points during care to determine if state and territory specialised mental health services are achieving this goal.[55]

In 2016–17, 71% of consumers who completed inpatient care experienced significant improvement in their symptoms and functioning, as did 52% of consumers who completed community-based care and 26% of consumers whose community-based care was still ongoing (Figure 4). The data also shows that 29% of consumers who completed inpatient care experienced no improvement or were experiencing worse symptoms and functioning at the end of their care. This figure was 48% for consumers who had completed community-based care. The proportions of consumers in either setting who experienced no improvement or worse symptoms have been relatively consistent over the past 10 years.[56]

Non-clinical outcome for consumers

In addition to the responsibility to help consumers manage their clinical symptoms, the mental health sector has a role in supporting consumers to lead a contributing life. Improving social inclusion and meaning in life for consumers is a key priority of all governments under the Fifth National Mental Health and Suicide Prevention Plan.[35] Due to a lack of data, it is not currently possible to report on progress towards achieving these outcomes. The Australian Mental Health Outcomes and Classification Network, in collaboration with the Mental Health Information Strategy Standing Committee, is currently working to develop a measure, the Living in the Community Questionnaire Summary Form, that aims to fill this data gap.

The NMHC recommends that the Australian Government supports the implementation of the Living in the Community Questionnaire Summary Form in the mental health services they fund. The NMHC also suggests that state and territory governments implement the Living in the Community Questionnaire Summary Form in mental health services they fund. All resulting data should be publicly reported.

Conclusion

A mental health system that meets the needs of consumers and carers is accessible, shows respect for consumers' dignity, provides care that is both coordinated and relevant to the person's needs, and achieves the desired outcome for the consumer.

Monitoring how well consumer and carer needs are being met by the mental health system is a key outcome measure. The data that is currently available indicates that mental health services are meeting the needs and expectations of consumers, at least some of the time. However, the data is not comprehensive and additional data is required.

To create a nationally consistent picture of how mental health services are meeting the needs of consumers, governments should implement and contribute to national data collections of consumer and carer experiences and outcomes, including the YES survey, the Mental Health Carer Experience Survey, and the Living in the Community Questionnaire Summary Form.

Recommendation 6: The NMHC suggests that state and territory governments offer the Your Experience of Service (YES) survey to consumers during every hospital stay or community health centre visit, and contribute to the national data collection on consumer perspectives of mental health care.

Recommendation 7: The NMHC suggests that state and territory governments investigate the feasibility of implementing the Mental Health Carer Experience Survey.

Recommendation 8: The Australian Government supports the implementation of the Living in the Community Questionnaire Summary Form in the mental health services they fund. The NMHC suggests that state and territory governments implement the Living in the Community Questionnaire Summary Form in mental health services they fund. All resulting data should be publicly reported.

Social determinants of mental illness and suicide

Section 2

Introduction

Social determinants refer to the social conditions in which people are born, grow, work, live and age, as well as the systems that shape the conditions of daily life.[57] Social determinants influence mental health and wellbeing and include factors such as housing, education, employment, income and social justice. People living with mental illness are more likely to experience poor social, economic and health outcomes, including experiencing homelessness, being unemployed, being incarcerated and dying prematurely.

The relationship between mental illness and other social, economic and health factors means that many investments and policy reforms that have the potential to improve the mental health of Australians may come from outside the health sector, and vice versa. A whole-of-government approach is needed to successfully address the impacts of the social determinants of mental health. This means looking beyond the impacts of the health system, and collaborating across systems and across governments. Box 6 presents key statistics for social determinants of mental health in Australia.

Understanding social determinants and their connection to mental health is central to the work of the NMHC. The NMHC's Contributing Life Framework acknowledges the social determinants of mental health, and the ambition that individuals can lead contributing lives.[69] The framework recognises that a fulfilling life requires more than just access to health care services. It means that people with a mental illness can expect the same rights, opportunities, and physical and mental health outcomes as the wider community.

The Contributing Life Framework aligns closely with actions to address social determinants of health identified by the World Health Organization (WHO; Table 2). The WHO social determinants approach to improving mental health advocates for a collaborative approach, and emphasises that reducing health inequalities is most effectively achieved when health equity is prioritised in all policies and across all sectors. WHO also proposes that policies from non-health portfolios should explicitly state their likely contribution to health.[70, 71]

Table 2: Comparison of NMHC Contributing Life Framework and areas for action identified by the World Health Organization to address social determinants of health

Contributing Life Framework	WHO actions to address social determinants of health
• Feeling safe, stable and secure • Connections with family, friends, culture and community • Something meaningful to do, something to look forward to • Effective support, care and treatment • Thriving, not just surviving[69]	• Improving early child development • Improving access to fair employment and decent work • Improving social protection through social protection • Improving the living environment[71]

Box 6: Social determinants of mental health in Australia – key statistics

Early childhood and adolescence

Social and demographic factors associated with mental illness in children and adolescents include household income, parent and carer education, parent and carer employment, family functioning and area of residence. It is estimated that in 2013–14 approximately 560,000 children and adolescents in Australia between the ages of 4 and 17 had a mental illness. Around two-thirds (64%) of these children experienced a mild or moderate impact of their mental illness on school or work, and around one-fifth (21%) experienced a severe impact on school, or did not go to school or work.[6]

Education and employment

People with mental illness have lower levels of education and lower rates of employment compared to the general population.[58] The majority of people with psychotic illness (85%) rely on a government pension as their main source of income, and only one-third (33%) are in paid employment.[5] Nearly one-third (31%) of young people who are not in employment, training or education, have very high levels of psychological distress, compared to 17% of other young people.[59] Poor mental health has an effect on employment, both in securing and retaining work. In 2017–18, 62% of those who reported having a mental illness were employed, compared with 80% of the general population.[60]

Social isolation

In 2010, the majority (85%) of people with psychotic illness, who were in contact with specialised mental health services, relied on a government pension as their main source of income. Nearly 1 in 4 (22%) people with a psychotic illness, who were in contact with specialised mental health services in 2010 reported feeling socially isolated and lonely, and two thirds (69%) said that their illness made maintaining close relationships difficult. Over half (56%) of this population reported receiving no or minimal support from any source.[5]

Housing and homelessness

Around 3% of people living in private households in 2007 reported that they had been homeless at some point in their life. The prevalence of mental illness in this group (54%) was more than twice that of the general population (20%).[1] Homelessness can have detrimental effects on a person's mental health, and reduced mental health may persist for some time even after the person finds new housing.[61] More than one-quarter (28%) of people who sought assistance from specialist homelessness services in 2017–18 had a current mental health issue.[62]

Physical health

In 2014–15, 3.6 million Australians (16% of the total population) reported having a mental illness and a co-existing long-term physical health condition. Of these, the majority (84%) had at least one mental illness with two or more physical health conditions, and the remaining 16% had only one co-existing physical health condition. Compared to people without mental illness, people with a mental illness in 2014–15 were nearly twice as likely to report having diabetes (8% compared with 5%), almost three times as likely to report pulmonary disease (6% compared with 2%), and twice as likely to report osteoporosis (6% compared with 3%).[63] The life expectancy for people with mental illness is estimated to be 30% lower than life expectancy for people without mental illness. This increased mortality is attributed primarily to physical diseases including diabetes, respiratory illnesses, cardiovascular disease, and cancer.[64]

Social disadvantage for Aboriginal and Torres Strait Islander people

In 2016, nearly half (48%) of Aboriginal and Torres Strait Islander people lived in the most socio-economically disadvantaged areas, compared with 18% of non-Indigenous Australians. Aboriginal and Torres Strait Islander people are also less likely to live in the most socio-economically advantaged areas (5% compared with 22% of non-Indigenous Australians). Aboriginal and Torres Strait Islander children experience poverty at significantly higher rates than their non-Indigenous counterparts.[65,66]

Aboriginal and Torres Strait Islander people are overrepresented in prisons, and in the child protection and juvenile justice systems. In 2018, Aboriginal and Torres Strait Islander prisoners accounted for just over one-quarter (28%) of the total Australian prison population, despite representing approximately 2% of the Australian population aged 18 years and over.[67] In 2018, Aboriginal and Torres Strait Islander children were 10 times more likely to be in out-of-home care than non-Indigenous children.[68] Fewer than half of Aboriginal and Torres Strait Islander children are placed with Aboriginal and Torres Strait Islander carers.[68]

In Australia, the emphasis on collaboration across systems and between governments underpins major reforms monitored by the NMHC, such as:

- Primary Health Networks are tasked with commissioning services that address the needs of specific communities and regions (Section 3, Chapter 1).
- The introduction of psychosocial disability in the National Disability Insurance Scheme (NDIS) has increased the connection between the disability and mental health systems. Participants who are eligible for NDIS funding receive support to help carry out their day to day tasks, including building social and employment capacity (Section 3, Chapter 2).
- Suicide prevention reforms address the social factors leading to distress, particularly in high risk groups such as young Australians and Aboriginal and Torres Strait Islander children and youth (Section 3, Chapter 3).
- The Fifth National Mental Health and Suicide Prevention Plan has committed all governments to work together to prevent suicide and improve mental health (Section 3, Chapter 4).

The NMHC notes that current mental health reforms have been progressively rolled out in response to a number of mental health and broader health reviews and inquiries.[69,72-76]

Productivity Commission inquiry into the social and economic benefits of improving mental health

The Productivity Commission inquiry into the social and economic benefits of improving mental health presents a significant opportunity to review investments in mental health and suicide prevention in Australia from a broad perspective.[77,78]

Announced in October 2017, this inquiry will consider how mental illness affects all aspects of a person's quality of life, including physical health, social participation, education, employment and financial status. The Productivity Commission is consulting widely to examine a range of impacts on mental health, and to determine the efficiency, effectiveness and sustainability of current investment in mental health. The inquiry terms of reference are broad, and go beyond the health sector to examine how other sectors can improve mental health, economic participation and productivity (Box 7).

The NMHC welcomes the opportunity that this inquiry provides to fundamentally change the way governments approach mental health.

Box 7: Productivity Commission inquiry into the social and economic benefits of improving mental health – Terms of Reference

The Productivity Commission will:

- examine the effect of supporting mental health on economic and social participation, productivity and the Australian economy
- examine how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity
- examine the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups
- assess whether the current investment in mental health is delivering value for money and the best outcomes for individuals, their families, society and the economy
- draw on domestic and international policies and experience, where appropriate
- develop a framework to measure and report the outcomes of mental health policies and investment on participation, productivity and economic growth over the long term.[79]

Addressing social determinants through a whole-of-government approach to mental health

The relationship between social determinants and mental health is dynamic and complex. As a result, the effects of social determinants on mental health and wellbeing should not, and cannot, be addressed by mental health interventions alone.[80] Although mental health sector interventions are critical, they are not sufficient to counter the significant influence of the social determinants of mental illness and suicide.

Mental health policy and program development in Australia needs to move to a coordinated approach that addresses whole-of-life needs.

However, there is currently a fragmented approach to dealing with social determinants and their influence on mental health, with responsibility for mental health-related policies and programs dispersed across Australian Government portfolios (Table 3).[81] Mental health and social determinants policies should not be created in silos.

Under a whole-of-government approach to addressing the social determinants of mental health:

- mental health policies in portfolios relating to social determinants would be created in collaboration with different agencies and following reciprocal consideration of relevant policies
- consumers and carers, community organisations and other relevant non-government stakeholders would be appropriately consulted, and their views considered in the development of new policies
- policy outcomes would be independently monitored and reported on, with results of these processes used to refine or improve the policy and inform future policies.

The NMHC notes the increasing commitment, both in Australia and overseas, to move towards a whole-of-government approach to addressing wellbeing (Box 8). The NMHC recommends that, subject to the findings of the Productivity Commission inquiry into mental health, the Australian Government considers the role of a central government agency to coordinate a whole-of-government approach to mental health policy.

Monitoring and reporting on mental health expenditure

To ensure that mental health investment is effective and appropriately targeted, governments need to better understand current levels of expenditure including how much is spent, what it is spent on, and how well it is working. Monitoring and reporting are essential to evaluate the outcomes of mental health expenditure, and to ensure that future investments are evidence based.

Current mental health expenditure

Current reporting of mental health expenditure is limited due to data gaps and different methods for calculating expenditure. This is particularly important given that expenditure on mental health is not restricted to the health system. For example, Australian Government expenditure on mental health includes investments in:

- mental health-specific payments to states and territories
- national programs and initiatives across all policy areas, including social services, defence, veterans' affairs, justice, education, and employment
- Aboriginal and Torres Strait Islander social and emotional wellbeing programs
- the Medicare Benefits Scheme
- the Pharmaceutical Benefits Scheme
- the National Suicide Prevention Program
- private health insurance premium rebates
- research.

State and territory governments also provide funding for mental health through other systems including disability, education, and community and social services.

Table 3: Snapshot of mental health policy and program responsibilities in Australian Government departments and agencies

Australian Government department or agency	Responsibilities
Department of Health	Provides funding for: • mental health promotion and mental illness prevention programs • web-based self-help programs • primary mental health services • direct specialised clinical and non-clinical mental health programs • 'Be You' program • Medicare Benefits Schedule • Pharmaceutical Benefits Scheme • Primary Health Networks to commission regionally delivered mental health programs.[82]
Department of Social Services	Supports Australians' mental health and wellbeing through programs and services, benefits and payments, and grants for service providers. • Provides funding to eligible community-based mental health services to provide: • early intervention support to vulnerable families • support for young people with mental illness to achieve and maintain participation in education and/or employment • support for carers of people with mental illness who have employment as a primary goal • support for the recovery of people with mental illness that includes drug and alcohol use disorders and/or gambling disorders.[83]
Department of Education	Provides a variety of national information and resources for schools, parents and students to support the resilience and wellbeing of students. For example, the Student Wellbeing Hub website (www.studentwellbeinghub.edu.au), which houses the Australian Student Wellbeing Framework. To promote mental health, the Department of Education also works with other Australian Government departments and states and territories on initiatives that influence mental health, such as the prevention of bullying and cyberbullying, and online safety.[84]
Department of Employment, Skills, Small and Family Business (formerly Department of Jobs and Small Business)	Responsible for national policies and programs that help Australians find and keep employment and work in safe, fair and productive workplaces. It also helps individuals develop the skills they need to secure and maintain rewarding and sustainable employment. The Department of Employment, Skills, Small and Family Business delivers a range of programs and services to support Australians, including people with mental illness, and help them to move from welfare to work, as well as train and upskill.[85]
Department of Agriculture	To improve access to mental health and suicide prevention services for people in regional and remote areas, the Department of Agriculture funds local governments and community organisations to provide free support services, such as: • family support services • one-to-one counselling • outreach support • community mental health and wellbeing events • advice and referrals.
Safe Work Australia	Leads development of national policy to improve work health and safety, and workers' compensation arrangements across Australia. Provides health and safety advice, including resources on workplace mental health, for employers and employees.
National Disability Insurance Agency (NDIA)	As an independent statutory agency, the NDIA delivers the National Disability Insurance Scheme, which enables people with a psychosocial disability to access psychosocial supports.[86]
National Indigenous Australians Agency (NIAA)	Operating since 1 July 2019, the NIAA is leading and coordinating Australian Government policy development, program design and implementation, and service delivery for Aboriginal and Torres Strait Islander people. The NIAA prioritises coordination across the Australian Government, and building and maintaining partnerships with Indigenous Australians. The NIAA will provide advice on priority areas, such as health and wellbeing.[87]

Box 8: Snapshot of whole-of-government initiatives

New Zealand Government Inquiry into Mental Health and Addiction

The New Zealand Government Inquiry into Mental Health and Addiction commenced in February 2018. The inquiry was established to identify how well New Zealand's current mental health and addiction services are working. On 4 December 2018, the New Zealand Government released the report *He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction* which provides recommendations for improvements. In scope were activities directly related to mental health and addiction within the health and disability sector, as well as the education, justice and social sectors. A key recommendation from the report was to take a whole-of-government approach to wellbeing to tackle the social determinants of mental illness and support prevention activities that affect multiple outcomes. To do this, it was recommended that a clear locus of responsibility for social wellbeing be established within central government to oversee and coordinate cross-government responses to social wellbeing.

