Monitoring mental health and suicide prevention reform

National Report 2020

Australian Government
National Mental Health Commission

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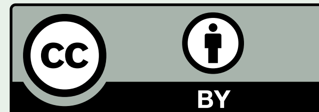

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Message from Lucy Brogden
Chair of the National Mental Health Commission Advisory Board

The National Mental Health Commission Advisory Board is pleased to have contributed to the Commission's work to respond to the challenges of 2020. In doing so, we have worked closely with our stakeholders, including consumers and carers, mental health organisations and peak bodies.

We have also welcomed Associate Professor Mathew Coleman as a new Commissioner. Mat brings a wealth of experience as a psychiatrist working in rural and regional Western Australia.

When considering the impact of the events of 2020 through the lens of the Commission's Contributing Life Framework, we are reminded that its whole-of-person, whole-of-system, whole-of-life approach is necessary to ensure that our responses meet the needs of people. The year impacted us as individuals, and where we live, work and learn. We were conscious of the need to maintain close connections with family and friends. The Contributing Life Framework highlights the importance of each of us having something meaningful to do each day and to make a contribution to our communities, and this was particularly relevant in 2020.

We were particularly pleased to see the mental health and suicide prevention sectors respond rapidly and collaboratively to redesign services and support each other. Together, we created many lasting achievements. The National Mental Health and Wellbeing Pandemic Response Plan has created a blueprint for future collaborative efforts. Public mental health messages have been crucial to support Australians' mental health and wellbeing. The Commission collaborated with mental health organisations, experts and leaders across the country to develop and launch #InThisTogether and the subsequent #GettingThroughThisTogether campaigns.

The Advisory Board is proud of the achievements of the Commission this year. The Commission has progressed Vision 2030, a long-term blueprint envisaging what people would experience in a successful, connected and well-functioning mental health and suicide prevention system that meets the needs of the whole community. We are in the final stages of analysing and translating feedback from the public consultation on the National Children's Mental Health and Wellbeing Strategy. As well, the National Workplace Initiative is progressing well under the guidance of the Mentally Healthy Workplace Alliance. This project initiated a quick response to mental health and wellbeing impacts in the workplace during the COVID-19 pandemic, through the development and promotion of evidence-based Mentally Healthy Workplaces during COVID-19 guides, which provided 'fit for purpose' information for large and small organisations, as well as sole traders.

Further achievements this year include progress on actions under the Fifth National Mental Health and Suicide Prevention Plan; holding a collaborative workshop to shape the National Mental Health Research Strategy; progress with consultation, and development of the National Lived Experience (Peer) Workforce Development Guidelines; progress on the Mental Health Safety and Quality Engagement Guide; and consultation with consumers and carers through our online 2020 survey on their experiences of the mental health and suicide prevention system.

I would like to take this opportunity to thank all the organisations, individuals, consumers and carers who have connected with the Commission in its work this year. We appreciate in these challenging times that time itself is precious. The impacts of 2020 are still being felt. By working together, we maintain the collaborative approach and partnerships that are critical to progressing the mental health and wellbeing of all Australians.

Lucy Brogden
Chair of the National Mental Health Commission Advisory Board

Message from Christine Morgan
Chief Executive Officer of the National Mental Health Commission

We are pleased to present the National Mental Health Commission's 2020 National Report on mental health and suicide prevention in Australia. Reflecting on 2020, we are reminded of the incredible contributions of so many, including our essential workers in health and aged care, schools, supermarkets, cleaning and transport.

Our first responders put themselves on the front line to protect and support their communities. Mental health professionals have been challenged to continue providing support and services through these difficult times, with the COVID-19 pandemic having a significant impact on our mental health and wellbeing as well as on our physical health. Innovation and flexibility in our responses have been critical.

Although we have all been challenged in 2020, some people have required more support as a result of pre-existing inequities in access to health care, housing, income and social supports. The coordinated response to this year's challenges by governments, service providers, support networks and community organisations has shown what can be done when we work together collaboratively. Since 2012, the Commission has called for a whole-of-government approach to mental health and suicide. Never has this approach been more important.

In 2020, a number of significant reports on mental health and suicide prevention reform were released, including the report of the Productivity Commission inquiry into mental health, the interim report of the Royal Commission into Victoria's Mental Health System and the interim advice in my role as National Suicide Prevention Adviser. These have detailed the significant and lengthy work required to improve our mental health and suicide prevention system to efficiently and effectively meet the needs of, and improve outcomes for, people with lived experience, their families and the community more broadly.

It was also a year of national awareness of the importance of mental health and wellbeing, as each new challenge brought home the need to stay connected, check in with each other, and reach out for support. There has been a strong commitment to system reform in response to the natural disasters of fires, floods and hail, as well as to COVID-19. This includes recognising the importance of supporting people to access help and treatment where it is needed—where people live, work and learn, or in their community.

We welcomed the formation of the National Bushfire Recovery Agency to lead and coordinate a national response to rebuilding communities affected by bushfires across large parts of Australia. The agency administers the National Bushfire Recovery Fund, which is supporting recovery efforts across Australia, including a mental health package for first responders and communities. The Commission is working across many sectors in developing the National Disaster Mental Health and Wellbeing Framework, including consulting with people in areas affected by bushfires and natural disasters, state and territory governments, people with lived experience, local governments, community organisations involved in disaster support, and mental health and disaster management researchers.

One of the most significant achievements was the endorsement by National Cabinet of the National Mental Health and Wellbeing Pandemic Response Plan as a response to the national public emergency of COVID-19. The plan is a testament to a unified commitment by governments and the mental health sector to support all Australians' mental health and wellbeing during the response to, and recovery from, the COVID-19 pandemic. It will continue to guide a concerted and coordinated response from all levels of government as we face the long-term impacts of COVID-19 on mental health and wellbeing. The leadership of this work by New South Wales, Victoria and the Commission, with coordinated input from all governments, was a demonstration of the new levels of collaboration achieved in 2020. The plan was informed by more than 100 submissions, including from those with lived experience.

We have heard from many stakeholders of the anxiety and distress caused by the national crises of bushfires, drought and floods, and the restrictions to bring COVID-19 under control throughout the year. Through the concerted efforts of all governments, organisations and the community, we have weathered an unprecedented year. By working together, we can continue to make real change at all levels of the system, and improve the lives of those impacted by mental illness.

National Mental Health Commission

Christine Morgan
Chief Executive Officer,

About us

The National Mental Health Commission (the Commission), which was established in 2012, 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 Commission's strategic directions and priorities. The current Commissioners are Mrs Lucinda Brogden AM, Professor Ngiare Brown, Associate Professor Mathew Coleman, Ms Kerry Hawkins, Ms Niharika Hiremath, Rabbi Mendel Kastel OAM, Ms Christina McGuffie, Professor Helen Milroy, Associate Professor Elizabeth-Ann Schroeder, Professor Maree Teesson AC, Mr Alan Woodward and Ms Christine Morgan, who is also the Chief Executive Officer.

Our vision

Our vision is that all people in Australia are enabled to lead contributing lives in socially and economically thriving communities.

Our National Report series

Since 2012, the Commission has published an annual report to the Australian Government and the community on the mental health and suicide prevention system in Australia. This report draws on data, indicators and frameworks, as well as people's experiences, to provide an assessment of the progress of current reforms, their impacts on communities, the incidence and impact of any significant events during the period, and areas of the system that still require reform.

The Commission acknowledges that, as a result of our commitment to act as a catalyst for change in the mental health sector and the nature of our work in 2020, there are sections of this report where the Commission is reporting on its own work, or work in which we have played a key leadership role.

A note on language

The Commission acknowledges that language surrounding mental health and suicide can be powerful, loaded and at times contested. Often, preferences differ across groups of people, and there is no single consensus on preferred terminology. Given this, the Commission has been conscious to use terminology throughout this report that is both most respectful and preferred by the majority of people to whom the terminology refers.

This report covers a broad range of topics in relation to mental health. The language used to discuss these topics has adhered to the language conventions outlined in the Life in Mind National Communications Charter, where applicable. This Charter represents a unified approach and promotes a common language when referring to issues around mental health, mental illness and suicide, with the intention of reducing stigma and promoting help-seeking behaviours. For these reasons, the Commission aligns its terminology in this report with the conventions in the Charter.

Where using certain terminology may misrepresent a source being cited, the terminology used by the source has been used.

For a detailed list of definitions of terms used throughout this report, refer to the Glossary of Terms at the end of the report.

The Commission endorses the Mindframe Media Reporting Guidelines and requests that any media using this report do so in accordance with the Guidelines.

Executive Summary

This National Report 2020 shows that mental health and suicide continue to be significant issues for Australia. The events of late 2019 to 2020 have highlighted both strengths and weaknesses in many of our health and mental health systems. While an ambitious reform agenda has been set, many challenges remain to be overcome by governments, the mental health sector and the community before we can collectively achieve our vision of a system that delivers better outcomes via an integrated, person-led approach to mental health and wellbeing.

Before the outbreak of the COVID-19 pandemic, many communities across Australia were already experiencing long periods of stress following severe drought, widespread bushfires and floods. Although the economic and mental health impacts of containing the COVID-19 pandemic are likely to be long term, Australia responded to the COVID-19 emergency through rapid collaboration between all governments to maintain the health and wellbeing of Australians.

The crises have presented opportunities for innovation in future reform, and Australia has demonstrated that adaptability and rapid response are possible. The greater use of digital health services and telehealth helped mitigate the loss of community engagement provided by face-to-face support during the pandemic and opened up service access to a number of cohorts, particularly rural communities. This innovation expands options for service delivery of mental health support in the future.

Furthermore, during the pandemic, government agencies and the research sector responded quickly to establish new collaborations and data collections, or pivot existing collections to rapidly produce relevant data. These rapid responses demonstrate the capacity for change and improvements in system and data processes when the impetus is present. This approach needs to be embedded into practice over the longer term in sector reform.

In the midst of these positive changes, the past year has also presented considerable additional challenges for our mental health and resilience. It has tested the capacity of many support systems, such as the health and social services systems, and the economy in general to deal with complex crises and respond rapidly in innovative ways.