To reflect a whole-of-government approach, the New Zealand Government 2019 Budget, 'The Wellbeing Budget', takes a transformative approach to mental health, wellbeing and addiction systems and services in New Zealand. Many of the budget initiatives strongly align to the government's response to the inquiry. Funding was provided to establish a Mental Health and Wellbeing Commission to provide leadership and oversight. Additionally, to support the mental wellbeing of all New Zealanders, funding was provided for 1,044 new places in the Housing First initiative, to tackle homelessness.

National Indigenous Australians Agency

The National Indigenous Australians Agency (NIAA) is an executive agency attached to the Australian Government Department of the Prime Minister and Cabinet. Announced on 12 June 2019 and operating since 1 July 2019, the NIAA is led by the Minister for Indigenous Australians, the Hon. Ken Wyatt AM, MP. The agency is leading and coordinating Australian Government policy development, program design and implementation, and service delivery for Aboriginal and Torres Strait Islander people. The agency prioritises coordination across the Australian Government, and building and maintaining partnerships with Indigenous Australians.

National Suicide Prevention Adviser

In July 2019, the Prime Minister appointed a National Suicide Prevention Adviser, whose core tasks include:

- developing options for whole-of-government coordination and delivery of suicide prevention activities to address complex issues contributing to Australia's suicide rate, with a focus on community-led and person-centred solutions
- working across government and departments to embed suicide prevention policy and culture across all relevant policy areas, to ensure that pathways to support are clear, and people who are at an increased risk of suicide are able to access support.[88]

The Australian Institute of Health and Welfare reports on mental health expenditure in its Mental Health Services in Australia report. In 2016–17, the most recent available data, $9.1 billion was spent on mental health-related services in Australia. State and territory government funding accounted for around two-thirds (62%) of the total national expenditure on mental health, while Australian Government funding accounted for one-third (33%; Table 4).

These figures do not include all spending on mental health in Australia due to gaps in publicly available data (Box 9). Without sufficient data, it is difficult to understand and develop accurate estimates of the amount and distribution of mental health expenditure.

Estimating broader mental health expenditure

The NMHC supports a broad approach to estimating mental health expenditure that incorporates costs and expenditure, beyond the health system, such as investments in programs and services in other portfolios, including disability, social services, employment and education. Estimates of expenditure using broad approaches are considerably higher than the expenditure data reported by the Australian Institute of Health and Welfare. For example, Medibank and Nous Group have estimated that Australia spends at least $28.6 billion each year on mental health services and that expenditure on non-health services for mental illness exceeds direct health care spending (Table 5).

Accounting for spending related to mental health in other sectors such as housing, aged care, education and justice is complex and requires a coordinated approach, across all governments, to mental health investment and policy development. The NMHC recommends that, subject to the findings of the Productivity Commission inquiry into mental health, the Australian Government considers the role of an independent statutory body to monitor and evaluate mental health policy outcomes. This includes the current levels of expenditure on mental health and whether investment in mental health is effective, efficient and informed by evidence-based policy.

Table 4: Expenditure on mental health-related services, 2016–17

Source of funding	Expenditure	Per cent of mental health-related expenditure
State and territory governments	$5.6 billion	62%
Australian Government	$3.0 billion	33%
Private health insurance funds	$508.0 billion	6%
Total national expenditure	**$9.1 billion**	**100%**

Source: AIHW. Mental Health Services in Australia. Expenditure on mental health-related services 2016–17.
Note: Per cent does not add to 100 due to rounding of numbers.

Table 5: Distribution of health and non-health expenditure on mental health

Type of expenditure	Expenditure	Per cent of mental health expenditure
Direct health expenditure	$13.8 billion	48%
Direct non-health expenditure	$14.8 billion	52%
Total expenditure	**$28.6 billion**	**100%**

Source: Medibank and Nous Group, 2013.
Notes: 1. Direct health expenditure includes public and private mental health services, drug and alcohol services, juvenile correctional mental health services, medications, treatment for comorbid physical conditions, Australian Government expenditure on national programs and initiatives, mental health-related payment by injury compensation insurers, corporate expenditure on mental health services, and mental health services provided by health professionals and other health services. 2. Direct non-health expenditure includes support payments such as carers' payments, and services such as employment and housing provided to people with mental illness.

Box 9: Gaps in mental health-related expenditure data

Reasons for key gaps in publicly available data related to mental health expenditure include that:

- data is not available because it is not captured, is deemed confidential and not publicly released, or exists within organisations but cannot be accessed
- information for non-government expenditure is very limited, including for non-government organisations, private health insurers and consumers
- there is limited information available about the proportion of health expenditure that is related to mental illness. This includes information for ambulance and patient transport, health care, public health promotion and compulsory third party insurance payments
- data for Medicare-subsidised items is limited to reporting of mental health-specific items. This affects mental health expenditure estimates relating to general practitioners, paediatricians and speech pathologists
- mental health-specific Medicare items may not be used for all general practitioner consultations relating to mental illness. Consultations may be billed under general Medicare items rather than a mental health-specific Medicare item.[89]

Investing in childhood early intervention and prevention

Good mental health and wellbeing is important for children from infancy and early childhood through to adolescence and young adulthood. Children and young people with good mental health and wellbeing are more likely to have fulfilling relationships, cope with adverse circumstances and adapt to change. Poor mental health for children is associated with behavioural issues, and a decreased ability to cope.[90,91]

Early intervention is key to preventing mental illness later in life because:

- most mental illnesses experienced by adults have their onset in childhood
- childhood neglect, maltreatment, and deprivation are strong risk factors for future mental illness and physical health problems
- early intervention for high risk groups, such as children affected by violence, abuse, maltreatment or poverty, can contribute to a reduction in disparities between the mental health of these children and children in psychologically healthy environments.[90,91]

Supporting population mental health and wellbeing, and intervening early when individuals are at risk reduces distress, disadvantage and disability over the lifetime and the associated costs of service provision to mitigate these issues.

The potential economic benefits of investing in early intervention and prevention strategies include reducing the likelihood of people needing costly supports, services and systems, including the child protection and justice systems, acute hospital care, and social support payments.[92]

To build the evidence base for the value of investing in early intervention and prevention from an economic perspective, the NMHC has modelled the return on investment from 10 interventions. These interventions were selected based on a number of criteria established for the project including considerations of scalability, sustainability and opportunity costs. These 10 interventions are not the only preventative interventions that could be implemented, and the work does not provide recommendations for or against investment

in the different types of interventions. Instead, the objective of the project was to assist policy makers, funders, commissioning bodies and other organisations to make informed choices about the best use of resources to promote mental health in our community. The interventions were examined for both clinical effectiveness and cost-effectiveness (using a return on investment framework), as well as considerations beyond the economic rationale. Overall, the results showed that there is good evidence for investing in a range of preventative interventions, on the grounds of both cost-effectiveness and cost savings.[93]

Six of the models examined interventions aimed at children aged 0–12, including two for pregnant or early post-partum women. The results of the modelling for these six, including total cost, total savings and the return on investment are in Table 6.

Despite the growing evidence of the benefit and economic value of early intervention initiatives, Australia lacks a coordinated approach to their implementation.

A coordinated approach to early intervention and prevention for mental health is needed to ensure that investments in early intervention and prevention strategies are sustainable and effective.

The NMHC welcomes the recent announcement by the Australian Government for a National Children's Mental Health and Wellbeing Strategy, to be delivered by the NMHC and led by child mental health experts, Professor Frank Oberklaid and Professor Christel Middeldorp.

Table 6: Results of modelled interventions targeted at children aged 0-12 ranked by return on investment with total costs and total savings

Return on investment	Intervention	Target population	Length of modelled costs and benefits	Total costs of intervention	Total savings
3.06	E-health interventions for the prevention of anxiety disorders in young people	School students aged 11-17 years	10 years	$6.2m	$18.8m
2.54	Exercise programs for the prevention of postnatal depression	Women at least 4 weeks post birth	5 years	$5.5m	$14.0m
2.40	Parenting interventions for the prevention of anxiety disorders in children	Preschool children aged 4-5 years	3 years	$3.7m	$8.3m
1.63	Psychological interventions for the prevention of postnatal depression	Pregnant women	5 years	$14.6m	$23.3m
1.56	School based interventions for bullying prevention	School students aged 8-11 years	10 years	$66.8m	$103.9m
1.19	School based psychological interventions to prevent depression in young people	School students aged 11-17 years	10 years	$31.1m	$37.1m

Conclusion

The relationship between social determinants and mental health is dynamic and complex. As such, the effects of social determinants on mental health and wellbeing should not, and cannot, be addressed by mental health interventions alone. Although mental health interventions are critical, they are not sufficient to counter the significant influence of social determinants of mental health and suicide.

Mental health policy and program development in Australia needs to move to a coordinated approach that addresses whole-of-life needs. Part of this approach is to invest in early intervention and prevention policies, which are key to preventing mental illness later in life. Currently, the responsibility for mental health-related policies and programs is dispersed across different government departments and policy areas.

The NMHC welcomes the Productivity Commission inquiry into the social and economic benefits of improving mental health, which looks beyond the health system and at the social determinants of mental health. The inquiry also presents a significant opportunity to fundamentally change the way governments approach mental health.

To ensure that mental health investment is effective and appropriately targeted, governments need to better understand current levels of expenditure including how much is spent, what it is spent on, and how well it is working. Monitoring and reporting are essential to evaluate the outcomes of mental health expenditure, and to ensure that future investments are evidence based.

The NMHC supports a broad approach to estimating mental health expenditure, which goes beyond the health system and includes expenditure in other systems (for example, disability, education, and employment).

Recommendation 9: Subject to the findings of the Productivity Commission inquiry into the social and economic benefits of improving mental health, the Australian Government considers the role of a central government agency to coordinate a whole-of-government approach to mental health policy.

Recommendation 10: Subject to the findings of the Productivity Commission inquiry into the social and economic benefits of improving mental health, the Australian Government considers the role of an independent statutory body to monitor and evaluate mental health policy outcomes. This includes the current levels of expenditure on mental health and whether investment in mental health is effective, efficient and informed by evidence-based policy.

Key mental health and suicide prevention reforms

Section 3

Chapter 1:
Primary Health Networks

Primary Health Networks (PHNs) were established in 2015 by the Australian Government to plan and commission medical and health services within defined regional populations. This includes identifying and addressing gaps in primary health care in collaboration with relevant stakeholders (especially Local Health Networks (LHNs)).

PHNs are required to undertake targeted work in seven priority areas – one of which is mental health (Box 10)[94] – and are a key part of the architecture supporting a regionally driven approach to mental health and suicide prevention services.

Initially funded to deliver local primary health care services based on local needs, and to improve the coordination, efficiency and effectiveness of health services, the PHN Program has expanded significantly since it commenced.[95] Over the past four years, PHNs have been given the added responsibility of contributing to key reforms such as the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), and have received funding to deliver new activities in suicide prevention (through suicide prevention trial sites), youth services (through additional headspace centres) and commission services to support people ineligible for the National Disability Insurance Scheme (NDIS).

The requirement to simultaneously manage a range of program areas undergoing reform has added to the complexity of the task for PHNs.

The ongoing investment in, and expansion of, the PHN Program reflects the confidence of the Australian Government in the capability of PHNs to deliver improved mental health services in their regions.

However, as relatively new organisations, PHNs are faced with tight timelines, high expectations and a rapidly evolving scope, and they must be sufficiently supported to achieve the PHN Program's objectives.[95]

Box 10: Primary Health Network Program objectives and priority areas

The Primary Health Network (PHN) Program has two objectives, to:

- increase the efficiency and effectiveness of medical services, particularly for patients at risk of poor health outcomes
- improve coordination of care to ensure patients receive the right care, in the right place, at the right time.

Although the 31 individual PHNs are responsible for identifying and addressing the primary health needs in their region, priority areas have been identified to guide PHNs.

The seven priority areas are:

- mental health
- Aboriginal and Torres Strait Islander health
- population health
- workforce
- digital health
- aged care
- alcohol and other drugs.[95]

What has happened since National Report 2018?

To understand whether PHNs are fit-for-purpose and achieving their objectives, two separate evaluations were undertaken to determine their effectiveness (Box 11). This included the Evaluation of the PHN Program[95], commissioned by the Australian Government, and a report prepared by the PHN Advisory Panel on Mental Health (PHN Advisory Panel Report)[96]. The PHN Advisory Panel also developed the *Reform and System Transformation: A Five Year Horizon for PHNs* (The Five Year Horizon), which outlines enablers for the progress of the PHN Program.[97]

At the time of reporting, the Australian Government has not publicly responded to the 17 recommendations made in the PHN Advisory Panel Report or to the Five Year Horizon. The NMHC recommends that the Australian Government respond to the PHN Advisory Panel Report recommendations. The NMHC also recommends that the Australian Government endorse the implementation of the Five Year Horizon for PHNs (which includes progress indicators and actions for PHNs) and details how it will report on its implementation. In December 2018, a report by the Senate Inquiry into the accessibility and quality of mental health services in rural and remote Australia (Rural and Remote Senate Inquiry Report[98]) also made a number of findings and subsequent recommendations that are relevant to PHNs (Box 11).

Consistent findings across the Evaluation of the PHN Program, the PHN Advisory Panel Report and the Rural and Remote Senate Inquiry Report included the variation across PHNs in their levels of engagement with Aboriginal Community Controlled Health Services (ACCHS), and the significant impact of short-term funding cycles in commissioning local services with the community sector.[95,96,98]

The Evaluation of the PHN Program and the PHN Advisory Panel Report also reported significant variability across PHNs in terms of their operational maturity and level of change readiness and change adoption. Despite this, the Evaluation of the PHN Program and PHN Advisory Panel Report both noted that all PHNs are endeavouring to deliver against challenging timelines, and are committed to transforming mental health services in their region.[95,96]

Box 11: Key developments for Primary Health Networks

Evaluation of the Primary Health Networks Program, final report, July 2018

Commissioned by the Australian Government Department of Health, the Evaluation of the Primary Health Networks Program[95] examined the effectiveness of the PHN Program. The Evaluation of the Primary Health Networks Program found that Primary Health Networks (PHNs) have a critical role in helping to deliver sustainable, integrated and safe primary health care in Australia and that the overarching program objectives are sound.

The Evaluation of the Primary Health Networks Program suggests that an ongoing priority for PHNs is improving engagement and ways of working with service providers. In addition, the Evaluation of the Primary Health Networks Program recommends further work across the health system to better educate stakeholders about PHN commissioning processes, as it is currently not well understood.

Report of the PHN Advisory Panel on Mental Health, September 2018

The PHN Advisory Panel on Mental Health was convened to provide advice to the Minister for Health in light of differing opinions about the progress of mental health reform being implemented through PHNs.

The resulting report (PHN Advisory Panel Report[96]) discusses the opportunities and challenges facing PHNs in implementing mental health reforms.

The PHN Advisory Panel Report found there were differing opinions on the opportunities and challenges associated with the current status of PHN mental health reform. These differing opinions were stated to be reflecting tensions inherent in the PHN model relating to regional autonomy versus national consistency, and evidence based services versus scope for innovation. The PHN Advisory Panel Report recommended a principles based approach be applied to guide PHNs in determining the appropriate balance in their region.

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The PHN Advisory Panel also developed a strategic document, *Reform and System Transformation: A Five Year Horizon for PHNs* (The Five Year Horizon[97]). The Five Year Horizon articulates the key functions expected of PHNs in their role as regional commissioners and system integrators for mental health services. It also provides progress indicators and actions for PHNs, and other stakeholders, to support the achievement of better outcomes for mental health consumers.

Senate Inquiry into the accessibility and quality of mental health services in rural and remote Australia

In 2018, the Senate referred an inquiry into the accessibility and quality of mental health services in rural and remote Australia to the Senate Community Affairs References Committee. The Senate Community Affairs References Committee released its report on 4 December 2018 and made 18 recommendations that seek to address the barriers to accessing quality mental health services for people living in rural and remote communities.[98]

The recommendations focused on placing the community at the centre of service design, funding services appropriately, strengthening the strategic framework for Aboriginal and Torres Strait Islander mental health, supporting the rural and remote workforce and reducing stigma.

The Australian Government responded to the Rural and Remote Senate Inquiry Report in April 2019 supporting, or supporting the intent of, 15 of the recommendations made.[99]

Primary Health Network Mental Health Lead Site Project Evaluation

The Australian Government has funded the University of Melbourne to conduct an evaluation that involves gathering information about the approaches taken by PHN Lead Sites to five focus areas:

- regional planning and service integration
- stepped care
- low intensity services
- services for youth with, or at risk of, severe mental illness
- clinical care coordination for adults with severe and complex mental illness.

The evaluation commenced in 2017 and will help to inform future government decisions and the activities of PHNs more generally. There are two parts to the evaluation:

- Part A relates to the first four focus areas. Final results were scheduled to be submitted to the Australian Government in July 2019.
- Part B is a randomised control trial that is testing a new approach to helping people find support that works for them. Final results for Part B are due in July 2020.[100]

Additional funding for mental health

Since July 2018, PHNs have received additional funding for mental health-related services, including:

- $1.45 billion over three years (from July 2019 to 2021–22) to strengthen mental health services and support job security[101]
- $45 million per year for three years (from 2019–20 to 2021–22) for alcohol and other drug treatment services, that will provide additional stability for services to meet the needs of local communities[102]
- In addition to the $80 million over four years for the National Psychosocial Support measure (starting from 2017–18), the Australian Government announced $121.29 million over 12 months to support the transition of Commonwealth community mental health clients to the National Disability Insurance Scheme[103]
- $14.4 million over four years for additional mental health support initiatives for farmers and communities to help people deal with the uncertainty, stress and anxiety of drought conditions[99]
- $24.4 million over two years through the Empowering our Communities initiative for small to medium community groups and organisations to provide free group activities to reduce the stigma associated with mental illness in nine drought affected communities.[99]

What is the current situation?

Governance

As independent organisations, PHNs are not currently governed by any overarching structure and are responsible for their own governance arrangements. The role of the Australian Government Department of Health is to provide funding and contract oversight, and to act as a capacity builder for PHN networks. The Australian Government Department of Health is also required to provide guidance to support PHNs to achieve the program objectives. Multiple reports, however, have found that this guidance has often lagged behind the changes announced by the Australian Government to the PHNs' scope of work, which has impacted PHNs ability to progress work in these areas.[95,96]

The PHN Advisory Panel Report noted that stakeholders had suggested that the Australian Government Department of Health's role in governance and contract oversight is not compatible with its role as a capacity builder for PHNs.[96]

An entity that oversees PHNs on a national scale could address this apparent need for independent support and capacity building, separate from the Australian Government Department of Health.

Establishing such an entity to coordinate consistent communication with PHNs and assist with building capability may ease the administrative burden and strengthen the performance of PHNs.

The NMHC recommends that, in consultation with PHNs, the Australian Government establishes an overarching entity to govern, support and build PHN capacity on a national scale. With funding, this entity could:

- formally facilitate information and data sharing between PHNs
- gather expertise from across the sector to influence the way the Australian Government Department of Health manages PHNs on behalf of the Australian Government
- act as a conduit between the Australian Government Department of Health and PHNs to facilitate consistent communication and change management
- engage with existing clinical and professional bodies to conduct evaluation and dissemination of good practice among PHNs.

Individual autonomy is essential for PHNs to provide services to meet the needs of their local communities.

However, PHNs are also required to carry out reform in national priority areas. The NMHC suggests that an overarching PHN entity could provide assistance to balance these two areas across the PHN Program.

When considering additional governance, it is important to ensure that the administrative burden for PHNs and stakeholders is minimised to enable PHNs to continue to meet their objectives.

Performance

Ongoing monitoring and evaluation of PHN performance is essential in order to determine whether PHNs are effectively meeting their objectives.

It is also fundamental to inform future commissioning decisions and to ensure a transparent, accountable approach. Historically, however, monitoring has been hampered by a range of factors, including:

- lack of objective criteria against which to reliably measure performance
- limited availability of public information on PHN performance, which limits transparency and accountability
- the challenge of transitioning from activity-based to outcome-based performance management.[95,96]

To provide a structure for monitoring PHNs' individual performance and progress towards achieving their outcomes, the PHN Performance Framework was introduced in 2016. A key limitation of the PHN Performance Framework was its inflexibility in the face of the rapid expansion of PHNs' scope of work. The PHN Performance Framework was unable to incorporate new program areas as they were added to the PHNs' scope of work. This resulted in inconsistent and fragmented reporting progresses and additional mechanisms were needed to monitor program areas not covered by the framework.[95]

To address the limitations of the PHN Performance Framework, a revised version was introduced in July 2018.

The PHN Performance and Quality Framework provides a structure for monitoring PHN performance under all funding schedules of the PHN Program.[94,95]

The revised framework also incorporates a two yearly review process aimed at ensuring that the outcomes and indicators defined in the framework remain relevant and fit-for-purpose. Assessments made under this framework however, are not yet publicly available.

The framework provides a mechanism for the Australian Government to monitor and evaluate how effective PHNs (both individually and as a program) are at delivering their outcomes and meeting the needs of their regions. The NMHC is aware that a report on the performance of the PHN Program will be released in late 2019 under the new PHN Performance and Quality Framework. To measure performance of the PHN Program over time, the NMHC recommends that this report include baseline data about how the PHN Program is meeting outcomes under the PHN Performance and Quality Framework.

Regional planning

PHNs are required to periodically assess the mental health and suicide prevention needs of their region, and to commission services in alignment with a stepped care approach.[97] This is known as 'regional planning'. Regional planning is essential to identify and provide appropriate services that cater to the needs of the local community.

Strong regional partnerships are needed to facilitate and develop regional needs assessments and plans.

Co-design with consumers and carers is essential (Box 12), as is engaging with LHNs and other service providers. Effective regional planning aims to create a service delivery system that is easier for consumers and carers to navigate, and that works in a coordinated way to holistically meet the needs of consumers.[35]

Under the Fifth Plan, PHNs and LHNs are required to work together to develop joint regional and mental health and suicide prevention plans, to achieve integrated regional planning and service delivery.[35]

Box 12: Consumer and carer engagement

Consumer and carer participation is a key component of the Australian Government's policy relating to Primary Health Networks (PHNs). It includes an expectation that consumer and carer co-design will be embedded in all aspects of the commissioning cycle.

The PHN Mental Health Lived Experience Engagement Network (MHLEEN) has been established to enhance the work of PHNs in engaging with consumers and carers, including through co-design processes.

MHLEEN has led several initiatives to support and document the strategies currently being used by PHNs to engage with consumers and carers, and to share good practice among PHNs. These initiatives include:

- networking via regular virtual and face-to-face meetings
- circulating news, updates and resources for MHLEEN members
- attending and presenting at forums such as national PHN Stepped Care Workshops and the Mental Health Reform Stakeholder Group
- close liaison with the Australian Government Department of Health
- a stocktake report and collection of case studies of lived experience engagement activities across PHNs.

In June 2018, the Australian Government Department of Health extended funding for MHLEEN to continue and expand its activities for a further three years.

PHNs have made progress in developing partnerships with LHNs to facilitate integration of services across their regions. However, these partnerships have not yet been systematically embedded throughout the PHN Program. According to the Evaluation of the PHN Program and PHN Advisory Panel Report, PHNs need to develop additional strategies to solidify partnerships and gain support from regional stakeholders in order to successfully integrate services.[95,96] The first implementation progress report on the Fifth Plan found that PHNs are experiencing various challenges in developing these shared plans. These challenges include:

- considering the diversity across health care types and their existing strategies
- managing the competing priorities across stakeholders
- balancing the disparities in consumer types within the region
- the lack of dedicated funding to implement this Fifth Plan action.[32]

In addition to their work with LHNs, PHNs need to engage with a wide range of stakeholders as part of their regional planning.

PHNs continue to face challenges in integrating with other stakeholder groups in clinical mental health services, as well as other relevant health and social services.

The PHN Advisory Panel Report noted that the varied nature of funding and reporting structures across different areas was a key barrier to achieving such integration.[96] To address this, it has been recommended that PHNs engage with a wider range of stakeholders and programs, and that the PHN Program objectives are broadened beyond medical services to include all health services.[95,96]

PHNs have made some progress in developing partnerships with LHNs to inform their regional planning, but further work is required to solidify these relationships and engage with other stakeholders. The NMHC will continue to monitor the regional planning activities of PHNs through its annual Fifth Plan implementation progress reports.

To appropriately plan services based on a thorough understanding of regional needs, PHNs need access to mental health data from local, state and territory, and national sources.

Data can be used to inform gap analyses between existing and required services to ensure that regional planning meets the needs of the local community (Box 13).

Box 13: National Mental Health Service Planning Framework – Planning Support Tool

The National Mental Health Service Planning Framework – Planning Support Tool (NMHSPF – PST) is an evidence-based planning tool designed to help plan, coordinate and resource mental health services to meet population needs.[104]

The NMHSPF – PST can assist Primary Health Networks (PHNs) regional planning by estimating the resources required in their local area to meet the needs of consumers and carers. The NMHSPF – PST alone cannot currently be used to conduct a gap analysis between existing and required resources, as there is no dataset of existing resources that is comparable with the estimates produced by the NMHSPF – PST.

The NMHC is currently working with the University of Queensland to establish a process to transform existing data into a format that can be compared with NMHSPF – PST resource estimates.

This project will assist PHNs to regionally plan, by increasing the utility of available data.

These data sets will enable effective planning and commissioning practices, and allow PHNs to identify gaps and target at risk populations. Although some PHNs have had success in establishing data sharing protocols and agreements, access to relevant regional and local data remains a challenge for many APHNs.[95,96]

Funding model

In January 2019, the Australian Government announced a new PHN funding model aimed at providing greater certainty and allowing for longer-term planning. Under this new model PHN funding for mental health services was extended for three years from July 2019 until 30 June 2022. PHNs that meet agreed performance criteria under the PHN Program Performance and Quality Framework will receive an additional 12 months funding on an annual basis.

The shift to a longer-term funding model for PHNs is a welcome development. The short-term funding cycles used previously limited the capacity of PHNs to develop the stakeholder relationships necessary for effective planning and commissioning.[32,96]

Short-term contracts also led to heightened funding uncertainty for service providers, and presented challenges for service providers in rural and remote areas in particular, who already experience difficulties in attracting and retaining staff.[32,95,98]

The aim of longer-term funding cycles is to improve regional planning and align PHN funding arrangements with those of LHNs. Longer funding cycles that lead to longer contracts for services commissioned by PHNs will also help to ensure funding certainty for service providers, and allow time to demonstrate outcomes and develop long-term solutions.

In 2018, the PHN Advisory Panel Report recommended that PHNs be provided with contract certainty of five years as a matter of priority.[96] In the same year, the Rural and Remote Senate Inquiry Report recommended that governments develop longer minimum contract lengths for commissioned mental health services in regional, rural and remote locations.[98] In addition, the Rural and Remote Senate Inquiry Report recommended that governments develop policies to allow mental health service contracts to be extended where service providers can demonstrate the efficacy and suitability of the services provided, as well as a genuine connection to the local community.[98]

Although the Australian Government has extended the funding cycle for PHNs, the NMHC notes that there is no mechanism to ensure that PHNs pass on these longer funding cycles to the service providers they commission to provide services.

The NMHC has already heard of instances where service providers are not benefiting from the longer-term funding cycle recently afforded to PHNs. The NMHC recommends that the Australian Government encourages PHNs to:

- extend contracts with existing service providers that can demonstrate efficacy and suitability in providing services in their region
- where feasible, enter into longer-term contracts when commissioning services with new providers.

Aboriginal and Torres Strait Islander mental health

Working to improve the health of Aboriginal and Torres Strait Islander people is a priority area for PHNs.

To ensure that mental health and suicide prevention services are culturally appropriate and meet the needs of Aboriginal and Torres Strait Islander people in the region, PHNs should engage with these communities to co-design regional services.

PHNs recognise the importance of working in partnership with ACCHS and Aboriginal Medical Services (AMSs) in their region (Box 14), and some have developed proactive engagement and strong partnerships with stakeholders.[95,96] Some of the achievements reported by PHNs include successfully engaging in a co-design process to develop support services, and introducing dedicated positions for Aboriginal and Torres Strait Islander people in mental health services.[32]

Box 14: Aboriginal Community Controlled Health Services

Aboriginal Community Controlled Health Services (ACCHS) and Aboriginal Medical Services (AMSs) are primary healthcare services initiated and operated by the local Aboriginal and Torres Strait Islander community to deliver holistic, comprehensive and culturally appropriate health care to the community that controls the service, through a locally elected board of management.[105]

These Indigenous organisations deliver a range of clinical and allied health services and are also involved in community development and health promotion. Aboriginal and Torres Strait Islander people own, operate and oversee their community health services. ACCHS and AMSs are examples of Indigenous self-determination in practice, giving Aboriginal and Torres Strait Islander people a say in what their health services do and how they do it.[106]

The Fifth Plan 2018 progress report found that the development of partnerships with Aboriginal and Torres Strait Islander communities remains a work in progress for many PHNs.[32] Despite acknowledging the importance of these partnerships, PHNs report that the time and resources required to genuinely consult and engage with Aboriginal and Torres Strait Islander communities are critical barriers to building strong and meaningful relationships.[32]

Concerns regarding PHNs' engagement with Aboriginal and Torres Strait Islander communities relate to:

- the degree to which PHNs consult and engage with stakeholders from Aboriginal and Torres Strait Islander communities (including ACCHS and AMSs)
- the ability of PHNs to understand where targeted investment has already been made in Aboriginal and Torres Strait Islander health services, and their capacity to commission effective and culturally appropriate services
- the impact on ACCHS and AMSs if PHNs do not involve these services early in the commissioning process.[95]

The 2018 Senate Inquiry into accessibility and quality of mental health services in rural and remote Australia heard that, in spite of clear evidence demonstrating ACCHS as the preferred model of health service delivery for Aboriginal and Torres Strait Islander people, only a limited number of PHNs have worked towards establishing official partnerships.[98] Of concern to the Senate Inquiry were reports of ACCHS facing funding difficulties as PHNs frequently commission non-local organisations to deliver services. These non-local organisations would then seek to sub-contract portions of the work to local ACCHS as a junior partner with limited, if any, input into service design.