Some people with new presentations of mental health concerns sought help for the first time, and many found that the systems they encountered lacked connected pathways of care. Rapid access to assessment, treatment and support for individuals and their carers was missing across the spectrum of mental illness at the level that was required by the consumer.

Despite the challenges of 2019–20, progress has been made in the mental health sector. Of the 30 recommendations made in the National Mental Health Commission's (the Commission) Monitoring mental health and suicide prevention reform: National Report 2019 (National Report 2019), four have been completed and the majority have progressed.

The release of the report of the Productivity Commission inquiry into mental health has been welcomed, with the priority reforms focused on a person-led mental health system. The report highlights that the current mental health system has evolved as part of the health system rather than a system focused on how mental health is experienced by consumers. It calls for a nationally consistent, comprehensive mental health and suicide prevention system that is broader than health and encompasses the social determinants that can impact on our wellbeing. It recommends a mental health approach that spans a person's life, from early childhood to the later years of life, and includes housing, families, education, workplaces and the justice system. This aligns with Vision 2030, which is currently being developed by the Commission.

Other reports released in the past year will also inform mental health reform going forward: the Royal Commission into Victoria's Mental Health System, the Royal Commission into Aged Care Quality and Safety, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability and the National Suicide Prevention Adviser's interim advice to the Prime Minister on suicide prevention. The recommendations in these reports reflect different elements of what makes an efficient and effective system that meets the needs of, and improves outcomes for, people with lived experience, their families and the community more broadly.

The key message of 2020, as we consider the findings of the above-mentioned inquiries and the comprehensive feedback received from people with lived experience, is that any rethinking of the mental health system needs to take into account this new environment to ensure that the system is capable, and responsive to immediate, short-term and specific needs of people impacted by unexpected or major changes in their lives, as well as to their medium- and longer-term needs. It also needs to acknowledge that different people have been and will continue to be impacted in different ways.

Throughout this report, the Commission highlights areas that require further work to improve the mental health system and ensure that it meets the needs of all consumers and carers. From this analysis, the report makes four recommendations that the Commission views as priorities for the coming 12 months:

- The Australian Government should develop a National Older Persons Mental Health and Wellbeing Strategy.
- The Australian Government should develop a National Mental Health Workforce Strategy Implementation Plan.
- The Australian Government should develop a National e-Mental Health Strategy.
- The Australian Government should develop a National Regional and Remote Mental Health Strategy.

Section 1
The state of Australia's mental health and suicide prevention system

Chapter 1: National reform

The mental health and suicide prevention landscape has continued to evolve since the release of the National Mental Health Commission's (the Commission) Monitoring mental health and suicide prevention reform: National Report 2019, including the establishment of two national leadership roles (Box 1).

Key findings from major inquiries and investigations into mental health and suicide prevention have or are due to be released, and progress has been made on the majority of the National Report 2019 recommendations. The national discourse on mental health has not been limited to mental health–specific activities; inquiries into aged care, disability and domestic violence have highlighted significant mental health impacts on some of our most vulnerable cohorts. The message from these and other activities is clear: mental health and suicide prevention are issues for all governments, decision makers across all sectors, and all communities.

Box 1: New national roles

In February 2020, the Prime Minister announced a new National Commissioner for Defence and Veteran Suicide Prevention. This will operate as a permanent independent body to investigate and support the prevention of suicide among serving and ex-serving Australian Defence Force members.[1] In November 2020, Dr Bernadette Boss CSC commenced as the interim National Commissioner for Defence and Veteran Suicide Prevention.[2]

In May 2020, a Deputy Chief Medical Officer for Mental Health role was created to strengthen the coordinated medical and mental health response and decision making in relation to the COVID-19 pandemic, and support the delivery of mental health system reforms for all Australians. Dr Ruth Vine was appointed as Australia's first Deputy Chief Medical Officer for Mental Health.[3]

In October 2020, National Cabinet announced a new Mental Health National Cabinet Reform Committee. The committee will deliver a new National Mental Health and Suicide Prevention Agreement by November 2021. It will also oversee, and provide advice to National Cabinet on, the implementation of the National Mental Health and Wellbeing Pandemic Response Plan, which guides jurisdictions' responses to COVID-19.[4]

In December 2020, the Hon David Coleman MP was sworn in as Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention.[4]

Update on National Report 2019 recommendations

The National Report 2019 included 30 recommendations to improve the mental health and suicide prevention system. The Commission is pleased to see progress on some of these recommendations despite the disruption caused by the 2019–20 summer bushfires and the COVID-19 pandemic. Of the 30 recommendations, four have been completed, 17 are progressing, four are pending the Australian Government's response to the Productivity Commission inquiry into mental health, and five have not been progressed. The lack of progress on these five recommendations is mostly due to the changing landscape of mental health; the recommendations will be considered in line with the recommendations from the Productivity Commission (discussed below). A detailed progress update on the National Report 2019 recommendations is provided in **Appendix A**.

Progress has been made on Commission recommendations to address population data gaps and improve data collection for mental health and suicide prevention. In particular, the Commission welcomes the forthcoming update of national prevalence data through the National Survey of Mental Health and Wellbeing (discussed in **Section 1, Chapter 2**). The Commission also welcomes the routine analysis and publication of psychosocial risk factors associated with suicide deaths, which have been funded as part of the National Suicide and Self-harm Monitoring System project (discussed in **Section 1, Chapter 2**).

The National Disability Insurance Agency (NDIA), the Australian Government, and state and territory governments have been working to improve the experiences of people with psychosocial disability who access the National Disability Insurance Scheme (NDIS).

The introduction of the NDIS recovery coach, and enhanced roles for Partners in the Community and Community Connectors are important steps to help people with psychosocial disability access appropriate support and navigate the NDIS.

Concerns have been noted about access to the NDIS and transition arrangements for people with psychosocial disability. The routine release of data on NDIS participants with psychosocial disability has led to increased transparency. Together with evaluation of the transition measures for people transitioning into the NDIS, this provides important evidence on the extent to which people with psychosocial disability are receiving the support they need both within and outside the NDIS. Psychosocial disability and the NDIS are discussed further in **Section 1, Chapter 3.**

A number of developments have also occurred for Primary Health Networks (PHNs). The Australian Government Department of Health has released the 2018–19 PHN Program Performance and Quality Framework report, which provides baseline data on PHN performance. The Department of Health is also working in collaboration with PHNs and the National Aboriginal Community Controlled Health Organisation to review the current guiding principles of these organisations.

Some of the Commission's recommendations from the National Report 2019 for suicide prevention have progressed, and the majority are likely to be captured by final advice from the National Suicide Prevention Adviser. The Australian Government has funded the expansion of aftercare services for those who have self-harmed or attempted suicide, new postvention services to support families and carers who have been bereaved by suicide, youth peer support, and support for Aboriginal and Torres Strait Islander youth through the Pilbara trial and headspace services.[5,6] Developments in suicide prevention are discussed further in **Section 1, Chapter 3**.

National inquiries and activities

National inquiries and activities into mental health and suicide prevention have provided thousands of people and organisations with the opportunity to share their hopes and visions for reform, as well as their frustration, grief and at times anger with systems that often seemed broken. The following inquiries handed down reports documenting these stories and recommendations for reform.

Productivity Commission inquiry into mental health

The Productivity Commission inquiry into mental health has been described as a 'once in a lifetime' opportunity to reform the mental health system. The inquiry was given a broad remit to consider the effect of supporting mental health on economic and social participation, productivity and the Australian economy; how sectors beyond health can contribute to improving mental health; the effectiveness of current programs and initiatives; and whether current investment in mental health is delivering the best outcomes.

The final report was released on 16 November 2020. It reflects many of the recommendations made by the Commission in its submissions to the inquiry and in the National Report 2019—in particular, for a cross-portfolio and whole-of-government approach to mental health and suicide prevention, priority investment in early intervention and recovery, and clarification of funding arrangements for mental health services.

Recommended reforms to build a person-led mental health system were made across five broad areas:

- prevention and early intervention by focusing on children's wellbeing across the education and health systems, supporting the social inclusion of people living with mental illness, and taking action to prevent suicide
- recovery-focused health care by increasing informed access to mental health care, expanding supported online treatment, bridging mental health care gaps, improving crisis care and improving outcomes for people with comorbidities
- reorienting supports and services beyond health by improving the availability of psychosocial supports, providing supportive housing and homelessness services, and improving mental health outcomes for people in the justice system
- improving training and work by supporting youth economic participation, equipping workplaces to be mentally healthy, and tailoring income and employment support
- enabling reform by providing integrated care; supporting and involving families and carers; strengthening the mental health workforce; ensuring best-practice governance; providing funding; and commissioning and improving monitoring, evaluation and research.

Specifically, the Productivity Commission's final report articulated key roles and responsibilities by recommending the following:

- The Australian Government should involve carers and consumers in all elements of system governance and reform.
- The number of sessions provided through the Medicare Benefits Schedule (MBS) should be increased. The suite of online low-intensity services should be evaluated, and a cross-portfolio approach to mental health should be facilitated.
- State and territory governments should increase community ambulatory, bed-based services and aftercare, and provide alternatives to emergency department presentations for people suffering emotional distress.
- A whole-of-government approach is needed to prevention and early intervention across a range of institutions (for example, schools, tertiary education, workplaces) and linking mental health services with social services.
- The Commission should be responsible for evaluating mental health (and non-health) programs, developing and driving a national strategy to reduce stigma and discrimination, and monitoring and reporting on cooperation between PHNs and Local Health Networks (LHNs) for regional planning and implementation

Following the release of the final report, the Australian Government opened a three-month consultation for the public and key stakeholders to provide additional feedback on the report. The Australian Government will respond to the Productivity Commission's final recommendations in the context of the May 2021 Budget.

National Suicide Prevention Adviser's interim advice

The National Suicide Prevention Adviser's interim advice was released on 16 November 2020. The interim advice captures the voices of people with first-hand experience of suicidal distress, as well as carers, people bereaved by suicide, representatives of government and suicide prevention experts. It highlights the need for a cross-portfolio approach to reduce and respond to distress.

The interim advice calls for a comprehensive, coordinated and compassionate response that addresses vulnerabilities and provides supports long before a crisis emerges.

The report included a range of 'in principle' recommendations, which formed the basis of government and sector consultations ahead of the final advice, which was delivered to the Australian Government in December 2020.

As with the Productivity Commission's inquiry, the interim advice calls for a national whole-ofgovernment approach to suicide prevention. Its 13 in-principle recommendations provide a path for implementing this approach. The interim advice acknowledges that suicide prevention has generally been the responsibility of health departments, but that evidence shows that a broader focus is required to ensure that we can address the social and economic drivers of distress, and assist people as early as possible, building social connection and support.

The interim advice highlights that suicide prevention would benefit from involvement of the Prime Minister and premiers to provide this whole-of-government focus. It calls for development of a national suicide prevention strategy, a suicide prevention workforce plan, integration of lived experience knowledge, and improved data and evidence to inform decision making. It also emphasises the importance of targeted and coordinated approaches that meet the needs of priority populations.

Vision 2030: blueprint for the future

Vision 2030 is a long-term blueprint for a successful, connected and well-functioning mental health and suicide prevention system that meets the needs of the whole community. The development of Vision 2030, led by the Commission, began with consultations through the Connections project that sought the views of people with a wide range of experiences and from different stages in life on their experience with the mental health system.

This provided the opportunity for the Commission to hear at the local level what was happening, what was working and what needs to change.

Vision 2030 is consistent with the recommendations and approach of the Productivity Commission's inquiry into mental health, and other national, and state and territory inquiries that are underway. Vision 2030 provides a strategic framework through which current recommendations and future strategies and plans can be viewed.

Royal Commission into Victoria's Mental Health System

The Royal Commission into Victoria's Mental Health System was established in 2019 to provide the community with a clear and ambitious set of actions that would change Victoria's mental health system, and enable Victorians to experience their best mental health now and in the future. This commitment acknowledged that psychological distress and mental illness are significant health and social issues, and that the current mental health system is not sufficiently meeting the needs of Victorians.

The Royal Commission's interim report[7] was released in November 2019 and included nine priority recommendations to be addressed immediately by the Victorian Government. The mental health sector has welcomed the report's openness about the extent of problems within the existing system, as well as an acknowledgement of the harms these problems can cause. There was a positive response to recommendations to increase acute mental health beds, fund all area mental health services to offer the Hospital Outreach Post-suicidal Engagement program,[8] establish a Collaborative Centre for Mental Health and Wellbeing, and expand the consumer and family–carer lived experience workforces.[9] However, the report was also criticised for failing to sufficiently address issues around housing and homelessness, and the specific experiences of women and girls.[10]

The interim report's views about the need for a person-led mental health system align with the reform agenda to be outlined in Vision 2030. The Royal Commission has indicated that much broader, sweeping reform actions are required to redesign a failing system and that these will be advanced in the final report, which is due in early 2021. The Royal Commission is expected to result in significant reform—the Victorian Government has already established Mental Health Reform Victoria to implement seven of the nine priority recommendations and has committed to implementing all the interim report's recommendations.[11]

Royal Commission into Aged Care Quality and Safety

The Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) was established on 8 October 2018 to investigate the quality of aged care services currently being delivered to older Australians in the community and in residential aged care facilities. An overview of the aged care system is provided in **Box 2**. The Aged Care Royal Commission delivered an interim report on 31 October 2019, and a final report is due by 26 February 2021.

The interim report, titled *Neglect*, highlighted a number of opportunities for aged care reform. One area highlighted was the lack of access to appropriate mental health care for residents in residential aged care facilities. The interim report recommended the need for strong linkages between aged care service providers and more specialised services to assist older people who need additional services, such as specialist mental health services.[12] For many older people, deteriorating mental health can be overlooked as dementia or general cognitive decline, with low visibility of the underlying causes of depression and other mental illness. The aged care workforce requires more education on the effects of aging with regard to the mental health needs of older people, suicide prevention, and the behavioural and psychological symptoms of dementia, from mild to severe.

The Commission provided a preliminary response to the Aged Care Royal Commission draft propositions.

This indicated that having an aged care workforce skilled and trained in mental health literacy is essential as a core competency for all residential aged care facility staff within the first year of employment.[13]

The Aged Care Royal Commission's draft propositions, which were discussed at its mental health hearing, had a strong clinical focus on access to, and delivery of, services. Whereas this approach may be appropriate for those who are experiencing severe mental illness, most people would benefit from a more holistic approach to their mental health and wellbeing. The Commission recommends an approach based on the Contributing Life Framework, which provides a whole-of-person, whole-of-system, whole-of-life framework to mental health and wellbeing. This approach would include the expansion of programs, outside clinical services, to contribute to the mental health and wellbeing of older people, such as 'befriending' programs, and an enhanced role for peer workers in both community and residential aged care settings.[14]

Box 2: Overview of the aged care system

Most people who reach older age in Australia will require care and support, either from family members or from the formal aged care system. Around 80% will access some form of government-funded aged care during their life.[15] The majority receive home-based care and support; few live in an aged care home.[15] Yet, as noted by the Aged Care Royal Commission, the prevalent media and community debate is focused on residential aged care, and indeed mainly on any quality failures that occur there.

In 1997, the Australian aged care system was restructured into one system, providing a continuum of care; funding and regulation is now predominantly the responsibility of the Australian Government. A further reform occurred as part of the National Health Reforms in 2010, when the states and territories agreed to transfer responsibility for community care services for older people delivered under the Home and Community Care Program to the Australian Government.

Overall spending on aged care services is forecast to grow from $18.0 billion in 2018–19 to $22.1 billion in 2021–22.[16]

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) was established in April 2019 in response to community concern about widespread reports of violence against people with disability, and their neglect, abuse and exploitation. The Disability Royal Commission has been tasked with looking at ways to:

- prevent and better protect people with disability from experiencing violence, abuse, neglect and exploitation
- achieve best practice in reporting, investigating and responding to violence, abuse, neglect and exploitation of people with disability
- promote a more inclusive society that supports people with disability to be independent and live free from violence, abuse, neglect and exploitation.[17]

In its interim report, released on 30 October 2020, the Disability Royal Commission indicated that it had received a number of submissions that highlighted the difficulties people with disability face in navigating the mental health sector. Submissions have reported the use of seclusion and physical restraint to manage mental health in people with disability.[18] The Commission's submission provided evidence from its collaborative work in 2017 and 2018 with the Australian College of Mental Health Nurses to promote best practice in reducing use of restrictive practices in mental health services.[19]

People with psychosocial disability continue to require mainstream services such as health care, education, housing and transport.

The Commission supports continued efforts to ensure that mainstream services are not only accessible to people with psychosocial disability, but are also inclusive, person led, and free from stigma and discrimination.

Progress should be made to eliminate stigma and discrimination because they restrict access to social and community resources relevant to good health and expose individuals to more toxic environments, which in turn further erode the health of those being stigmatised.

The Disability Royal Commission's interim report highlighted systemic challenges in providing health care over a person's lifetime, including preventive and mental health care.

Royal Commission into National Natural Disasters Arrangements

The Royal Commission into National Natural Disasters Arrangements (Natural Disasters Royal Commission), established on 20 February 2020, released its report on 28 October 2020. The report looked at all aspects of emergency management and made two recommendations on mental health: for all governments to develop consistent and compatible methods for measuring the health and mental health impacts of natural disasters, and for governments to take steps to ensure that this data is shared.[20]

The Natural Disasters Royal Commission heard during the inquiry that often services were brought in temporarily, which did not allow continuity of care or development of long-term community-based mental health care.[20] The Royal Commission therefore recommended that all governments should support localised planning and delivery of mental health services.

The findings are discussed further in **Section 2**.

Chapter 2: The importance of data, evaluation and research

Innovation in the way we collect and use data, research and evaluation is vital to form a comprehensive picture of mental health in Australia, and to effectively monitor, evaluate and report on mental health and suicide.

The Commission welcomes the increasing focus on strengthening the evidence base for mental health and suicide prevention. Decision making, policy and program development, and service delivery are facilitated by robust and timely collection and use of data, effective evaluation, and innovative and targeted research. This chapter presents current data on prevalence and burden of disease, and discusses recent activities in data collection, evaluation and research.

Prevalence and burden of mental illness and suicide

The Productivity Commission has estimated that mental illness and suicide cost the Australian economy up to $70 billion in 2018–19, and that the cost of disability and premature death due to mental illness, suicide and self-inflicted injury was a further $151 billion.[21] It is predicted that global costs of mental illness will more than double from US$2.5 trillion in 2010 to more than US$6.0 trillion by 2030.[22] This means that mental illness will represent more than one-third of the global economic burden attributable to noncommunicable diseases.

The burden of mental illness and suicide in Australia is substantial. In 2015, mental illness and substance use disorders were responsible for 12% of the total burden of disease in Australia, making them the fourth biggest contributor to Australia's total burden of disease.[23] Mental illness and substance use disorders were the second largest cause of nonfatal burden in Australia (23%), and accounted for almost half of the nonfatal burden in people aged 15–30 years.[23] Suicide was the leading cause of death among people aged 15–49 years in 2019 and, together with self-inflicted injuries, accounted for an estimated 6% of the total years of life lost in Australia in 2015.[24]

To address the economic and social burden of mental illness and suicide, we need to understand the extent to which the population experiences mental illness. There are currently four national population surveys that provide an overview of the prevalence and impact of mental illness in Australia. These include the suite of surveys under the National Survey of Mental Health and Wellbeing (**Box 3**) and the Australian Bureau of Statistics (ABS) National Health Survey. Current prevalence estimates are presented in **Snapshot 1**. Reliable and timely data on suicide and suicide related behaviours also helps to inform approaches to suicide-prevention. Selected data on suicide and psychosocial risk factors is presented in **Snapshot 2.**

The National Report 2019 highlighted the importance of data for policy development and system reform. The Productivity Commission's final report also emphasised the significance of data and recommended that national prevalence estimates are routinely collected no less than every 10 years.

Developments in mental health data collection

The availability of, access to, and use of, timely data can facilitate improvements in mental health service delivery, promotion and prevention.[21] This is consistent with the World Health Organization's Mental Health Action Plan 2013–2020, which has highlighted the need to strengthen information systems, evidence and research as a key mental health priority.