To address this issue, the PHN Advisory Panel Report recommended that PHN funds for mental health and suicide prevention for Aboriginal and Torres Strait Islander people should be provided directly to ACCHS as a priority, unless a better arrangement can be demonstrated.[96] The Rural and Remote Senate Inquiry Report also recommended that services commissioned by PHNs be delivered by, or in genuine long-term partnership with, ACCHS and Aboriginal and Torres Strait Islander community organisations.[98] The Australian Government has supported this recommendation.[99]

Effective engagement and partnerships with Aboriginal and Torres Strait Islander people are critical to establishing responsive, culturally appropriate mental health services for these communities.

Research conducted by the Lowitja Institute for the NMHC highlighted the particular strengths of ACCHS in addressing the mental health needs of Aboriginal and Torres Strait Islander communities, such as their capacity to build trust and cultural credibility among clients and the local community.[107]

The NMHC supports the recommendations made in the PHN Advisory Panel Report and the Rural and Remote Senate Inquiry Report and recommends that the Australian Government encourages PHNs to position ACCHS as preferred providers for mental health and suicide prevention services for Aboriginal and Torres Strait Islander people. The NMHC also supports the guidance outlined in the Five Year

Horizon, which includes strategies on how to achieve the best outcomes for Aboriginal and Torres Strait Islander people through co-design and collaboration.

Conclusion

The significant public funding provided to PHNs to contribute to key mental health and suicide prevention reforms highlights their important role in improving the mental health of Australians. As relatively new organisations, PHNs are faced with tight timeframes, high expectations and a rapidly expanding scope of work.

Two separate reviews of PHNs have been undertaken in the past 12 months to evaluate their effectiveness. This included an Evaluation of the PHN Program commissioned by the Australian Government, and a report prepared by the PHN Advisory Panel on Mental Health.

The PHN Advisory Panel also released the Five Year Horizon, which outlines enablers for the progress of the PHN Program.

To address the increasing expectations placed on PHNs as the PHN Program expands, there is a need for support and guidance for PHNs. To provide this support and guidance the NMHC recommends that, in consultation with PHNs, the Australian Government establishes an overarching entity to govern, support and build PHN capacity on a national scale.

Improvements have been made to support PHNs in achieving their outcomes. These include the introduction of a new PHN Performance and Quality Framework and an extended funding model for PHNs. These changes are positive steps. The NMHC would like to see PHNs enter into longer-term contracts with service providers (where feasible) so that service providers can also benefit from the longer-term funding certainty. The Australian Government should include data on how PHNs are performing under the PHN Performance and Quality Framework in the report, expected to be released by the end of 2019.

For some PHNs, engaging with ACCHS and AMS remains a work in progress. PHNs should continue to work on formalising partnerships with these Aboriginal and Torres Strait Islander organisations as a matter of priority.

Recommendation 11: In consultation with PHNs, the Australian Government establishes an overarching entity to govern, support and build PHN capacity on a national scale.

Recommendation 12: The Australian Government responds fully to the 17 recommendations in the PHN Advisory Panel Final Report.

Recommendation 13: The Australian Government endorses the implementation of the Five Year Horizon for PHNs and details how it will publicly report on its implementation.

Recommendation 14: The report on the performance of the PHN Program to be released by the Australian Government includes baseline data about how the PHN Program is meeting outcomes under the PHN Performance and Quality Framework.

Recommendation 15: The Australian Government encourages PHNs to extend contracts with existing service providers who can demonstrate efficacy and suitability in providing services in their region; and where feasible, enter into longer-term contracts when commissioning services with new providers.

Recommendation 16: The Australian Government encourages PHNs to position Aboriginal and Community Controlled Health Services as preferred providers for mental health and suicide prevention services for Aboriginal and Torres Strait Islander people.

Chapter 2:
National Disability Insurance Scheme

There are now more than 25,000 people with psychosocial disability accessing and receiving support through the National Disability Insurance Scheme (NDIS).[108]

The NDIS was never intended to replace community mental health services or reduce the responsibility of other systems to respond to the needs of people with mental illness (Box 15).[109] There is increasing evidence that the reform is changing the way in which psychosocial support is accessed and provided. Specifically, implementation of the NDIS is impacting the psychosocial disability workforce, the type of support available and the quality of support provided.[110]

As the NDIS moves to full national implementation, more people are being affected by these changes.

It is important that all people with psychosocial disability continue to have access to the support needed to live a contributing life, regardless of whether or not they are participating in the scheme.

In recognition of this, the National Disability Insurance Agency (NDIA) is working with governments and the mental health sector to improve the experiences of NDIS participants, and the Australian Government and state and territory governments have committed funding to provide support for those not eligible for the scheme.[111]

What has happened since National Report 2018?

The NDIS is available across all regions in Australia, except parts of Western Australia which started transitioning into the scheme from 1 July 2019.[108]

As at 30 June 2019, there were 298,816 participants in the NDIS. Of these, 16,417 (6%) identified as Aboriginal and Torres Strait Islander and 24,023 (8%) identified as being from culturally and linguistically diverse backgrounds.[108]

The number of people accessing the scheme has increased each quarter. An additional 11,710 people with a psychosocial disability have accessed the NDIS since 30 June 2018.[108] This means that 46% of all NDIS participants with a psychosocial disability, gained access to and commenced the scheme between 1 July 2018 and 30 June 2019. Possible factors influencing this increase in new participants include the increased availability of the scheme, and the implementation of the streamlined transition process for Commonwealth community mental health program clients.

The NMHC has continued to engage with states and territories, key government agencies, and representatives from the mental health sector to better understand the local and national impact of the NDIS transition on mental health systems. Significant NDIS activities since October 2018 include the progressive rollout of the psychosocial disability service stream and complex support needs pathway, ongoing work by the Joint Standing Committee on the NDIS, a 12 month funding extension to support Commonwealth community mental health program clients' transition into the scheme, and an increase in the pricing for therapy, attendant care and community participation under the NDIS (Box 16).[118-120]

Box 15: About the National Disability Insurance Scheme and psychosocial disability

What is the National Disability Insurance Scheme?

The National Disability Insurance Scheme (NDIS) provides people (aged under 65) who have a permanent and significant disability with funding for supports and services based on their individual needs.

The scheme is designed to provide participants with choice and control over the services they need, and the certainty of lifetime support.[112]

How does the National Disability Insurance Scheme work?

The NDIS is administered by the National Disability Insurance Agency.

NDIS participants have an individual plan that lists their goals and the funding they have received. This funding is used to purchase supports and services that will help them to achieve their goals.[113]

The NDIS does not replace support that is available in other systems such as health, education, justice, employment and housing.

The NDIS helps connect all people with a disability (including people who are not eligible for the scheme), their family and carers to community and other government services.[114]

The NDIS also provides funding for information, linkages and capacity building for people with disability in the community.[115]

What is psychosocial disability?

Psychosocial disability refers to disability arising from a mental illness. It can be severe, longstanding and impact a person's recovery.

In the context of the NDIS, recovery is defined as achieving an optimal state of personal, social and emotional wellbeing, as defined by each individual, while living with or recovering from a mental illness.[116]

What is psychosocial support?

Psychosocial support is provided to enable people to live or remain in the community as opposed to clinical treatment or medication. Psychosocial support can refer to support provided by non-clinical but trained mental health workers and peer workers, as one-on-one support or in groups. This type of support may be considered within the range of supports offered in an NDIS plan.[117]

How does the National Disability Insurance Scheme work for participants with psychosocial disability?

The NDIS provides funding for supports that assist people with a psychosocial disability to live an ordinary life, including funding for assistance with planning decisions, household tasks, capacity building, participating in recreation, education, training and employment activities.

The NDIS does not fund supports that the health or mental health system is responsible for, such as medical and clinical services, and medication and pharmaceuticals.

Box 16: National Disability Insurance Scheme and psychosocial disability – summary of key activities since National Report 2018

Key reports

- The National Disability Insurance Agency (NDIA) released the Council of Australian Government Disability Reform Council 2nd, 3rd, and 4th quarterly reports.[108,121,122]
- The Joint Standing Committee on the National Disability Insurance Scheme (NDIS) held a roundtable on 26 February 2019 with representatives from the mental health sector to review progress of recommendations from its 2017 inquiry into the provision of services under the NDIS for people with psychosocial disability.[123] A final progress report with further recommendations relating to psychosocial disability was released on 29 March 2019.[110]

Improving National Disability Insurance Scheme participant experiences

- The psychosocial disability service stream and complex support needs pathway were implemented from 30 November 2018 in specific locations in Tasmania, South Australia, Victoria and New South Wales.[121]
- The NDIA has completed foundational psychosocial disability training for planners and Local Area Coordinators in June 2019. All new staff will complete this training as part of their standard induction training.[108]
- Streamlined access for people with psychosocial disability from state programs became available in all states and territories from 30 April 2019.[108]

Continuity of Support

- The National Psychosocial Support measure became available on 1 January 2019.[122]
- The Australian Government is funding Primary Health Networks (PHNs) to commission services to provide an additional 12 months of support (up to June 2020) for clients transitioning from Commonwealth community mental health programs.[103]
- PHNs received guidance in March 2019 for implementing the Continuity of Support measure and have started to commission services to support clients under the measure. Continuity of Support commenced on 1 July 2019.

Market and pricing

- The Australian Government announced an increase in price limits for therapy, attendant care and community participation under the NDIS, effective from 1 July 2019.[124]
- The NDIA and Australian Government Department of Social Services have commissioned the NDIS Thin Markets Project, which aims to develop a framework for dealing with thin markets.[125]
- The NDIS Quality and Safeguards Commission is available in all states, other than Western Australia, from 1 July 2019. The NDIS Quality and Safeguards Commission is responsible for regulating the NDIS market, supporting the resolution of complaints, and promoting the NDIS principles of choice and control by empowering participants to exercise their rights as informed consumers.[126]
- The NDIA released an updated *NDIS Price Guide and Support Catalogue 2019–20,* effective 1 July 2019.[120]

What is the current situation?

The NDIS is the first of its kind, both internationally and in magnitude. What the NDIA has achieved so far to implement this scheme and to build capability in the workforce is noteworthy and should not be underestimated. The NDIS is working for many and almost 100,000 participants have received supports for the first time.[108] The NDIA has increased collaboration with stakeholders, and representatives from both government and the mental health sector report that this engagement has been positive in building relationships.[110] Overall, progress has been made to ensure that people with psychosocial disability are supported through all phases of the scheme, from access request to application, planning and plan review. However, recent evidence suggests that although much has been achieved, there is still work to do to improve the experiences of participants with a psychosocial disability who engage with the NDIS.[108,110,121]

NDIS participants with a psychosocial disability

At 30 June 2019, there were 25,192 NDIS participants with a psychosocial disability as their primary disability.[108] This accounts for 9% of all NDIS participants but remains lower than the estimated 64,000 (14%) people with psychosocial disability at full scheme roll out.[109]

Other than in Tasmania and South Australia, the proportion of people with psychosocial disability has remained relatively stable since 30 June 2018 (Table 7). The increase in South Australia (from 1% in June 2018 to 4% in June 2019) and Tasmania (from 2% in June 2018 to 5% in June 2019) reflects the progressive rollout of the NDIS in both states – where the scheme was rolled out by age instead of by location. South Australia and Tasmania were also the first jurisdictions to commence the NDIA's streamlined access for participants and for NDIA staff to receive foundational training in psychosocial disability.[108,122]

An average of $63,000 has been committed in plan supports for people with psychosocial disability (Table 7), but there is currently no publicly available data about how participants with psychosocial disability use their funding. The NMHC has heard that plan utilisation is an issue. Specifically, participants with psychosocial disability are less likely to use their plans because they may not understand how to get access or support, or they receive insufficient support to access services.[123] Because data about why, how and when participants with psychosocial disability use their funding is not published, it is difficult to determine the main drivers of plan utilisation for NDIS participants with a psychosocial disability.

The nature of severe and complex mental illness means that people with psychosocial disability experience additional barriers to accessing and implementing NDIS plans. To address this, the NDIA has progressed several initiatives that aim to improve the experience of people with psychosocial disability as they transition into the scheme, including psychosocial disability training for NDIA staff, and providing streamlined access for state and territory psychosocial program participants.[108]

Table 7: NDIS participants with psychosocial disability and average funding in plans, as at 30 June 2019

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number	8,068	9,666	3,837	1,086	1,183	343	867	142	25,192
Per cent	8%	13%	8%	7%	4%	5%	12%	6%	9%
Average amount of funding	$75,000	$44,000	$86,000	$40,000	$64,000	$76,000	$65,000	$155,000	$63,000

Source: National Disability Insurance Agency, COAG Disability Reform Council quarterly report, 30 June 2019.
Note: Funding in plans refers to the average annual committed support.

Improving NDIS participant experiences for people with psychosocial disability

Two initiatives that will impact on people with a psychosocial disability engaging with the scheme are the complex support needs pathway and the psychosocial disability service stream (Table 8). The NMHC has previously noted that the timely implementation of proposed changes to the NDIS is key to improving participants' experience of the scheme.[109] There has been some progress, but the complex support needs pathway is still being rolled out. The NDIA has reported that the quality and timeliness of records, and problems with ICT systems has impacted and delayed the rollout of new participant pathways.[108]

The NMHC has heard from jurisdictions that the complex support needs pathway program and psychosocial disability service stream are working to improve the participant experience for people who have accessed these pathways, including providing faster decision making and approvals.

Participants not accessing the pathways were more likely to be subjected to inconsistent decisions and continue to face delays in accessing plans. The complex support needs pathway began expanding to all states and territories in March 2019.[108] The NDIA reported in June 2019 that service improvements to the psychosocial disability service stream have occurred. These improvements include working with Mental Health Australia, focusing on pre-access and streamlining access, and rolling out training for NDIA staff and partners.[108]

There are benefits to understanding learnings from the complex support pathway and psychosocial disability service stream as they are rolled out and how this information will be used to improve participant experiences.

The NMHC recommends that the NDIA publishes information about outcomes of the complex support pathway and psychosocial disability service stream as these improvements are rolled out and any learnings identified to improve participant experiences.