Australia has made some investments in the collection of national mental health data since the beginning of the National Mental Health Strategy in 1992. This has resulted in quality data on use of mental health services, seclusion and restraint, and consumer experiences of services and clinical outcomes such as the Your Experience of Service (YES) National Best Endeavours Data Set (**Box 4**).[21]

Box 3: Mental health prevalence data

Australia's currently available prevalence data on mental illness and suicide was collected by the National Survey of Mental Health and Wellbeing. The suite of surveys under the National Survey of Mental Health and Wellbeing was a program of three mental health epidemiological surveys:

- National Survey of Mental Health and Wellbeing —a population-based survey of adults aged 16–85 years, most recently conducted in 2007[25]
- National Survey of People Living with Psychotic Illness—a service-based survey of adults with psychotic disorders, most recently conducted in 2010[26]
- Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter) —a population-based survey of children and adolescents, most recently conducted in 2013–14.

All three surveys based their classification of mental disorders on existing diagnostic criteria to estimate prevalence.

Prevalence estimates will be updated through the Intergenerational Health and Mental Health Study (see below). Until then, the National Survey of Mental Health and Wellbeing remains the only national estimate of common mental distress in adults that captures undiagnosed mental disorders. Data from the National Survey of People Living with Psychotic Illness, and the Australian Child and Adolescent Survey of Mental Health and Wellbeing provides the only reliable, national estimates for psychotic illness and mental distress in children and adolescents.

Intergenerational Health and Mental Health Study

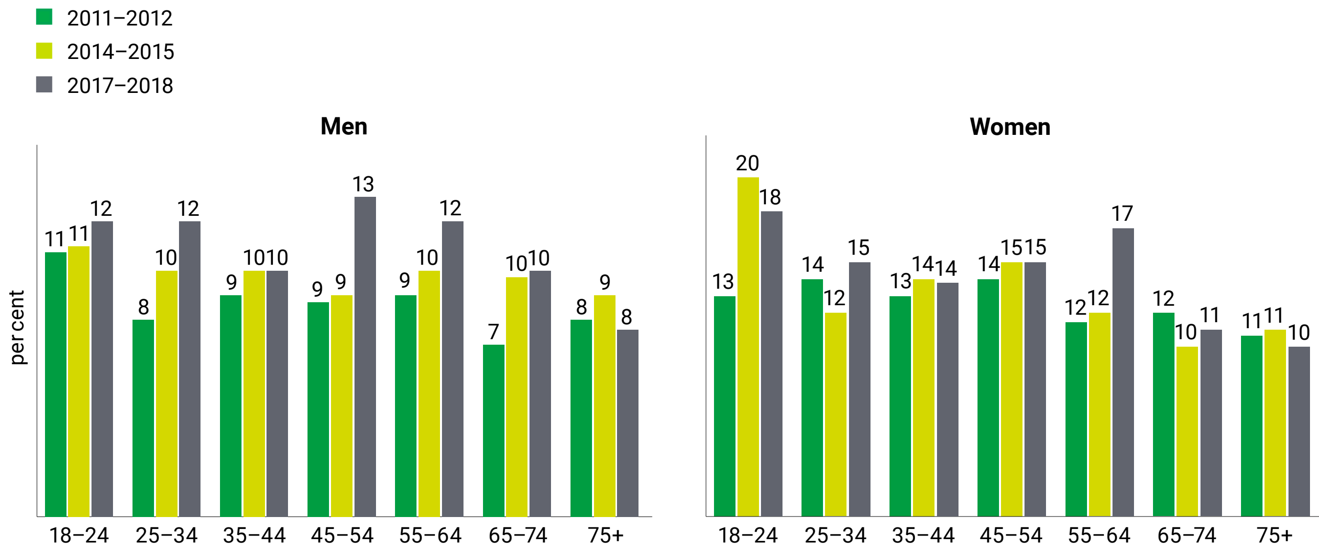
In August 2019, the Australian Government committed to funding another collection of prevalence data through the National Study of Mental Health and Wellbeing, as part of the Intergenerational Health and Mental Health Study, which will consist of four surveys over three years. Although it is a one-off study, it is hoped that future collections will occur.

The first phase of the Intergenerational Health and Mental Health Study has commenced. The study will measure the prevalence of mental illness, and provide updated statistics and insights into the impact of mental, behavioural and other chronic conditions on Australians; the use of health services and barriers to accessing them; and other health topics.

Snapshot 1
Prevalence of mental distress

- 2.4 million (13%) adults experienced high or very high levels of psychological distress in 2017–18.
- This pattern varies by gender and age.

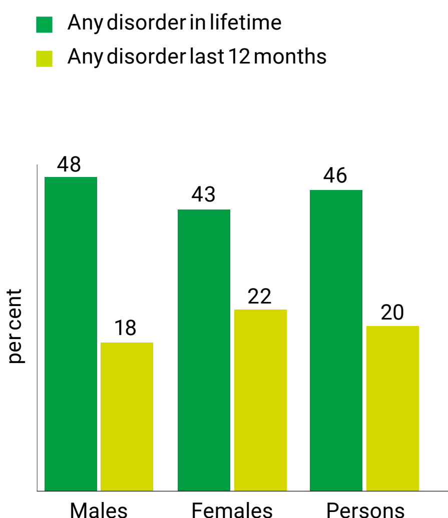
Figure 1: High and very high levels of psychological distress in men and women, by age group, 2011–12 to 2017–18



Source: ABS National Health Survey 2014–15 and National Health Survey 2017–18

- 46% of people aged 16–85 years will experience a common mental disorder in their lifetime.
- 20% experience a common mental disorder each year.

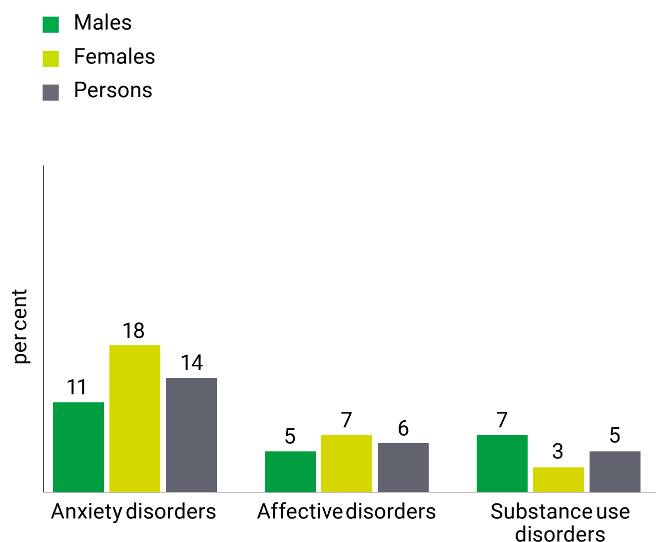
Figure 2: Prevalence of mental disorders



Source: Australian Bureau of Statistics. 2007 National Survey of Mental Health and Wellbeing, Summary of Results 2007

- 22% of women will experience a common mental disorder compared to 18% of men.
- Men (7%) are twice as likely as women (3%) to experience substance use disorder.

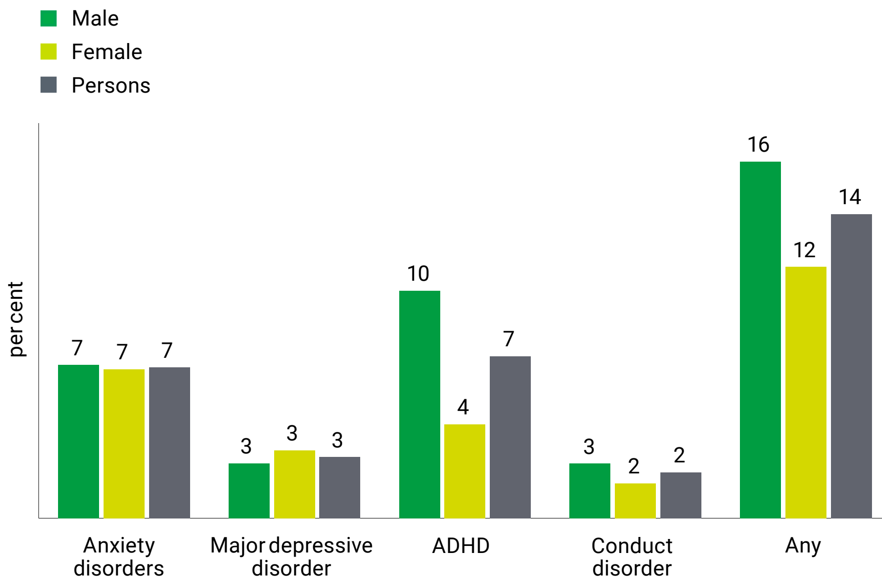
Figure 3: 12-month mental disorders, by major disorder group



Source: Australian Bureau of Statistics. 2007 National Survey of Mental Health and Wellbeing, Summary of Results 2007

- 14% of children and adolescents aged 4–17 experience a mental disorder each year. The rates of different disorders vary by gender.

Figure 4: 12-month mental disorders, by major disorder group



Source: Second Australian Child and Adolescent Survey of Mental Health and Wellbeing, 2013–14

Table 1: Number of people with psychotic illness in contact with public specialised mental health services

Sex	Number	Rate per 1,000 population
Male	38,859	5.4
Female	24,674	3.5
Persons	64,000	4.5

Source: Australian Government. People living with psychotic illness, 2010

- An estimated 64,000 people with a psychotic illness are in contact with public specialised mental health services in a 12-month period.

Table 2: 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
Male	5	3	2	2
Female	11	8	5	3
Persons	8	5	3	2

Source: Second Australian Child and Adolescent Survey of Mental Health and Wellbeing, 2013–14

Snapshot 2
Suicide and self-harm

- 3,318 people died by suicide in Australia in 2019 (12.9 suicide deaths per 100,000 population).
- This is an average of about 9 deaths per day.
- Males are 3.14 times as likely as females to take their own lives.
- Almost three-quarters (75%) of people who died by suicide were aged 20–59 years.

Figure 5: Suicide deaths, by sex, 2019

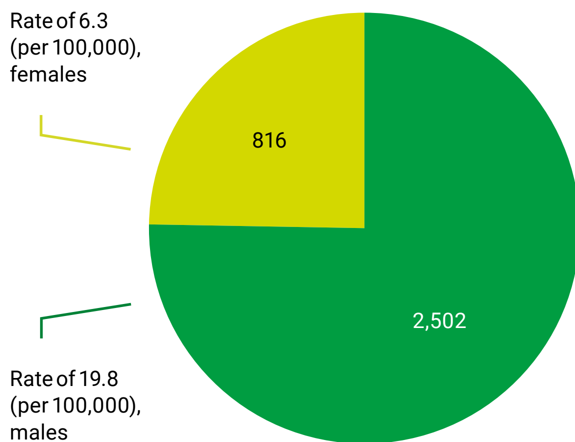
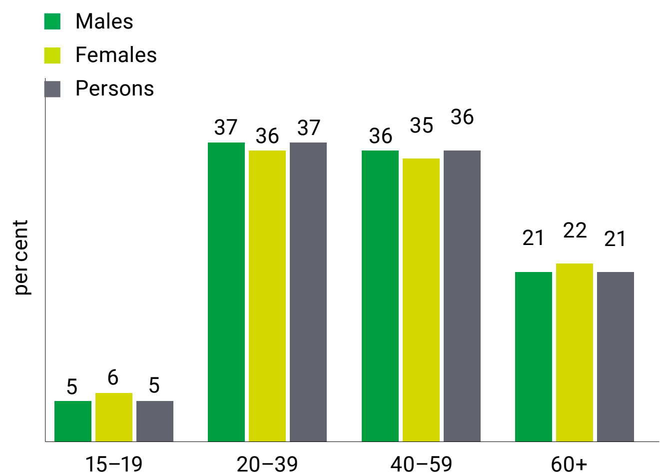


Figure 6: Suicide deaths, by age group and sex, 2019

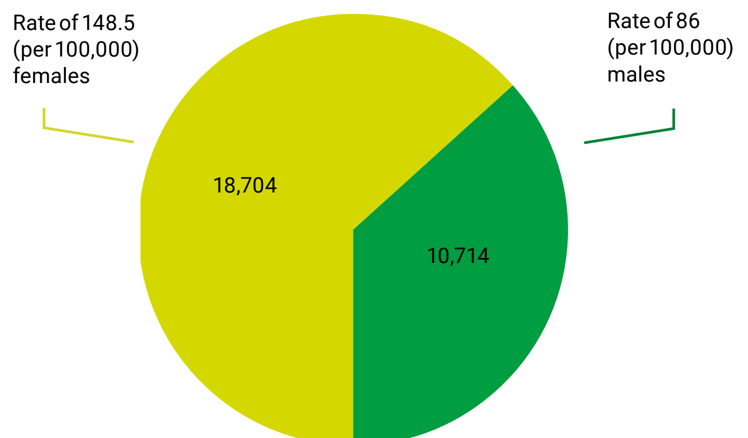


Source: Suicide and Self-harm Monitoring. National Mortality Database—Suicide (ICD-10 X60–X84, Y87.0)

- There were more than 29,400 hospitalisations for intentional selfharm in 2018–19.
- Two-thirds (64%) of hospitalisations for intentional self-harm were for women.

Figure 7: Hospitalisations for intentional self-harm, by sex, 2018–19

Source: Suicide and Self-harm Monitoring. National Mortality Database—Suicide (ICD-10 X60–X84, Y87.0)



- 384 children and young people died by suicide in 2019.
- Suicide accounted for 40% of deaths for people aged 15–17 and 36% of deaths for people aged 18–24.

Table 3: Suicide deaths of children and young people, 2019

Age group	Number	% of all causes of death
14 and below	19	7
15–17	77	40
18–24	384	36

Source: Suicide and Self-harm Monitoring. National Mortality Database—Suicide (ICD-10 X60–X84, Y87.0)

- 195 Aboriginal and Torres Strait Islander people died by suicide in 2019.
- This accounted for 6% of all suicides in 2019 and is twice the suicide rate of non-Indigenous Australians.
- Suicide is the fifth leading cause of death for Aboriginal and Torres Strait Islander people.

Table 4: Suicide deaths, by Indigenous status, 2019

Sex	Number	Rate per 100,000 population
Indigenous	195	27.1
Non-indigenous	2,202	12.7

Sources: Suicide and Self-harm Monitoring. National Mortality Database—Suicide (ICD-10 X60–X84, Y87.0); Australian Bureau of Statistics. Causes of death, Australia, 2019.

Box 4: Your Experience of Service survey 2018–19 results

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.[27] The survey asks respondents to rate their experience of care. It also asks 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, Queensland and Victoria—have implemented the YES survey in mental health-related hospital and community mental health settings, and are contributing to a publicly reported data collection.

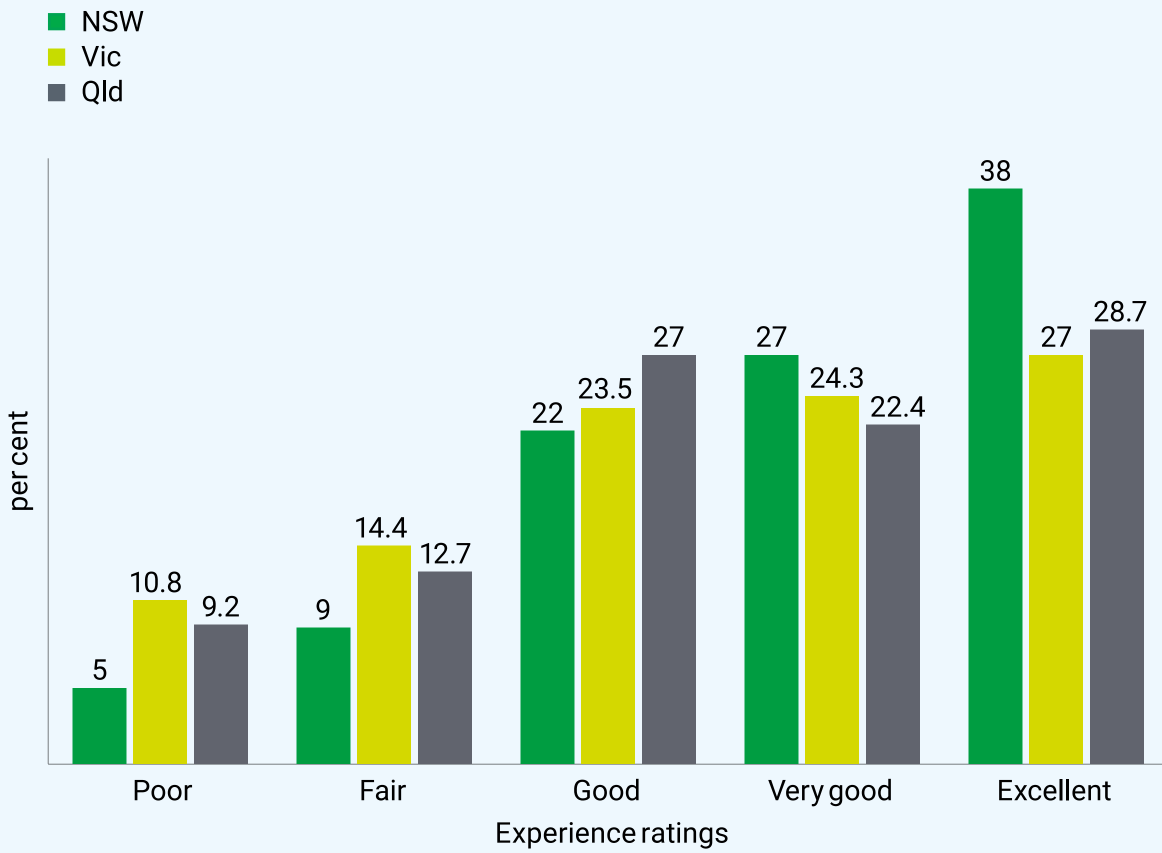
There are differences in how each state uses the YES survey. In New South Wales, consumers are offered the YES survey during every hospital stay or community health centre visit. In Victoria and Queensland, consumers are offered the YES survey in a particular week or month of the year.[27] While each state has chosen the survey delivery method that best suits their local needs, differences in collection practices make comparison difficult and reduce opportunities for jurisdictions to learn from each other about how best to meet consumer needs. In 2018–19, 31,282 YES surveys were collected from 86 mental health service organisations. Results suggest that the majority of mental health care provided meets the needs of consumers, with more than 70% of respondents across the three states rating the admitted care (acute care) they received as 'good', 'very good' or 'excellent'. However, 14–25% of consumers reported a 'fair' or 'poor' experience of their admitted patient mental health care (see **Figure 8**).[27]

Your Experience of Service Primary Health Network survey

In 2018, the Australian Government Department of Health funded the Australian Mental Health Outcomes and Classification Network to develop a version of the YES survey suitable for use by Primary Health Network (PHNs), with a focus on consumers receiving mental health services and potentially, alcohol and other drugs services.

A co-design approach was taken to ensure that the views of PHNs, commissioned service providers, and consumers and carers informed the content of the measure. The draft survey was tested in several PHNs. Analysis of the field trial data indicated that the survey demonstrated good internal consistency and satisfactory test–retest reliability. In April 2020, the survey became available for use by all PHNs.

Figure 8: Consumer's experience of care ratings, admitted patient care by state, 2018–19



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

Chapter 2: The importance of data, evaluation and research

Attention to the reliability and reporting of data related to suicide deaths has continued to increase. The evidence produced by collective government efforts has been supplemented by evidence produced via robust academic research through Australian academic institutions and international research (**Box 5**).

However, gaps and limitations in Australia's mental health data infrastructure hinder attempts to develop timely evidence-based policy responses, as well as attempts to monitor the performance of the mental health and suicide prevention system.