The inquiry of the Joint Standing Committee on the National Disability Insurance Scheme into general issues around the implementation and performance of the NDIS highlighted key issues affecting the experience of participants with a psychosocial disability.[127] Mental health sector representatives reported that inconsistencies in eligibility and planning outcomes were exacerbated by a lack of clarity around the eligibility criteria, an overreliance on diagnosis over functional needs within the assessment and planning process, and the absence of a validated assessment tool for planners.[110,123] Similar views have been echoed by state and territory representatives during consultations with the NMHC. All jurisdictions identified gaps in the NDIS meeting participants' needs, particularly in relation to the planning process, which was

Table 8: Complex support needs pathway and the psychosocial disability service stream

Complex support needs pathway	Psychosocial disability service stream
Provides specialised support for participants who have additional significant challenges impacting their lives, and who have to access multiple services across systems.	Provides tailored support for NDIS participants with psychosocial disability, their families and carers.
Includes specialised planning teams, NDIS liaison and support coordinators.	Includes specialised planners and Local Area Coordinators who support participants' journey through all points of access with the NDIS.
Aims to help participants transition from government services, and develop plans or access supports that are appropriate to their specific needs.	Aims to enhance service by focusing on recovery-based planning and episodic needs, upskilling the NDIA workforce to better understand psychosocial disability, and developing information resources that will assist participants, providers and government services to support access to the NDIS and active participation in planning.

Source: National Disability Insurance Agency, COAG Disability Reform Council quarterly report, 31 March 2019.

commonly connected to a lack of understanding of psychosocial disability by the NDIA workforce.[128]

The NDIA is currently considering a number of improvements including the inclusion of recovery-orientated practice into the scheme, a stronger focus on an episodic approach to psychosocial disability, working with states and territories on an outreach and more connected-up approach, and linking people who are unsuccessful in their access requests on grounds of primary psychosocial disability to other sources of psychosocial and clinical support. The NMHC looks forward to seeing the details on how support and guidance can be provided to people with a psychosocial disability. This could include providing support to people before they access the NDIS and to help NDIS participants navigate the NDIS and other systems.

The NMHC understands that the NDIA is currently considering these recommendations as part of the NDIS psychosocial disability service stream. It is also important that the NDIA consider how people with psychosocial disability can receive support in their recovery journey and access services across systems.

Individuals with a psychosocial disability not engaging with the NDIS

There is growing concern about the transition rates of Commonwealth community mental health program clients into the NDIS, as they are lower than expected.

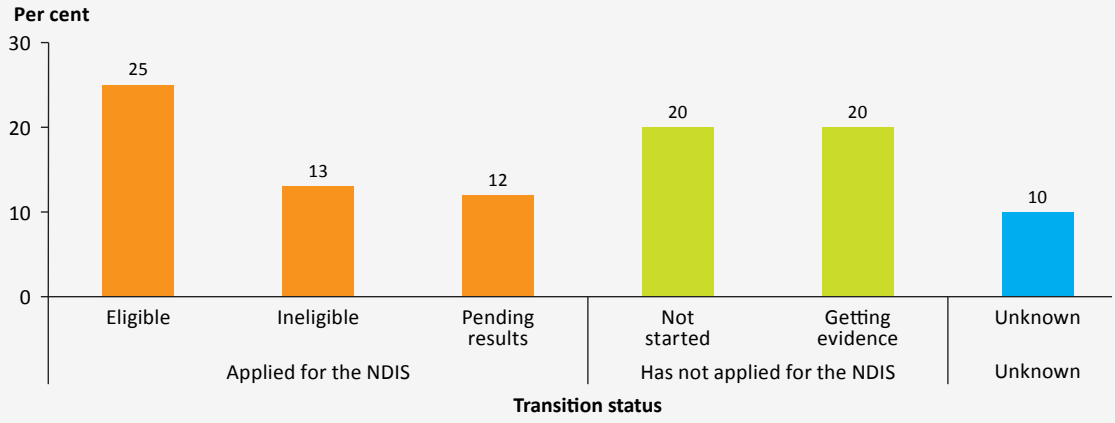
Consumers, carers and mental health sector representatives are concerned about the type and quality of support that people with psychosocial disability and their carers will receive once funding for programs cease.[123] The NMHC has heard that states and territories are concerned about emerging service gaps from Commonwealth community mental health programs, and the ability to meet demand for state funded community support services for a larger than anticipated group of people with psychosocial disability. The low transition rate appears to be driven by two key factors: the high proportion of current clients that are not engaging with the scheme, and the high proportion of clients that have been assessed as ineligible for the NDIS.

As part of the transition to the NDIS, people who currently access Commonwealth community mental health programs are contacted by the NDIA and invited to test their eligibility for the scheme.[129] Some people are unable to be contacted, while others decline to enter the scheme or withdraw from the NDIS access process. Understanding the number of individuals in this group and the reasons that they are not engaging will help the NDIA and service providers determine how people with a psychosocial disability can be encouraged to transition to the NDIS.

Findings from the Commonwealth Mental Health Programs Monitoring Project (Box 17) provide some insight into Commonwealth community mental health program clients not engaging with the NDIS. According to the most recent findings, half of all Commonwealth community mental health program clients had not applied for the NDIS because they were in the process of applying or had not yet applied, or because information about them was unknown (Figure 5).[130] The most frequently reported reasons for not applying for the NDIS were client distrust of the NDIS system, clients being too unwell, and clients being overwhelmed by the process of collecting evidence.[130]

The NMHC is aware that the NDIA has been working with key stakeholders to engage people in the scheme, including increased collaboration with states and territories and working with Mental Health Australia on how to better engage hard to reach clients. The NMHC acknowledges the efforts of the NDIA to help people transition into the NDIS, including extending the funding through Primary Health Networks (PHNs) for current Commonwealth community mental health program clients until June 2020 (Table 9). The NMHC welcomes the streamlined access for people with psychosocial disability which became available from 30 April 2019. The streamlined access process supports state and territory program clients who may be eligible, but who have not applied for the scheme. It is expected that an independent evaluation of the Tasmanian and South Australian sites for streamlined access will inform the future direction of the roll out of streamlined access across Australia.[108] The NMHC recommends that the NDIA publishes information about the evaluation outcomes for the streamlined access for people with psychosocial disability.

Figure 5: Commonwealth community mental health program clients, by current NDIS transition status



Source: Community Mental Health Programs Monitoring Project, Phase 2 Report.
Note: Unknown includes program clients that could not be contacted, had exited the program, or the program could not decipher the client's intention to apply.

Table 9: Summary of Primary Health Network funding for psychosocial support services

Program	Funding	Timeframe	Purpose
National Psychosocial Support (NPS) measure	$80m (with matched funding from states and territories)	Four years from 2017–18 to 2020–21.	Support for people who are not currently receiving support, and Commonwealth community mental health program clients who are yet to test eligibility for supports under the NDIS or who have not yet transitioned to the NDIS by 1 July 2019.
	$121.29m	12 months from 1 July 2019 – 30 June 2020	
Continuity of Support (CoS)	$109.8m	Ongoing from 1 July 2019	Support for Commonwealth community mental health program clients who are ineligible for support under the NDIS from 1 July 2019.
Interface	$19.1m	18 months from 2018–19 to 2019–20	For Primary Health Networks to commission services for Commonwealth community mental health clients under NPS and CoS, and to support the transition of clients.

Source: Table reproduced from Department of Health Fact Sheet for Primary Health Networks.

Box 17: Commonwealth Mental Health Programs Monitoring Project

The NMHC entered into a grant agreement in 2018 with Community Mental Health Australia (CMHA) for CMHA to monitor the transition of Commonwealth community support programs, including Personal Helpers and Mentors (PHaMs), Partners in Recovery (PIR) and Day to Day Living (D2DL), into the National Disability Insurance Scheme (NDIS).

The project is being conducted in partnership between CMHA and the University of Sydney.

The aim of the project is to monitor the transition, and to provide data for each state and territory on the number of people who are eligible for the NDIS from the PHaMs, PIR, and D2DL programs.

The project considers the NDIS transition rates and the numbers and experiences of Commonwealth community mental health program clients who may be eligible for the NDIS.

The project consists of three phases, each culminating in a quarterly report presenting transition data for that quarter. The Phase 1 report was released in December 2018, and the Phase 2 report was released in April 2019. The final release is expected towards the end of 2019.

A total of 31 organisations from all states and territories participated in the most recent (Phase 2) data collection, with data collected on over 8,000 individuals.[130]

Individuals with a psychosocial disability ineligible for the NDIS

The NDIA does not publish information about NDIS applicants with psychosocial disability that are found ineligible for the scheme. However, some information is available about current Commonwealth community mental health program clients from a Community Mental Health Australia project (Box 17). Of the 50% of current Commonwealth community mental health program clients that have applied for the NDIS, half have been found eligible, one-quarter have been found ineligible and the remaining quarter are awaiting an outcome (Figure 5).[130]

The Continuity of Support and National Psychosocial Support measures go some way to addressing the potential gaps in services for people who are not accessing the NDIS. Table 9 sets out the funding that has been provided to PHNs to commission services for people who are ineligible for the NDIS.[131]

The NMHC welcomes the additional funding under the National Psychosocial Support measure to support the transition of existing clients of Commonwealth community mental health programs until June 2020. However, this is less than the two year extension recommended by the Joint Standing Committee on the National Disability Insurance Scheme.110 Given the lower than expected transition rates, Commonwealth community mental health program clients' distrust of the NDIS, and the time it will take to see the effects of recent NDIA policy initiatives for people with psychosocial disability, it is likely that current clients will need more than an additional 12 months to transition into the NDIS.[130] The NMHC recommends that the Australian Government: extends support for Commonwealth community mental health program clients to at least June 2021; considers whether the funding available under the National Psychosocial Support and Continuity of Support measures matches the needs of people who are ineligible for the NDIS; and considers how funding and access to services for people ineligible for the NDIS can be simplified.

The NMHC has heard that states and territories will continue to provide support through state or territory funded programs for people with psychosocial disability who are ineligible for the NDIS. The NMHC understands that most states and territories have left in place their own psychosocial support programs or, in some cases, reinstated previous programs while people from these programs transition to the NDIS. The NMHC understands that future decisions about what funding and services are provided under state and territory programs will depend on how many people transition from these programs into the NDIS.

Access to services that focus on optimising mental health and support recovery will help to reduce the avoidable demand for mainstream health services, and reduce the burden on clinical mental health services and hospitals.[110] As the transition of existing clients from government funded programs to the NDIS occurs, all governments have a role in ensuring that people who are ineligible for the NDIS have access to appropriate psychosocial supports. The NMHC recommends that the Australian Government, with the state and territory governments ensure that people who are ineligible for the NDIS have access to adequate psychosocial support services.

NDIS market and provider of last resort

The nature of support required for people with psychosocial disability requires a stable and accessible market. There are two main issues that lead to thin markets (and potential market failure) for NDIS participants with a psychosocial disability – limited access to appropriate support, and a lack of providers, particularly in rural and remote regions of Australia.

Thin markets place pressure on the mental health system including increased pressure on both community and clinical mental health services. The NMHC has heard that pressures are impacting on service providers' ability to provide appropriate support, for example some community mental health providers are withdrawing or limiting their participation in the NDIS market.

The NDIA and the Australian Government have been working to address key market issues. However, further work is required to ensure continued support for participants with psychosocial disability who cannot access services as a result of insufficient market supply or because providers have failed to provide care.

Having a provider of last resort is an important safety net for NDIS participants whose needs cannot be addressed using existing provider options.

The NDIA has been working with states and territories to develop a provider of last resort policy, now known as the Maintain Critical Supports project. The NMHC is concerned by the continued lack of clarity and progress on this policy. In March 2019, the Joint Standing Committee on the National Disability Insurance Scheme noted that, although the NDIA is working on a number of actions, including piloting after hours crisis response arrangements, and working with the state and territory governments on the Maintaining Critical Supports policy, the committee's previous recommendation to release a policy on provider of last resort has not progressed.[110] People who have exhausted all options for care from existing providers need assurance of support. The NMHC recommends that the NDIA work with state and territory governments to progress the Maintain Critical Supports policy and release detail on what is happening with the policy.

Support coordination

Consumers must be able to make informed choices to participate in the NDIS. NDIS participants with psychosocial disability need help to navigate the NDIS, engage providers and navigate other mainstream systems. Participants need a single point of contact when something goes wrong – including when a provider decides to no longer provide them with a service.

Under the NDIS, support coordination is available to help participants implement their plan and access other supports outside the NDIS (Box 18).

Support coordination in the NDIS is delivered through registered providers. As at 30 June 2019, there were 2,240 providers registered to deliver support coordination in the NDIS, but only a quarter (27%) of these providers had been active at any stage during the life of the NDIS.[130] In terms of demand for support coordination, 42% of all active participants between March and June 2019 included support coordination in their plan. There is no recent publicly available data on the use of support coordination in NDIS plans for people with a psychosocial disability. Evidence provided to the Joint Standing Committee on the National Disability Insurance Scheme also highlighted that support coordination is commonly not being provided or adequately funded in plans.[123]

Support coordination for NDIS participants with psychosocial disability has the potential to drive improvements in case management and coordination for this cohort. However, such improvements are hampered by the low uptake of support coordination in NDIS plans for people with psychosocial disability. Consistent with recommendations by Mental Health Australia, the NMHC recommends that the NDIA include support coordination as a standard item in all plans for people with psychosocial disability.[135]

Box 18: What is support coordination?

Many National Disability Insurance Scheme (NDIS) participants need a range of supports, and make use of these supports to differing levels.[121] To help participants effectively use their supports, the NDIS provides assistance through an additional support called support coordination.[133] The aim of support coordination is to help participants incorporate other supports into their plan, including informal, mainstream, community and funded supports. There are three levels of support coordination:

1. **Support connection** helps develop a participant's ability to connect with their informal, community and funded supports.
2. **Support coordination** helps develop the skills necessary for participants to understand, implement and use their NDIS plan.
3. **Specialist support** coordination provides additional, targeted support to participants who require specialist support due to their high complexity situations and/or high levels of risk.[133]

Support coordination is not a standard inclusion in participant's plans.

While participants with more complex needs may receive additional help from support coordinators to implement their plans, all participants have access to Local Area Coordinators. Local Area Coordinators help participants at the initial stages to understand and access the NDIS, assist participants to prepare their plans, help participants begin implementation of their plans, provide ongoing advice, and carry out plan reviews. Local Area Coordinators also connect participants with informal, local community, and other supports external to the NDIS.[134]

Mental health system impacts

The implementation of the NDIS is having an impact on the mental health system. The NMHC has heard that participants are not getting the support they need. This lack of support is leading to deterioration of consumers' mental health and greater reliance on clinical mental health services, including increased presentations at emergency departments. The NMHC has also heard that delayed plans and plan reviews are resulting in delayed discharge from hospitals, with some delays of up to six months while people wait for plan reviews to be finalised. The Disability Reform Council has endorsed a National Hospital Discharge Action Plan aimed at reducing the number and length of stays in hospital experienced by NDIS participants.[108]

Mainstream services are also dedicating time and resources to assisting consumers through the NDIS application process. This increased support can help consumers access the NDIS and receive appropriate packages, but it also affects the time and resources that mainstream services can dedicate to their core function of clinical treatment and service provision.

Addressing system impacts of the NDIS begins with understanding how people with psychosocial disability engage with the scheme.