Some key issues identified by the Productivity Commission in its report include the following:

- Data is currently underutilised because of restrictions on access and use, or because it is not fit for purpose.
- Limited data linkage affects the ability of policy makers and decision makers to understand the broader impacts of mental illness and distress on consumer and carer outcomes, access to health and non-health services, and the social determinants of mental health and suicide-related behaviours.
- Establishing, collecting and maintaining national datasets can be costly and burdensome, resulting in long delays between collection and release.
- There continue to be significant data gaps, including outdated data on prevalence and service use; limited information on services provided by nongovernment organisations and MBS-rebated practitioners; limited information on particular demographic groups (such as Aboriginal and Torres Strait Islander populations, multicultural groups and LGBTIQ+ people), and limited information on mental health impacts in sectors such as education, employment and social services.[21]

Without these vital pieces of information, the current picture of mental health in Australia is incomplete. The Commission supports the need for a more coordinated, forward-thinking national approach to data collection, including the type and quality of data collected. This will require collaboration across jurisdictions and key stakeholders, and clear coordination points for collation and interpretation of data received.

Box 5: Recent developments in data collection and research

National Suicide and Self-harm Monitoring System

In April 2019, the Australian Government committed to establishing a new national system for collating and communicating information on suicide and self-harm. The Australian Institute of Health and Welfare (AIHW) is working with the Commission to develop this system, with support from an Expert Advisory Group and Lived Experience working group.

The public interface was released in September 2020 on the AIHW website (and is accessible from the Commission's website). A separate state and territory information portal will be available in mid-2021 to support government policy makers and program managers. The content on both sites will be regularly updated as new data becomes available.

The national monitoring system will improve the coherence, accessibility, quality and timeliness of national data and information on suicide, suicide attempts and self-harm. The system will provide a more nuanced understanding of who is at immediate risk of suicide and who may be at heightened risk of suicide. A better understanding of this is critical to knowing how to help people at risk of suicide more effectively.

Million Minds Mental Health Research Mission

The Million Minds Mental Health Research Mission (announced in May 2018 as part of the Long Term National Health Plan) will invest $125 million over 10 years from 2018–19 in innovative mental health research. The mission aims to support one million Australians with mental health issues access new approaches to prevention, diagnosis, treatment and recovery by encouraging translation of research into practice.[28]

To date, the mission has funded $27.4 million in grants for seven research projects in the areas of Aboriginal and Torres Strait Islander mental health, child and youth mental health, and eating disorders.[28] An additional $10.3 million in grants was announced in May 2020 for three research projects focusing on suicide prevention.[29] The Australian Government has also announced $3 million of funding under the mission for rapid research into improving the response of the mental health and suicide prevention system to the COVID-19 pandemic.[30]

Chapter 2: The importance of data, evaluation and research

Evaluation and research

Evaluation and research are required alongside data, to building a comprehensive picture of mental health in Australia and to drive improvements in policy and practice. Evaluation and research in mental health are also critical to the evidence base for clinical care, to targeted investment in prevention and early intervention to understanding the progress of existing reforms and to support the case for future reform.

Evaluation

Routine evaluation provides valuable information about how well programs are working, how they can be improved and new areas for development. Specifically, robust evaluations inform how funding should be allocated to improve service delivery, and ultimately the outcomes for people accessing mental health services.

The Productivity Commission inquiry into mental health highlighted a clear lack of program evaluation across all levels of the mental health and suicide prevention system. It made a suite of recommendations designed to develop and promote a culture of evaluation. Key factors driving this include:

- limited workforce capability in evaluation
- insufficient funding, planning and use of evaluation
- weak incentives to prioritise evaluations, which tend to be costly and resource-intensive
- lack of consistency in how programs are evaluated and the extent to which evaluation findings are shared.[21]

Research

Mental health and suicide prevention research is pivotal in the implementation of new knowledge. It also drives innovation by generating knowledge and evidence about prevention, causes, impacts and treatment of mental illness.

Australia performs well internationally in mental health and suicide prevention research. Analysis of research published in mental health and suicide prevention indicates that, in the category of general mental health, around 12% of Australian publications are in the top 10% of those most highly cited, and around 20% are above world average citations during the past 10 years (2007–2017). Australia is also rated 10th internationally in terms of publication volume, equivalent to about 2.5% across all mental health–related areas of research.[31]

Despite Australia's strong performance in research, and the significant global and national burden of mental illness, investment in mental health research is significantly lower than for other health-related fields. For example, recent analysis by the International Alliance of Mental Health Research Funders found that, although mental ill-health in Australia and New Zealand accounts for more years of life lived with a disability than physical ill-health, mental health research receives less funding than research into physical conditions such as infections, cancer and cardiovascular disease (see **Figure 9**).[32]

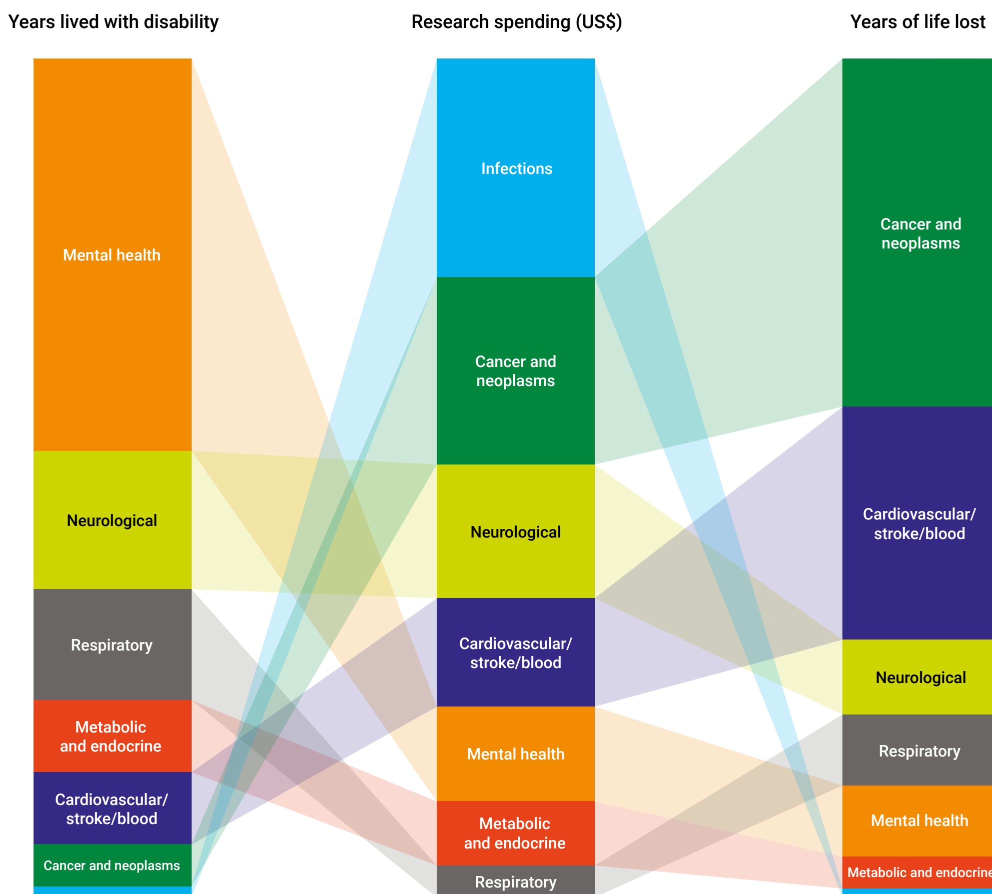
At present, mental health research in Australia does not have an overarching strategy and is therefore largely driven by two factors: investigator-initiated grants funded through a variety of peer-reviewed processes such as the National Health and Medical Research Council; and targeted funding through vehicles such as the Medical Research Future Fund (MRFF), where specific research priorities are identified, and investigators apply within that priority area. There is also a dedicated Suicide Prevention Research Fund, established in 2018.

The complexity of the mental health system and the changes it is currently undergoing require the development of a clear strategic approach to prioritising research objectives, targeting research funding, improving data collection and sharing protocols.

The growing understanding of the complexity of mental health also affords an opportunity to review whether current mental health research funding and activity are fit for purpose. A review of both current and past investment in mental health research and the impact of that investment is needed to determine the gaps and opportunities.

Australia's first national mental health research strategy is currently being developed. It aims to provide a principles-based framework to inform planning, funding, conduct and implementation of mental health research in Australia. A task under the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) is to develop a research strategy to drive better outcomes across the mental health sector in Australia. The Commission is working in collaboration with people with lived experience, carers, states and territories, research funding bodies and prominent researchers to develop the strategy.

Figure 9: Research funding in Australia and New Zealand for selected fields, including mental health, compared to measures of disease burden



Source: Extracted from International Alliance for Mental Health Research Funders—The inequities of mental health research funding, 2020

Chapter 3:
Current mental health and suicide prevention reform activities

As discussed in Chapter 2, how governments respond to the findings and recommendations of key inquiries will affect long-term systemic reforms of the mental health and suicide prevention system. In the meantime, initiatives to better meet the needs of consumers and carers continue to be implemented at national, state and territory, and regional levels.

Implementing the reform agenda requires collaborative leadership and cooperative planning. It also takes time, investment, commitment and flexibility to respond to barriers and emerging issues, and requires evaluation, monitoring and reporting on progress and outcomes to inform future planning and improvements.

A key theme identified in the Commission's 2019 Connections tour to inform Vision 2030 was that the mental health system continues to present barriers to identifying needs and providing quality care that is accessible to all.

Consultation participants experienced disconnected and reactive services that did not cover the essential components of community-based care because of the split of responsibilities across governments.

Barriers to accessing the system were also raised by participants, who noted difficulties entering the appropriate level of care because services were not coordinated or were hard to navigate.

Also reported was a lack of consistency in services available across the spectrum of care, with different gaps experienced in different locations (including the gap in service provision between primary and acute services, commonly referred to as the 'missing middle').
For example, often moderate-intensity care is accessible only when self-financed, or financed through private insurance or disability programs. This means that many people with a complex or chronic mental illness do not receive the full scope of care they need and cycle through the acute care system.

Results from the Commission's Consumer and Carer survey (**Box 6**) offers similar insights to those highlighted in the Connections project. The Consumer and Carer survey is conducted annually to inform the Commission's reporting on the progress of the Fifth Plan.