Data is an important part of building this knowledge and will enable jurisdictions to monitor participant outcomes and experiences, and address system issues to ensure adequate support for people with psychosocial disability.

Improving data transparency

The NDIA quarterly report to the Disability Reform Council is currently the primary source of information about NDIS participants with a psychosocial disability.[136] Although useful, the reports do not provide the level of detail required to understand the individual and system impacts of the NDIS for people with psychosocial disability.

Greater transparency and access to information about NDIS participants with psychosocial disability is essential, particularly in relation to:

- NDIS application, access and planning outcomes for people with psychosocial disability, including information about population groups, who is applying, who is eligible and not eligible, how long it takes to get access to the scheme, and the extent to which participants use their funding
- the transition of current mental health program clients into the NDIS
- the extent to which participants with a psychosocial disability are accessing and using support coordination.

The NMHC recommends that NDIA routinely publish data about participants with psychosocial disability including information about application, access and planning outcomes by population groups, eligible/ineligible status, plan utilisation, the extent of support coordination in plans, and current rates of expenditure on supports in plans.

Conclusion

The number of people with psychosocial disability who are accessing and receiving support through the NDIS continues to grow. However, people with a psychosocial disability need to be able to access the support they need to live a contributing life, regardless of whether they are participating in the NDIS. The NMHC welcomes the considerable efforts of the NDIA, governments and stakeholders to improve the experiences of NDIS participants and ensure continued support for those not accessing the scheme. The NDIS is working for many, especially for participants who are experiencing support for the first time. Overall, much progress has been made, but there is still work to do by all parties to improve participants' experiences, and to ensure that the NDIS and mental health systems are equipped to address the needs of people with psychosocial disability.

As the transition of existing clients from government funded programs to the NDIS occurs, all governments have a role in ensuring that people who are ineligible for the NDIS have access to appropriate psychosocial supports.

The NDIS is having an impact on the mental health system. Addressing system impacts of the NDIS begins with understanding how people with psychosocial disability engage with the scheme. Data is an important part of building this knowledge and will enable jurisdictions to monitor participant outcomes and experiences and address system issues to ensure adequate support for people with psychosocial disability.

Recommendation 17: The NDIA publishes information about the outcomes of the complex support needs pathway and the psychosocial disability service stream, and the evaluation outcomes of streamlined access for people with psychosocial disability.

Recommendation 18: The Australian Government: extends support for Commonwealth community mental health program clients to at least June 2021; considers whether the funding available under the National Psychosocial Support and Continuity of Support measures matches the needs of people who are ineligible for the NDIS; and considers how funding and access to services for people ineligible for the NDIS can be simplified.

Recommendation 19: The Australian Government, with the state and territory governments ensure that people who are ineligible for the NDIS have access to adequate psychosocial support services.

Recommendation 20: The NDIA works with state and territory governments to progress the Maintain Critical Supports policy and release detail on what is happening with the policy.

Recommendation 21: The NDIA includes support coordination as a standard item in all plans for people with psychosocial disability.

Recommendation 22: The NDIA routinely publishes data about participants with psychosocial disability including information about application, access and planning outcomes by population groups, eligible/ineligible status, plan utilisation, the extent of support coordination in plans, and current rates of expenditure on supports in plans.

Chapter 3:
Suicide prevention

Suicide has a significant impact on families, communities and society, prompting multiple governments to commit themselves to specific reduction targets and others to working towards a target of zero suicides.[137,138] Unfortunately, there is a long way to go to reach this goal. Australia's suicide rate has increased over the past 10 years.[7] In 2017, 3,128 people died by suicide in Australia, an increase of 9% from the previous year.[7]

Suicide prevention is a complex area, with interrelated roles and responsibilities spanning governments, non-government organisations, service providers, peak bodies, commissioning agencies and the community. This complexity has resulted in an uncoordinated response to suicide in Australia, including gaps and duplication in services for people at risk of suicide.[35]

Although state, territory and national governments are working to improve the alignment of suicide prevention efforts, to create a comprehensive and coordinated approach, the infrastructure required to ensure that Australia's suicide prevention sector is responsive to the needs of people at risk of suicide is incomplete, and a number of the existing components need strengthening.

What has happened since National Report 2018?

In the past 12 months, there have been a number of significant developments in the suicide prevention sector, including a move towards a whole-of-government approach to suicide prevention and additional funding for suicide prevention initiatives (Box 19). Although these reforms are welcome improvements to Australia's suicide prevention sector, there is still more work to be done.

What is the current situation?

Australia's national suicide prevention strategy

Under the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), health ministers committed to developing a National Suicide Prevention Implementation Strategy that embodies a systems approach to suicide prevention.

The draft National Suicide Prevention Implementation Strategy, which was released for public consultation in April 2019, represents a targeted plan for advancing the health system's response to suicide prevention.[145] However, as acknowledged in the draft strategy, the health sector is just one component of a comprehensive response to Australia's suicide problem.

Australia needs coordinated and combined efforts across a range of systems and from all levels of government to address the social and cultural determinants of poor mental health and suicidality, including childhood trauma, family violence, poverty, displacement, experiences of discrimination and bullying, adverse educational and workplace experiences, and isolation.

Box 19: Suicide prevention – key activities since National Report 2018

- In December 2018 the Australian Government committed to:
  - elevating suicide prevention to a whole-of-government issue and a Council of Australian Governments (COAG) priority.[139]
  - establishing a national system for timely collection and communication of statistics and information on self-harm and suicide to help communities across the country respond early to emerging problems.[139] The Australian Government committed $15 million to establish this system.[140]
  - strengthening Primary Health Networks' capability to deliver evidence-based, demographically appropriate supports in their local communities.[139]
- The Australian Government appointed a National Suicide Prevention Adviser to:
  - report on the effectiveness of the design, coordination and delivery of suicide prevention activities in Australia, with a focus on people in crisis or at increased risk, including young people and Aboriginal and Torres Strait Islander people
  - develop options for whole-of-government coordination and delivery of suicide prevention activities to address complex issues contributing to Australia's suicide rate, with a focus on community-led and person-centred solutions
  - work across government and departments to embed suicide prevention policy and culture across all relevant policy areas, to ensure that pathways to support are cleared, and people who are at an increased risk of suicide are able to access support
  - draw upon all current work that governments and the sector are undertaking to address suicide, including the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) and Implementation Strategy, the findings of the Productivity Commission inquiry into mental health and the Royal Commission into Victoria's Mental Health System.[88]
- The Victorian Government began the Royal Commission into Victoria's Mental Health System, which is expected to make recommendations on how to most effectively prevent suicide. Results of the Royal Commission are expected by October 2020.[141]
- The Coroner's Court of Western Australia completed its inquest into the 13 deaths of children and young people in the Kimberley region. The State Coroner found that 12 of the 13 deaths were the result of suicide, and made 42 recommendations aimed at supporting communities and preventing future suicides.[142] The Western Australian Government also released its preliminary response to the inquiry and the 2016 Message Stick Inquiry into Aboriginal youth suicide in remote areas.[143] Of the combined 86 recommendations included in both reports, the Western Australian Government has fully accepted 22, accepted 33 in principle, has already implemented or started implementing 16 and is still considering the feasibility or implications of a further 11.[144]
- The National Suicide Prevention Implementation Strategy, being developed under the Fifth Plan, was released for public consultation and is awaiting COAG Health Council endorsement.[145]
- The Australian Government announced $15 million for Aboriginal and Torres Strait Islander suicide prevention.[140]
- The Queensland Government announced $61.9 million to be spent on suicide prevention in its 2019–20 Budget, including funding for services such as aftercare and alternatives to emergency departments for people experiencing mental health and suicidal crisis.[146]
- The New South Wales Government committed $87.1 million over three years to suicide prevention activities such as aftercare, alternatives to emergency departments for people experiencing mental health and suicidal crisis, improved collection and distribution of suicide data, and resilience building in communities.[147]
- The Productivity Commission completed its inquiry into compensation and rehabilitation for veterans. The final report, *A better way to support veterans* recommends the development of a new veterans mental health strategy that has an identified focus on suicide prevention (Box 22).[148]
- The Australian Bureau of Statistics released the results of a pilot study into the psychosocial risk factors associated with suicide deaths in 2017.[8]
- The Australian Government announced that the November 2019 round of Million Minds mental health research funding will include suicide prevention as a specific priority area. The November 2019 round of funding will distribute $8 million.[149]

Given that the draft strategy is a Fifth Plan action with a focus on health ministers, it is limited in how far it can go towards acknowledging the shared responsibility held by non-health portfolios. The draft strategy's actions that require all health ministers to attempt to collaborate with non-health portfolios are a good starting point for the future development of a whole-of-government, comprehensive suicide prevention strategy. To facilitate cross-portfolio and cross-government collaboration and acknowledgement of their shared responsibility in preventing suicide, particularly for Indigenous Australians, the NMHC recommends that any future national suicide prevention strategies be co-designed and co-governed by all relevant portfolios under the Australian Government, including health, education, justice, social services and employment.

National Aboriginal and Torres Strait Islander suicide prevention plan

The impacts of colonisation, transgenerational trauma, racism, discrimination, marginalisation and disadvantage have resulted in poor mental health outcomes for Indigenous Australians[145] and a significant disparity between the suicide rates of Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians, with Indigenous people dying by suicide at a rate two times that of non-Indigenous people.[7]

To reduce the disparity in suicide deaths between Indigenous and non-Indigenous Australians, an appropriately resourced, comprehensive, whole-of-government Aboriginal and Torres Strait Islander suicide prevention plan is required.

The draft National Suicide Prevention Implementation Strategy acknowledges the need for a dedicated Aboriginal and Torres Strait Islander suicide prevention plan. The draft National Suicide Prevention Implementation Strategy proposes that health ministers commit to developing a new national plan for Aboriginal and Torres Strait Islander suicide prevention, in order to focus, accelerate and coordinate efforts, including expanding the evidence base for effective interventions.

It has been proposed that the new plan would be drafted with an Aboriginal and Torres Strait Islander governance model, but would be endorsed by health ministers. As with the National Suicide Prevention Implementation Strategy, limiting the proposed national Aboriginal and Torres Strait Islander suicide prevention plan to the remit of health ministers is likely to limit the plan's ability to influence structures and systems outside the health portfolio. As a result the plan risks not adequately addressing the key social and cultural determinants of Aboriginal and Torres Strait Islander suicide.

The NMHC recommends that the Australian Government work with the state and territory governments to commit to a national Aboriginal and Torres Strait Islander suicide prevention plan, that is led by the knowledge and expertise of Indigenous people.

Services provided to people experiencing suicidal crisis

Not everyone who is having a suicidal crisis seeks help, but a significant minority do and this provides an important opportunity for intervention.[150] Whether a person's experience of accessing support is positive or negative can influence future help-seeking behaviour.[150]

Each year, more than a quarter of a million Australians present to emergency departments seeking help for acute mental and behavioural conditions, including people experiencing a suicidal crisis.[15] Yet the evidence suggests that emergency departments are not adequately resourced or positioned to be a timely and accessible entry point to the mental health system.[151]

In some cases, people leave the emergency department before receiving the care they need. For others long stays in emergency departments are associated with suboptimal treatment such as restraint, seclusion and lengthy periods of sedation.[151]

A range of options require exploration in order to ensure that people experiencing mental health or suicidal crisis get the high quality care and support

they need, including the provision of alternatives to emergency departments for those who do not require medical intervention, and strategies to improve the management of mental health and suicidal crisis within emergency departments.

A number of alternative models to emergency department care have been trialled (Box 20). Although some Australian trial results are not yet available, the positive evaluations that are available suggest that non-medical alternatives to emergency departments for people experiencing mental health or suicidal crisis in Australia may be both effective and cost-efficient.

Initiatives to improve emergency department care for people experiencing mental health and suicidal crises have also been trialled. This reflects increasing acknowledgement among mental healthcare professionals that improvements need to be made to provide a range of crisis intervention services.[152]

The Victorian Government is currently establishing six new emergency department crisis hubs – specially designed 24-hour short-stay units in emergency departments– to treat people during times of mental health and drug and alcohol crisis.[158]

As part of its Suicide Prevention in Health Services Initiative, the Queensland Government continues to implement training for hospital emergency department staff and other frontline acute mental health care staff in recognising, responding to and providing care to people presenting to Hospital and Health Services with suicide risk. A published evaluation of this initiative suggests that the training was effective in improving staff confidence in working with suicidal people, but did not analyse if this has translated into improved outcomes for consumers.[159]

These initiatives are welcomed attempts to improve emergency department services, but will be limited in their impact if they are not systematically evaluated for their effect on consumer care and outcomes. To ensure that future government funding can be invested in initiatives that produce meaningful outcomes for the community, the NMHC recommends that the Australian Government work with state and territory governments to ensure that all evaluations of initiatives to improve emergency department care extend beyond measures of process and impact on hospital staff, to include impact on meaningful outcomes for consumers and carers as a primary outcome measure.

Box 20: Alternatives to emergency department care

In the United States of America a walk-in crisis service called The Living Room has been established as an alternative to emergency department care for suicidal people.[152] An evaluation of The Living Room's first year of operation suggests that community crisis respite centres are cost-effective, and effective in helping many individuals alleviate crises, and have the potential to decrease the use of emergency departments for mental health crisis.[152]

In the United Kingdom, Maytree, a short-term residential respite service, has shown short-term relief and longer-term benefits.[153]

In Victoria, the Safe Haven Café is an after-hours drop-in centre run by clinicians and peer support workers, for adults experiencing loneliness, personal difficulties, or seeking social connection. Although this initiative is not specifically targeted at suicidal people, an economic evaluation estimated that the Safe Haven Café saved $225,400 per year due to a reduction in mental health-related emergency department presentations.[154] From July 2019, the New South Wales Government is implementing a similar service in 20 locations. The New South Wales initiative is modelled after the United Kingdom's Safe Haven café, that showed a 33% reduction in admissions to mental health inpatient units in their catchments.[147]

In Queensland, the Living EDge room has also been trialled. The Living EDge room is a peer-hosted space that can be used as an alternative waiting room for people in mental health or suicidal crisis seeking emergency department care, or as a safe space where people can self-manage and avoid presenting to the emergency department. This trial will conclude at the end of September 2019 and evaluation results are not yet available.[155]

The Australian Government has funded the development and trial of a Suicide Prevention and Recovery Centre (SPARC), where peer workers will provide empathic care and support in a homelike environment. The SPARC is expected to launch in late 2019.[156,157]

Consistent care standards

The NMHC has heard that there is significant variation in the quality of care received by consumers when they present to health or mental health services in suicidal crisis. These experiences range from receiving excellent care and support, through to experiences so poor that the consumers were reluctant to seek care for their suicidality in future. People who present to health and mental health services at risk of suicide deserve a consistent, evidence-based minimum standard of care.

Currently, Australian public and private hospitals and community mental health services must comply with the National Safety and Quality Health Service (NSQHS) Standards, as well as the National Standards for Mental Health Services. These service standards are intended to provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.[160] Both sets of service standards include one or more high level requirements relating to the care of people who are at risk of suicide and broad guidance about how to meet the mandated standards. However, neither the mandated standards nor the guidance are sufficiently detailed to ensure that Australians at risk of suicide receive a consistent, evidence-based minimum standard of care across services. This lack of detail likely contributes to the wide variation in consumer and carer experiences reported to the NMHC.