Box 6: Consumer and Carer survey

The Commission has extended its Fifth Plan reporting by including an annual survey of mental health consumer and carer perspectives. The survey aims to measure whether consumers and carers are experiencing the improvements and benefits outlined in the 'what will be different for consumers and carers' section of the eight Fifth Plan priority areas.

The results from the 2020 Consumer and Carer survey suggest the following:

- The intended benefits from improving integrated regional planning and service delivery have not yet been realised for a significant proportion of consumers and carers.
- Most consumers and carers are aware of support services available to those at risk of suicide, but fewer people are aware of active follow-up care for people who have attempted suicide or services that are available for carers, families and communities affected by suicide.
- Many consumers with severe and complex mental illness do not have access to the clinical and nonclinical community-based services required to live a contributing life.
- Coordination of physical and mental health care continues to be limited.
- Stigma and discrimination remain common for people with mental illness, both in healthcare settings and in the broader community.
- Although mental health services are a safe place for the majority of people, a significant proportion of respondents do not consistently feel safe using these services.
- Most consumers and carers have not observed improvements in mental health services and have not been invited to contribute to service improvement.

Chapter 3: Current mental health and suicide prevention reform activities

Collaborative partnerships in system reform

To effectively address mental health and suicide prevention in Australia, a national approach is required to improve strategic oversight and coordination of mental health policy and investment.

The National Mental Health Strategy is the policy framework, introduced nearly 30 years ago, that guides mental health reform for all governments to work together to change a system that has been widely acknowledged as inadequate and long neglected by policy makers.

A complex web of strategies, plans and frameworks representing national, and state and territory priorities has been developed and implemented (at times only partially). The Fifth Plan is the main instrument that sets out the current national reform agenda for mental health and suicide prevention in Australia from 2017 to 2022. State and territory plans align with the national plan, but reflect their own priorities. The approach to how consumers and carers, the community sector and private providers are engaged is not consistent. The Fifth Plan was agreed by all governments, and was accompanied by an implementation plan with actions, responsibilities and time frames. For the first time, the National Mental Health Plan included annual public monitoring and reporting. Some limited national projects received funding from the Council of Australian Governments under the Fifth Plan, but most activity was unfunded.

Under the Fifth Plan, a number of key national activities have been progressing, including initiatives led by the Commission, such as the National Mental Health Research Strategy and the National Lived Experience (Peer) Workforce Development Guidelines (see **Box 7**). Additionally, under the Long Term National Health Plan announced in 2019, reform initiatives such as Vision 2030, the Primary Health Care 10 Year Plan, the National Preventative Health Strategy and the Medical Research Future Fund investment plan have been progressing.

Box 7: National Lived Experience (Peer) Workforce Development Guidelines

Under the Fifth Plan, the Commission is leading the development of the National Lived Experience (Peer) Workforce Development Guidelines by 2021. The guidelines support ongoing development of the lived experience workforce in Australia, providing a roadmap for organisational and sector leaders across diverse settings to inform the development of governance, policies and practices that support sustainable and effective growth.

This work aligns with recommendations from the Productivity Commission inquiry into mental health and the Royal Commission into Victoria's Mental Health System to grow and enhance workplace supports for the peer and lived experience workforce.

The guidelines will provide guidance for governments and employers on the knowledge and supports required to grow the workforce in a sustainable and effective manner. Although some local and regional frameworks for the peer and lived experience workforce exist, the development of national guidelines aims to foster consistency across Australia.

The Productivity Commission considers that the National Mental Health Strategy does not meet consumer and carer expectations and should be strengthened by facilitating a genuine whole-of-government approach, linking funding with the strategy, setting a clearer vision, ensuring greater coherence, and widening stakeholder engagement. To achieve this, the Productivity Commission has recommended a new national strategy between the Australian Government and state and territory governments that comprehensively integrates the roles played by health and non-health sectors, and guides the efficient allocation of funds and resources.[21]

In line with this, Vision 2030 addresses these concerns by prioritising governance structures that are clearly defined and implementable through formal agreements between the Australian Government and state and territory governments in a way that is transparent, consistent and measurable.

In October 2020, National Cabinet announced a new Mental Health National Cabinet Reform Committee to deliver a new National Mental Health and Suicide Prevention Agreement by November 2021 and to oversee, and provide advice to National Cabinet on, implementation of the National Mental Health and Wellbeing Pandemic Response Plan.[4] The Commission supports this national collaboration and focus on addressing long-term recovery from the mental health impacts of the COVID-19 pandemic. The development of a new National Mental Health and Suicide Prevention Agreement also provides an opportunity to improve our national approach and supporting governance structures, particularly if related recommendations from the Productivity Commission's inquiry into mental health are taken on board. The interim advice from the Prime Minister's Suicide Prevention Adviser also supports whole-of-government leadership and governance.

New ways of working have started to impact on governments. Of particular significance is the new National Agreement on Closing the Gap that involved all levels of government and representation of the peak Aboriginal and Torres Strait Islander organisations. For the first time, the National Agreement on Closing the Gap includes a target aimed at reducing Aboriginal and Torres Strait Islander suicide rates, in addition to the inclusion of social and emotional wellbeing as a priority area. Other priority areas include justice, housing, early childhood care and development, and Aboriginal and Torres Strait Islander languages.[33]

Prioritising lived experience in system reform

The Productivity Commission and the Royal Commission into Victoria's Mental Health System both recognised that a well-informed, functioning mental health system that adequately meets the needs of consumers and carers is achievable only with the inclusion of lived experience.

Beyond inclusion, mental health reform needs to place those with lived experience at the centre, as the driving influence for change and system improvements.

Engaging effectively with consumers and carers requires a new way of working that recognises the value of lived experience perspectives, and acknowledges consumers and carers as equal partners.

Lived experience groups and organisations currently contribute to mental health reform in various ways through systemic advocacy, and working to embed consumer and carer interests and voices. For example, the National PHN Mental Health Lived Experience Engagement Network (MHLEEN) was established in 2018 to share approaches around lived experience engagement and co-design. Since then, MHLEEN has increased the participation of people with lived experience in the development of new PHN programs, increased the number of PHNs employing or engaging consultants with lived experience, and conducted a stocktake of engagement and participation opportunities within PHNs across Australia.[34]

Mental health services must be designed, planned and evaluated via partnerships between the consumers and carers who use the service and service leaders.

Chapter 3: Current mental health and suicide prevention reform activities

The Mental Health Safety and Quality Engagement Guide, a Fifth Plan action the Commission was responsible for, aims to empower and support mental health consumers and carers, and health service leaders to engage in meaningful partnerships to improve safety and quality in mental health services. The guide specifically focuses on participation by consumers and carers at a governance level. It recognises the importance of people with lived experience influencing strategic decision making and in promoting systemic changes in all aspects of mental health services.

Another co-design model is the development of the Reimagine Today website managed by the Mental Health Coordinating Council of New South Wales and partially funded by the NDIA. Reimagine Today provides information and resources to assist with understanding NDIS psychosocial disability provisions, and provides clear and practical advice on how to access the NDIS. The website was co-designed with and for people living with mental health conditions and their supporters.[35] This model provides a sound example of an effective co-design process leading mental health reform, which can be applied more broadly across other initiatives.

Another significant initiative is the Aboriginal and Torres Strait Islander Lived Experience Centre, which was established in 2020 as the culmination of the Indigenous Lived Experience Project in 2018, led by the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention and supported by the Black Dog Institute.[36] The centre aims to embed the expertise of Aboriginal and Torres Strait Islander people with lived experience in mental health and suicide prevention initiatives across the country. It will foster the support, connections and learnings required to establish and enable an Indigenous-led National Lived Experience Network.[37]

In April 2020, the Australian Government launched the new Carer Gateway to provide a single entry point for carers seeking information on, support for and/or referral to mental health services.[38] The Commission encourages co-designed evaluation of the new gateway to establish how effective it is and inform improvements, where required.

Eliminating stigma and discrimination

Eliminating stigma and discrimination is essential if all Australians who experience mental ill-health, trauma or distress are to access care and support, and participate fully in the life of their community.

Increasing knowledge and understanding of mental ill-health can encourage those who may be struggling with their mental health to seek help, to know how and where to seek help, and to find out what services might be helpful for them. At the same time, it begins to break down the self-stigma that those experiencing mental ill-health may face.[39] Shame and the fear of being stigmatised or discriminated against by others can act as a barrier to seeking help and support.

Research shows that, although attitudes towards people living with anxiety and depression have improved over the past two decades, attitudes towards those living with complex mental health issues such as schizophrenia are less favourable.[40] Findings from SANE Australia's National Stigma Report Card, released in October 2020, have indicated that experiences of stigma and discrimination continue to be pervasive in Australia for people with complex mental health issues.[41]

The 'Our Turn to Speak' survey identified that interpersonal relationships, employment, healthcare services, social media and mental health care services were the areas in which people were most affected by stigma and discrimination. However, stigma and discrimination were not limited to these domains.[42]

These findings indicate that stigma and discrimination remain entrenched in our society and culture, experienced in the close personal relationships we form, and in the mass media and social media that surround us.

They are institutionalised in the services we access to seek help for our mental health and the broader institutions we interact with in our daily lives. Notably, these broader institutions often seek to address factors that are essential for good mental health and wellbeing, such as safe and secure housing or economic security.

In the Commission's Spotlight report on complex trauma (due for release in 2021), focus groups with people who had experienced complex trauma reported facing significant levels of stigma.

Often, stigma and discrimination were perpetrated by those within the system, including nurses, doctors and police. The profound impact these experiences can have on a person's sense of self-worth and on their recovery journey cannot be overstated.

Under Priority Area 6 (Reducing stigma and discrimination) of the Fifth Plan, governments are required to take action to reduce stigma and discrimination experienced by people living with mental illness, with a focus on reducing stigma and discrimination in the health workforce. Stigma in a workplace is generally the result of discriminatory and/or prejudicial beliefs, attitudes and assumptions.