Under the Fifth Plan, governments have committed to developing a mental health supplement to the NSQHS Standards that aligns the National Standards for Mental Health Services and the NSQHS Standards in all public and private hospitals and community services provided by Local Health Networks (LHNs), and establishes a single set of standards for these services.[35] However, the extent to which the mental health supplement will comment on the care required by people at risk of suicide is currently unclear.

To establish a national regulatory framework that ensures a consistent minimum standard of care is achieved across all public and private hospitals and community services provided by LHNs, the NMHC recommends that the Australian Government work with the Safety and Quality Partnership Standing Committee to ensure that the mental health supplement to the NSQHS Standards includes detailed requirements and guidance on the care required by people at risk of suicide.

While the mental health supplement to the NSQHS Standards provides an important opportunity to establish mandatory care standards in public and private hospitals and community services provided by local health networks, these standards will not cover the full range of suicide prevention activities in all service settings. Other suicide prevention service types and settings do not have existing regulatory processes through which to implement consistent care standards.

The NMHC recommends that the Australian Government work with the Mental Health Principal Committee, to oversee the development of suicide prevention service standards guidelines that cover the full range of suicide prevention activities, from primary prevention to postvention, in all settings. These guidelines should consider and complement existing NSQHS Standards and the mental health supplement to the NSQHS Standards.

Data on suicide prevention expenditure, workforce and service activity

Monitoring the effectiveness of the suicide prevention system requires analysing the human and financial resources available, the activity occurring within the system and the outcomes it produces.

Accurate measurement and regular reporting of data relating to the experience of service of people who are at risk of suicide, can reduce negative variations in care and improve the quality of service provision.

Significant improvements have been made in the collection and reporting of Australia's suicide rates, including the recent commitment to more timely and detailed information about suicide attempts and deaths.[139] However, data on suicide prevention expenditure, workforce and program and service activity are not systematically collected and publicly reported at the national and jurisdictional levels.[161] This reduces transparency and hinders attempts to monitor the systemic effectiveness of suicide prevention strategies, plans, policies and services in Australia.

Australian Government expenditure on suicide prevention is reported annually, but there is limited reporting on the number and type of services resulting from this investment.[161] State and territory governments complement Australian Government initiatives with their own suicide prevention plans, designed to meet local needs, but data on expenditure and service activity for these plans are not publicly reported in any state or territory.[161] National, state and territory, and regional suicide prevention plans should be designed to be measured, including expenditure on the activity and the outcomes and impact of the activity.

The NMHC recommends that the Australian Government work with the state and territory governments on the development of routinely collected data on suicide prevention expenditure, workforce and program and service activity. This would allow for more detailed monitoring of what is working well and what needs to be improved in the sector, and may ultimately lead to better care for those at risk of suicide and a reduction in the suicide rate.

Longer-term funding and evaluation

Evidence of the effectiveness of Australian suicide prevention activities is needed to ensure that governments and others who commission services can make informed funding decisions. Without appropriate outcome measurement, funders and policy makers may rely on anecdotal and other information to determine whether a program should be continued, expanded upon, refined or eliminated. Such evidence may not fully reflect the outcomes being achieved.[162]

Methodological problems commonly associated with suicide prevention evaluations, such as the statistically small number of suicide deaths in any given year, small program size and short program duration can diminish the statistical power of evaluations and thus limit the ability to establish the effects of the program.[163]

Understandably, change in the suicide rate is a common outcome measure used to evaluate the effectiveness of suicide prevention initiatives. Although the impact of suicide on the community is significant, the actual number of people who take their own lives is statistically small, accounting for 2% of all deaths in 2017.[7,163] This makes it difficult to achieve the statistical power needed to identify patterns or draw conclusions about any changes in the suicide rate.[163] This issue is particularly prominent when evaluating initiatives targeted at specific communities, such as Aboriginal and Torres Strait Islander people, who have an even smaller number of suicide deaths. Suicide of Aboriginal and Torres Strait Islander people accounted for 0.1% of all deaths in Australia in 2017.[7]

Meaningful evaluation of suicide prevention activities can be limited by short-term funding.

Short-term funding for complex and novel initiatives, such as local area suicide prevention trial sites (Box 21), can result in insufficient time to plan, implement and evaluate the initiative before the end of the funding period. This can result in initiatives being smaller and shorter in duration than required to be fully effective, and can reduce the statistical power of the evaluation. Short-term funding can also make it difficult to measure the impact of initiatives that are expected to have a long-term benefit, such as early intervention programs.[162]

To overcome these methodological issues and ensure that future investments can be informed by robust evidence, the NMHC recommends that the Australian Government, with the state and territory governments commit to longer-term funding for suicide prevention activities and evaluations of these activities to better assess outcomes over a longer period of time. For the local area suicide prevention trials, the NMHC recommends that the Australian Government commit to the timely public release of the evaluation of the National Suicide Prevention Trial. The Australian Government should also work with the Victorian Government, Australian Capital Territory Government and the Black Dog Institute to encourage the timely public release of their evaluations of the local area suicide prevention trials. This will allow governments to consider the findings of all evaluations as they determine whether expansion or revision of the place-based suicide prevention trial sites is required.

Box 21: Local area suicide prevention trial sites

Integrated, whole-of-systems, local area approaches to suicide prevention are currently being trialled in four independent local area suicide prevention trials, across a total of 29 sites. The trials have different community needs, models, timeframes and funding.

The trials include:

- 12 National Suicide Prevention Trials, funded by the Australian Government Department of Health
- 12 Victorian place-based trials, funded by the Victorian Government
- 4 LifeSpan Black Dog Institute research trials, funded by the Paul Ramsay Foundation
- an Australian Capital Territory LifeSpan research trial, funded by the Australian Capital Territory Government.

The trials were established in response to criticism that Australia's suicide prevention efforts were lacking in coordination, and that successful suicide prevention requires a multilevel, multifactorial approach, involving both health and non-health sectors, and government and non-government agencies.[164]

Evaluations of both the trial site planning and implementation process, and outcomes within local communities are currently underway. The final reports are expected in mid-2021.

Box 22: Suicide prevention in veterans

Veterans are at increased risk of suicide. From 2002 to 2016 male veterans had an age-adjusted suicide rate 18% higher than for all Australian men.[165] There has been a heightened focus on veterans' mental health and suicide in recent years and the introduction of a range of new policies and programs, including a Veteran Suicide Prevention Pilot, an early intervention measure for people in the Coordinated Veterans' Care program and a suicide prevention trial called Operation Compass, in Townsville.[148]

The final report of the Productivity Commission inquiry into compensation and rehabilitation for veterans, *A better way to support veterans*, found that a new Veteran Mental Health Strategy is required to build and improve on recent policy changes and trials.

The proposed Veteran Mental Health Strategy would:

- cover mental health activities in each of the life stages of military personnel — recruitment, in service, transition and ex-service
- ensure there are activities in each life stage that address the needs of those who are mentally healthy (promotion and prevention activities), are at risk (early intervention) and have a mental illness (treatment)
- ensure that systems are in place to identify and support at risk individuals and that there is an identified focus on the prevention on suicide
- ensure that the needs of family members of veterans, including those of deceased veterans, are appropriately identified
- be evidence based, incorporating outcomes from trials and research on veterans' mental health needs
- set out priorities, actions, timelines and ways to measure progress
- commit the Australian Government Department of Defence and Department Veterans' Affairs to publicly report on progress towards the goals of the strategy.[148]

Conclusion

Suicide has a significant impact on families, communities and society, prompting multiple governments to set themselves targets of zero suicide.

The NMHC is encouraged by the current developments in Australia's suicide prevention sector, including moving towards coordinated prevention initiatives, committing to the regular production of detailed data on suicide attempts and deaths, and trialling alternatives to emergency departments for people in suicidal crisis. However, governments must work together to strengthen Australia's suicide prevention infrastructure in a number of areas, including:

- systems, structures and co-designed strategies that facilitate cross-portfolio and cross-government collaboration and acknowledgement of their shared responsibility in preventing suicide, particularly for Aboriginal and Torres Strait Islander people
- adequate support options for people experiencing suicidal crisis
- mandated meaningful service standards for the care received by people at risk of suicide
- data collection and reporting systems around the characteristics of Australia's suicide prevention sector, including data on suicide prevention expenditure, workforce and program and service activity
- longer-term funding for suicide prevention activities and their evaluations.

Building this infrastructure will ensure that Australia achieves and maintains a suicide prevention sector that is responsive to the needs of people at risk of suicide, and will help Australia move towards zero suicides.

Recommendation 23: In acknowledgement of their shared responsibility for preventing suicide, any future national suicide prevention strategies be co-designed and co-governed by all relevant portfolios under the Australian Government, including health, education, justice, social services and employment.

Recommendation 24: The Australian Government work with the state and territory governments to commit to a national Aboriginal and Torres Strait Islander suicide prevention plan, that is led by the knowledge and expertise of Indigenous people.

Recommendation 25: The Australian Government work with state and territory governments to ensure that all evaluations of initiatives to improve emergency department care extend beyond measures of process and impact on hospital staff, to include impact on meaningful outcomes for consumers and carers as a primary outcome measure.

Recommendation 26: The Australian Government work with the Safety and Quality Partnership Standing Committee to ensure that the mental health supplement to the National Safety and Quality Health Service Standards includes detailed requirements and guidance on the care required by people at risk of suicide.

Recommendation 27: The Australian Government work with the Mental Health Principal Committee, to oversee the development of best practice suicide prevention guidelines that cover the full range of suicide prevention activities, from primary prevention to postvention, in all settings.

Recommendation 28: The Australian Government work with the state and territory governments on the development of routinely collected data on suicide prevention expenditure, workforce and program and service activity.

Recommendation 29: The Australian Government, with the state and territory governments commit to longer-term funding for suicide prevention activities and evaluations of these activities to better assess outcomes over a longer period of time.

Recommendation 30: The Australian Government commit to the timely public release of the evaluation of the National Suicide Prevention Trial. The Australian Government should also work with the Victorian Government, Australian Capital Territory Government and the Black Dog Institute to encourage the timely public release of their evaluations of the local area suicide prevention trials.

Chapter 4:
The Fifth National Mental Health and Suicide Prevention Plan

The release of the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) in August 2017 marked a significant point in the history of mental health reform in Australia. It is the first mental health plan to commit all governments to work together to achieve integration in planning and service delivery at a regional level.

The Fifth Plan also requires that consumers and carers are central to the way in which services are planned, delivered and evaluated.

The aim of the Fifth Plan is to establish a national approach for collaborative government action to improve the provision of integrated mental health and related services in Australia. To achieve this, the eight priority areas (Box 23) and 32 actions of the Fifth Plan are designed to improve the transparency, accountability, efficiency and effectiveness of the Australian mental health system. Ultimately, the Fifth Plan aims to improve the lives of people with a mental illness and the lives of their families, carers and communities.

Reporting on the implementation progress of the Fifth Plan

The NMHC was given responsibility for delivering an annual report, to be presented to health ministers, on the implementation progress of the Fifth Plan actions and performance against the identified indicators.

To measure the progress of implementation, the NMHC surveyed stakeholders (governments, Primary Health Networks, Australian Health Ministers' Advisory Council committees and state mental health commissions) tasked with implementing the actions of the Fifth Plan. The NMHC delivered the *Fifth National Mental Health and Suicide Prevention Plan: 2018 progress report* (2018 Progress Report) to the COAG Health Council in October 2018.

The 2018 Progress Report is the first in a series that will be published annually over the life of the Fifth Plan, and outlines the progress achieved against actions in the Implementation Plan as of 30 June 2018. The report also presents baseline data for the available performance indicators. Given the relative infancy of the implementation of the Fifth Plan, the 2018 Progress Report did not provide detailed analysis of progress to date. With governance arrangements and committee structures well established in the first year of implementation, stakeholders now have appropriate support in their roles implementing Fifth Plan actions. The NMHC expects to see progress against the Fifth Plan actions in 2019.

Box 23: Fifth Plan priority areas

- **Priority Area 1** – Achieving integrated regional planning and service delivery
- **Priority Area 2** – Suicide prevention
- **Priority Area 3** – Coordinating treatment and supports for people with severe and complex mental illness
- **Priority Area 4** – Improving Aboriginal and Torres Strait Islander mental health and suicide prevention
- **Priority Area 5** – Improving the physical health of people living with mental illness and reducing early mortality
- **Priority Area 6** – Reducing stigma and discrimination
- **Priority Area 7** – Making safety and quality central to mental health service delivery
- **Priority Area 8** – Ensuring that the enablers of effective system performance and system improvement are in place

While the NMHC is required to report on the implementation progress of the Fifth Plan, reporting on progress from the perspectives of the stakeholders responsible for implementation cannot, nor will ever be, the sole measure of success. The Fifth Plan requires that consumers and carers are central to how services are planned, delivered and evaluated. All eight priority areas have statements that specifically outline 'what will be different for consumers and carers?', based on the successful implementation of relevant actions. Understanding how implementation of the Fifth Plan is affecting the experiences of consumers and carers is a priority for the NMHC.

To assess whether the changes being made under the Fifth Plan are leading to genuine improvements for consumers and carers, the NMHC developed a public survey and invited mental health consumers and carers to participate and share their experiences. The results from this public consultation formed the basis of the report *Fifth National Mental Health and Suicide Prevention Plan 2019: The consumer and carer perspective* (2019 Consumer and Carer Report), that was published in September this year. The key findings of the 2019 Consumer and Carer Report are outlined in Box 24.

Annual monitoring and reporting on outcomes for consumers and carers, in addition to the stakeholders identified in the Fifth Plan Implementation Plan, will allow the NMHC to assess whether the reform is achieving its objectives.

As both the 2018 Progress Report and the 2019 Consumer and Carer report are the first in a series, they will be used as the baseline for ongoing reporting. As such, the NMHC is not able to use them for comparative analysis at this time. It is clear that improvements still need to be made across all Fifth Plan priority areas, and that these improvements may take time before they translate into tangible improvements for how consumers and carers experience mental health care.

The NMHC hopes that, as implementation of the Fifth Plan progresses, the two reports will be used to identify the key achievements and areas for improvement in the mental health system as a direct result of the reform.

Taken together, the Fifth Plan implementation progress reports and the consumer and carer report will assist the NMHC to understand

Box 24: 2019 Consumer and Carer Report – key findings

The aim of the *Fifth National Mental Health and Suicide Prevention Plan 2019: The consumer and carer perspective* (2019 Consumer and Carer Report) was to establish a baseline of consumer and carer experiences of mental health services. Of the 546 survey responses received, 64% were from consumers and 36% were from carers.

The report found several key issues that were consistent across priority areas of the Fifth National Mental Health and Suicide Prevention Plan, including:

- awareness, availability and adequacy of services (Priority Areas 1, 2 and 3)
- consideration of consumer needs in conjunction with their mental health needs, such as income support, adequate housing and physical health (Priority Areas 3 and 5)
- service quality issues (Priority Areas 1, 2, 3, and 8).

High levels of stigma and discrimination were also reported across multiple priority areas. Respondents indicated that stigma and discrimination are still prevalent in the broader community, as well as within the health system. The stigma and discrimination experienced in the mental health system is particularly concerning. Respondents reported that the quality of care that they, or the person they care for, received over the last 12 months was impacted by encountering negative, unhelpful, or uncaring attitudes among health providers (Priority Areas 1, 2, 3, 7, and 8).

Aboriginal and Torres Strait Islander respondents also reported experiencing issues with service availability and adequacy, with the majority of Aboriginal and Torres Strait Islander respondents indicating that service providers 'rarely' or 'never' considered all of their needs (clinical, social and emotional), provided culturally appropriate care, or provided appropriate support to navigate the system.

The NMHC acknowledges that the sample size from the consumer and carer survey is small and that the results therefore might not be representative of the broader consumer and carer population in Australia.

whether the implementation progress reported by stakeholders named in the Fifth Plan is translating into positive changes for consumers and carers as they access mental health services.

The Fifth Plan Consumer and Carer reports could also provide Fifth Plan stakeholders with valuable insights into potential areas for improvement and further development.

NMHC Fifth Plan actions

The NMHC has been tasked with leading a number of actions in the Fifth Plan Implementation Plan (Box 25). These include developing a consumer and carer guide to support the participation of consumers and carers in safety and quality initiatives in mental health services, developing Peer Workforce Development Guidelines, and developing a mental health research strategy.

Box 25: Fifth Plan – NMHC actions

Consumer and Carer Guide

It is essential that consumers and carers are engaged in decisions that affect their ability to lead a contributing life. The NMHC is developing a guide for consumers and carers to support their participation in safety and quality initiatives within mental health services. The guide will focus on supporting consumers and carers to engage effectively on safety and quality issues at a governance level. It is expected that consumer and carer participation in higher-level decision-making about the planning and delivery of mental health services will contribute to organisational culture change, as well as driving service-level improvements in consumer and carer-focused safety and quality practices. The guide is due to be published by the end of 2020.

Peer Workforce Development Guidelines

Peer workers are integral to ensuring that the voices of consumers and carers are central to the work of the mental health system. There is strong policy support and direction for strengthening the role of the consumer and carer peer workforces, but significant challenges remain. These include stigma and discrimination, unclear role definitions for peer workers, lack of dedicated resources for recruitment of peer workers, lack of peer supervision and professional development opportunities, inappropriate and complex award structures and remuneration, and the need for additional data to measure the growth and effectiveness of the workforce.

The NMHC is currently coordinating the development of Peer Workforce Development Guidelines. The guidelines will provide formalised guidance for governments, employers and the peer workforce about the support structures required to sustain and grow the workforce. Work is also under way through the Mental Health Information Strategy Standing Committee to develop national mental health peer workforce data under the Fifth Plan.

National Mental Health Research Strategy

Innovation in our responses to the complexities of mental health and suicide requires ongoing and targeted research. The NMHC is leading the development of the National Mental Health Research Strategy and has established a steering committee that includes consumers and carers, representatives of states and territory governments, research funding bodies, and prominent researchers to develop the strategy. The strategy will include a principles-based framework, and aims to improve health outcomes by supporting the translation of research into evidence-based practice. The NMHC anticipates completion of the strategy by the end of 2020.

Conclusion

Reporting on the progress of mental health reform is fundamental to understanding whether the commitments made in the Fifth Plan are being honoured and are making a difference.

By monitoring the progress of the stakeholders responsible for implementing the Fifth Plan, as well as consumers and carers across Australia, the NMHC will gain a broader understanding of whether the reform is successfully meeting its objectives. Monitoring the implementation progress of the Fifth Plan is also essential for identifying barriers, challenges or significant system change that may impede progress. However, it is important to note that the Fifth Plan was endorsed by health ministers, and therefore the actions under the plan are largely for governments and associated stakeholders to implement. For this reason, the Fifth Plan is limited in its ability to influence non-government and private organisations.

As implementation of the Fifth Plan progresses incrementally over the coming years, the NMHC expects to see changes in Australia's mental health system. The NMHC will continue to survey and report on the experiences of consumers and carers to ensure that these changes result in genuine improvements for people living with mental illness.

The upcoming Fifth Plan progress report for the 2018–19 period will be delivered to health ministers in early 2020.

Concluding statement

Mental illness and suicide in Australia continue to be issues despite substantial investments in the mental health system. Current national reforms such as the National Disability Insurance Scheme, Primary Health Networks, and the Fifth National Mental Health and Suicide Prevention Plan are key to strengthening Australia's mental health system. It is clear that the implementation of these reforms is challenging. However, the NMHC acknowledges the continued commitment of all governments to ensuring that mental health and suicide reforms lead to sustained positive change for consumers and carers.

Throughout this report the NMHC has identified a number of areas where improvements can be made. The NMHC has recommended a number of actions that governments and other stakeholders can begin implementing in the short-term, to improve outcomes for consumers and carers.

As part of the NMHC's ongoing monitoring and reporting, the NMHC will liaise with governments and other relevant stakeholders to seek responses about how they will progress these recommendations in the future. The progress of adopted recommendations will be reported against in the National Report 2020. The NMHC will also continue to monitor the key national reforms that are in progress.

Although there have been many previous inquiries into Australia's mental health system, the Productivity Commission inquiry is unique because it is looking at the social and economic benefits of improving mental health. This Productivity Commission inquiry presents a significant opportunity to rethink how governments should invest in mental health services. The NMHC will continue to engage with the Productivity Commission and looks forward to the release of its draft report expected by the end of 2019.

Acronyms and abbreviations

ACCHS	Aboriginal Community Controlled Health Services
ADF	Australian Defence Force
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Services
CMHA	Community Mental Health Australia
COAG	Council of Australian Governments
CoS	Continuity of Support
D2DL	Day to Day Living
Fifth Plan	The Fifth National Mental Health and Suicide Prevention Plan
LHN	Local Health Networks
MHLEEN	Mental Health Lived Experience Engagement Network
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NIAA	National Indigenous Australians Agency
NMHC	National Mental Health Commission
NPS Measure	National Psychosocial Support measure
NSQHS Standards	National Safety and Quality Health Service Standards
PHaMs	Personal Helpers and Mentors
PHN	Primary Health Network
PIR	Partners in Recovery
WHO	World Health Organization
YES	Your Experience of Service

Glossary

Affective disorders

A category of mental illnesses. The common feature among affective disorders is mood disturbance. Depression, dysthymia and bipolar affective disorder are all types of affective disorder.

Anxiety disorders

A category of mental illnesses that are marked by the experience of intense and debilitating anxiety. Panic disorder, social phobia, agoraphobia, generalised anxiety disorder, post-traumatic stress disorder and obsessive compulsive disorder are all types of anxiety disorder.

Australian Mental Health Leaders Fellowship

A national program that supports the development of leadership skills among emerging leaders with a passion and commitment to mental health. These leaders include consumers, carers, mental health professionals and others outside the traditional boundaries of the mental health sector, including emergency service workers, students and early career researchers, and professionals in industry, finance and the justice system.

Burden of disease

The quantified years of healthy life lost, either through premature death or living with a disability due to illness or injury. Burden of disease is a measure of the impact of a disease or injury on a population.

Carer

In this document, the term carer refers to an individual who provides ongoing personal care, support, advocacy and/or assistance to a person with mental illness.

Co-design

An approach to design that includes all stakeholders (for example, consumers, carers, researchers, health workers, clinicians, funders, policy makers).

Community supports

Non-clinical services, provided in a community setting, that assist people with mental illness to live meaningful and contributing lives. These may include services that relate to daily living skills, self-care and self-management, social connectedness, housing, education and employment.

Complex support needs pathway

An improvement to the NDIS aimed at providing specialised support to participants living with a disability who need a higher level of specialised supports in their plan. Participants under this pathway are identified by the complexity of their situations and personal factors, such as being homeless or returning to the community from living in residential aged care.

Consumers

People who identify as having a living or lived experience of mental illness, irrespective of whether they have a formal diagnosis, who have accessed mental health services and/or received treatment. Consumers include people who describe themselves as a 'peer', 'survivor' or 'expert by experience'.

Continuity of Support measure

A program that provides psychosocial support to people who are currently accessing services from PIR, D2DL or PHaMS and have been assessed as ineligible for the NDIS.

Current mental health issue

A derived category used in the Specialist Homelessness Services (SHS) Collection. SHS clients are identified as having a current mental health issue if any of the following apply:

- the client indicated at the beginning of a support period that they were receiving services or assistance for their mental health issues, or had received them in the past 12 months
- the client's formal referral source to the specialist homelessness agency was a mental health service
- the client reported 'mental health issues' as a reason for seeking assistance
- the client's dwelling type either a week before presenting to an agency, or when presenting to an agency, was a psychiatric hospital or unit
- the client had been in a psychiatric hospital or unit in the past 12 months
- at some stage during the client's support period, a need was identified for psychological services, psychiatric services or mental health services.

Day to Day Living (D2DL)

D2DL was a program providing funding to improve the quality of life for individuals with severe and persistent mental illness by offering structured and socially based activities.

Funding for D2DL has transitioned into the Continuity of Support measure as part of changes to the way in which psychosocial support is provided with the introduction of the NDIS.

Depression

A mental illness characterised by periods of low mood and significant impairment due to symptoms such as loss of interest and enjoyment, reduced energy and concentration, and changes in sleep and appetite.

Discrimination

The unjust or prejudicial treatment of a person based on the group, class or category to which the person is perceived to belong.

Early intervention

Identifying signs and risks of mental illness early, followed by appropriate, timely intervention and support that can reduce the severity, duration and recurrence of mental illness and its associated social disadvantage.

Information, Linkages and Capacity Building

The component of the NDIS that provides information, linkages and referrals to efficiently and effectively connect people with disability, their families and carers, with appropriate disability, community and mainstream supports.

Lived experience

In this report, lived experience refers to people who have either current or past experience of mental illness as a consumer and/or a carer.

Local Health Network (LHN)

A legal entity established by a state or territory government to devolve operational management for public hospitals, and accountability for local service delivery, to the local level. An LHN can contain one or more hospitals.

Maintain Critical Supports program

A program under the NDIS to provide a safety net for participants whose needs cannot be addressed using existing provider options.

Mental health

The World Health Organization defines mental health as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community.

Mental illness

A wide spectrum of diagnosable health conditions that significantly affect how a person feels, thinks, behaves, and interacts with other people. Mental illness can vary in both severity and duration. In this report 'mental illness' is used in place of 'mental health problem', 'mental health disorder', 'mental ill-health' and 'mental health disease'.

Mentally Healthy Workplace Alliance

A national approach by business, community and government to encourage Australian workplaces to become mentally healthy for the benefit of the whole community and businesses, big and small.

National Disability Insurance Scheme (NDIS)

The NDIS provides individualised support packages for eligible people with permanent and significant disability, their families and carers. Roll out commenced on 1 July 2016 and is expected to be complete by 2020.

National Multicultural Mental Health Project

Also known as Embrace Multicultural Mental Health or the Embrace Project, the National Multicultural Mental Health Project provides a national focus on mental health and suicide prevention for people from culturally and linguistically diverse backgrounds.

National Psychosocial Support measure

Provides psychosocial support to people with severe mental illness who are not currently receiving supports through another program, and to people who have not yet tested their eligibility for the NDIS, or are waiting for an access decision or approved support plan under the NDIS.

NDIS Quality and Safeguards Commission

An independent agency established to improve the quality and safety of NDIS supports and services.

Non-government organisations

Private, not-for-profit community-managed organisations that receive government funding specifically for the purpose of providing community support services.

Partners in Recovery (PIR)

Aims to support people with severe and persistent mental illness with complex needs, and their carers and families, by getting multiple sectors, services and supports they may come into contact with (and could benefit from) to work in a more collaborative, coordinated and integrated way.

Funding for PIR has transitioned into the Continuity of Support measure as part of changes to the way in which psychosocial support is provided with the introduction of the NDIS.

Peer workforce

The supply of people who are employed, either part-time or full-time, on the basis of their lived experience, to provide support to people experiencing a similar situation.

The people who make up the peer workforce may be called peer workers, consumer workers, carer workers or lived experience workers.

Performance indicators

A concise list of indicators used to measure effectiveness in achieving outcomes.

Personal Helpers and Mentors (PHaMs)

Provides practical assistance for people aged 16 years and over whose lives are severely affected by mental illness. PHaMs helps people overcome social isolation and increase connections with their community.

Funding for PHaMs has transitioned into the Continuity of Support measure as part of changes to the way in which psychosocial support is provided with the introduction of the NDIS.

Poor mental health

Low levels of mental health that are not diagnosable. Poor mental health may be associated with suicidality.

Postvention

An intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers).

Prevalence of mental illness

The proportion of people in a population who meet diagnostic criteria for any mental illness at a given time.

Primary Health Network (PHN)

An administrative health region established to deliver access to primary care services for patients, as well as co-ordinate with local hospitals to improve the operational efficiency of the network. The seven key priorities for targeted work for PHNs are: mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, digital health, aged care, and alcohol and other drugs.

Private hospital

A privately owned and operated hospital, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital, and relevant medical and paramedical practitioners.

Provider of last resort

See Maintain Critical Supports program.

Psychological distress

One measure of poor mental health, which can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness.

Psychosocial disability

A term used in the context of the NDIS to describe a disability arising from a mental illness that is likely to make the person eligible for an individual support package under the scheme.

Psychosocial disability service stream

The pathway through which people with psychosocial disability are able to access the NDIS.

Psychosocial support

Refers to support provided to enable people to live or remain in the community as opposed to clinical treatment or medication. Psychosocial support can refer to support provided by non-clinical but trained mental health workers and peer workers, and as one to one support or in groups. This type of support may be considered within the range of supports offered in an NDIS plan.

Psychotic illnesses

Psychotic illnesses are characterised by distortions of thinking, perception, and emotional responses. They include schizophrenia, schizoaffective disorder, bipolar disorder, and delusional disorder.

Public hospital

A hospital controlled by a state or territory health authority. In Australia, public hospitals may offer free diagnostic services, treatment, care and accommodation.

Recovery

Recovery is different for everyone. For the purposes of this report, recovery is defined as being able to create and live a meaningful and contributing life, with or without the presence of mental illness.

Restraint

The restriction of an individual's freedom of movement by physical or mechanical means.

Seclusion

The confinement of an individual at any time of the day or night alone in a room or area from which free exit is prevented.

Social and emotional wellbeing

A holistic concept that reflects the Aboriginal and Torres Strait Islander understanding of health, and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual.

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

An evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs. In a stepped care approach, an individual will be supported to transition to higher intensity services or lower intensity services as their needs change.

Stigma

A mark of shame, disgrace or disapproval on the basis of an individual's characteristics, which results in that individual being rejected, discriminated against, and/or excluded from participating in a number of different areas of society.

Substance use disorders

A category of mental illnesses that relate to problems arising from the use of alcohol or drugs.

Suicidality

A term that covers suicidal thoughts, suicide plans, and suicide attempts.

Suicide

Deliberately ending one's own life.

Support coordination

An additional support provided to NDIS participants that aims to develop a participant's ability to connect with their supports, develop the skills necessary to understand and implement their plan, and—where necessary—provides additional targeted support to participants in highly complex or high risk situations.

Thin market

A market in which the number of providers or consumers is too small to support the competitive provision of services.

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