Stigma is embedded in our society and institutions, and the language we use to talk about mental health can reinforce stigma. Therefore, encouraging safe and appropriate language when discussing mental health and suicide can work to reduce stigma and discrimination. The Life in Mind project, led and developed by Everymind, published a National Communications Charter in 2018 that is designed to guide the way we talk about mental health, social and emotional wellbeing, mental ill-health and suicide prevention, with each other and the community. Organisations and individuals are asked to make a formal commitment to work together, and develop better structures and processes for collaboration.[43]

The Commission has recently been tasked with developing a National Stigma and Discrimination Reduction Strategy, as recommended in the Productivity Commission's final report. This strategy will build on the work started under the Fifth Plan, and will be co-designed with people who are affected by mental ill-health, trauma or distress.

The strategy will outline a long-term vision for a society where all Australians can live long and contributing lives, free from stigma and discrimination. The strategy will also articulate clear priorities, focus areas, objectives and actions over four years to:

- eliminate structural stigma and discrimination in identified settings
- reduce public stigma by changing attitudes and behaviours in the general community and among identified target audiences
- reduce self-stigma among those who experience mental ill-health, trauma and distress, and those who support them.

Facilitating access to, and delivery of, mental health care

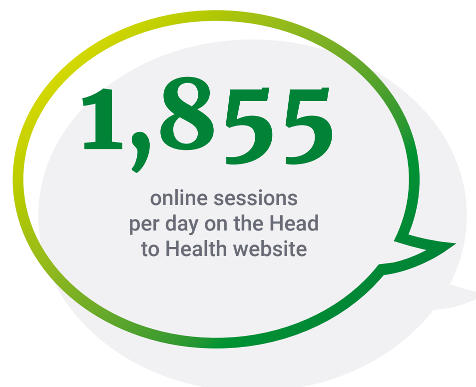
To increase equity of access to services, innovative and flexible approaches to service delivery are required. It is essential that new models of treatment, care and support are developed that are affordable, culturally appropriate, timely and available regardless of where a person lives.

Accessing mental health care can often be more difficult for certain groups of people who face unique geographic, social, cultural and economic barriers, including those in rural and remote regions, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and older people.[44]

The role of digital mental health

Digital technologies are increasingly being used to break down various access barriers and provide effective treatment, care and support to consumers. Digital services have been key in ensuring the continuation of mental health service delivery in the absence of face-to-face supports during the COVID-19 pandemic. Digital technologies and online services can also benefit the rural and regional mental health workforce by facilitating multidisciplinary treatment when workers are in different locations, and delivering education and training.[45]

In October 2017, the Australian Government launched Head to Health, a digital mental health gateway website. The website lists for ease of access in a single location digital mental health services and resources, including a range of free or low-cost apps, online support communities, online courses and phone services.[46] As at October 2020, more than 2,035,318 online sessions (people accessing the online resources) had taken place through the website, averaging approximately 1,855 sessions per day.[47]



The website provides a useful resource for health practitioners by increasing accessibility to evidence-based mental health supports, particularly in rural areas. However, research has highlighted issues around the integration of digital mental health services into clinical practice, recommending the development of integration guidelines to provide clarity.

Although digital services offer an innovative solution to address the digital divide and equitable access to mental health care, it is a relatively new approach. They require a coordinated, consistent approach to ensure safety and quality, and tighter guidance around best practice for service providers and developers.

The Australian Commission on Safety and Quality in Health Care is developing the National Safety and Quality Digital Mental Health Standards to address these concerns. Consultations with consumers, carers, providers and technical experts were conducted in early 2020, and the standards were released on 30 November 2020.

In addition, under the Fifth Plan, development of the National Digital Mental Health Framework is currently underway. The framework aims to provide an integrated and strategic approach to digital mental health service delivery within the broader context of Australia's mental health system. This includes defining optimal delivery of digital mental health services to improve service access (including workforce considerations), reduce duplication of effort and investment, and embed digital mental health services in the broader mental health service system.

The role of Primary Health Networks in access to and delivery of mental health care

The Commission has previously monitored the establishment of PHNs as a core component of mental health system reform. As PHNs become increasingly responsible for commissioning a range of services, the focus is now on the role of PHNs in working with LHNs to provide integrated regional plans for service delivery, and as regional bodies in, coordinating services to improve access to and delivery of mental health care.

Adult Mental Health Centres

In May 2019, the Australian Government committed $114.5 million over five years to trial one Adult Mental Health Centre in each state and territory.[48,49]

The centres will complement existing services in the community setting, especially state and territory services. Lessons will be learned from the joint work in developing the HeadtoHelp hubs by the Australian Government and the Victorian Government (discussed in **Section 2**).

Given the significant investment in this initiative, it is important to evaluate it to inform any future rollout of these centres, and ensure that they are effective in complementing existing community mental health services. Equally important is ensuring that evaluation outcomes are made publicly available to inform future policy and service delivery initiatives. Mental Health Australia's response to the proposed service model has suggested that evaluation processes should report on the degree of local co-design and the relationship between this and service outcomes.

The mental health sector's response during the consultation phase for the proposed model has largely been positive. However, lack of clarity in how the centres will integrate or interact with existing community mental health services has been raised.[50,51] Building on PHN–LHN local mapping to identify the specific role of each centre in its local area has been suggested as a way of ensuring that the centres are tailored to meet local needs and to avoid duplication of existing local services.[50]

Other issues are tensions associated with balancing national consistency with local and regional tailoring, and potential equity issues for rural and remote areas due to existing workforce shortages. Management of these issues will require strong national governance and direction.[52] Further, understanding the complexities of supporting people in crisis will be crucial to the success of the model.

Community-based residential eating disorder treatment centres

In April 2019, the Australian Government announced the establishment of six new community-based residential treatment centres for people with eating disorders across Australia. This is in addition to funding previously provided for the Wandi Nerida residential eating disorder centre in Queensland.[53] Establishment of the centres is currently underway in each jurisdiction. The centres are intended to provide wraparound support and specialist care through delivery of evidence-based treatment programs.[53]

The centres will be well placed to provide tailored access and support for people with eating disorders, by providing a safe and healing environment for those most in need of psychological and physical care. This will also be an important pilot project to inform future treatment models for eating disorders in Australia.

Link-me trial

Three PHNs have participated in Link-me, a large-scale trial of a new approach to stepped mental health care in general practice, particularly for those with complex needs. A final report has been delivered to the Australian Government that considers whether the use of a purpose-built decision support tool (DST) leads to clinical, cost-effective benefits relative to usual care. The DST is built to systematically identify, and provide tailored treatment recommendations to, people with low and high levels of mental health needs.[54]

The Productivity Commission's findings have suggested that the DST can improve the assessment and referral practices of general practitioners (GPs) by identifying the mental health needs of people going to the GP. The Productivity Commission also proposed that the extent of benefits resulting from the tool, clinical benefits and cost savings, should inform governments commissioning activities in line with the stepped care model.

> Use of the DST is significant in relation to navigation of the system because it has the potential to improve GPs' abilities to provide appropriate mental health referral pathways at the appropriate level of care. This could provide a smoother path through the mental health system for consumers and their carers.[55]

Psychosocial disability and the National Disability Insurance Scheme

Various concerns have been noted about access to the NDIS for people with psychosocial disability and access to appropriate mental health supports for people who are not eligible for the NDIS. These concerns were raised in the Commission's National Report 2019, and efforts to address them have been progressing. The NDIA has provided clearer guidance on the evidence required by people with psychosocial disability to access the NDIS. Additionally, the role of the Partners in the Community program has been enhanced to include outreach activities to increase access to the NDIS for people with psychosocial disability. New NDIS Psychosocial Disability Community Connectors have now commenced in seven regions across Australia.

In June and December 2019, the NDIA released reports on participants with psychosocial disability. These provided detailed information about plan funding, numbers of participants, client funding, satisfaction and outcomes. The NDIA has also released quarterly reports that provide national and state-based data on participants in the NDIS, including figures on new participants with psychosocial disability.[56,57]

The Australian Government has also implemented three programs to assist with the transition of people from a number of Australian Government–funded mental health programs that are ceasing as a result of transfer of funding to the NDIS. These are the Continuity of Support measure, the National Psychosocial Support Transition measure (NPS-T) and the National Psychosocial Support measure (NPS-M). On 29 March 2020, the Australian Government announced that it would invest a further $28.4 million to extend support for the remaining clients of the NPS-T until 30 June 2021.

An evaluation of the Continuity of Support measure and the Australian Government component of the NPS-M commenced in March and will be completed in early 2021. While the number of people on these programs has decreased significantly (from 15,484 at 1 July 2019 to 1,854 remaining clients at 30 September 2020),[58] concern continues about which ongoing services will be available for people who are found to be ineligible for the NDIS.

Chapter 3: Current mental health and suicide prevention reform activities

The Council of Australian Governments Disability Reform Council announced on 9 October 2019 a number of initiatives to improve access and experiences for participants with psychosocial disability. Key initiatives include:

- undertaking a joint examination of access and eligibility
- improving linkages and referrals to mental health supports for people not eligible for the NDIS
- assertive outreach to increase access to the NDIS for people with psychosocial disability
- a psychosocial disability recovery approach
- a national approach to concurrent supports.

The implementation of the recovery coach role has been welcomed by the sector. This involves choice of a recovery coach with lived experience, to help in coordinating and navigating the NDIS, including planning, reviewing and getting the services needed for recovery. There has been some criticism of the pricing of these roles and confusion around how the role is an improvement on the support coordinator role.[59]

Evidence provided to the Joint Standing Committee on the NDIS, outlined in a report released in December 2020, notes that, despite recent improvements to the NDIS, people with psychosocial disability continue to experience challenges accessing the scheme and obtaining supports.

The report recommends that the NDIA "regularly and systemically engage with people with psychosocial disability and representative organisations to better understand the needs of people with psychosocial disability and mental illness".[60]

The report also outlines concerns raised in submissions to the committee about the new independent assessments process to access the NDIS that is due to be introduced later in 2021. The independent assessor was introduced to address concerns about inconsistencies in assessments of a person's functional capacity. Concerns raised in the report included that the assessments would create stress and trauma for people with disability, do not provide understanding of a person's support needs without their own specialists' involvement, and are being implemented without effective consultation.[60] The NDIA intends to consult further on how assessments will operate over the coming months. The Joint Standing Committee on the NDIS launched an inquiry in December 2020 into the independent assessments.[61] The Commission will monitor the outcomes of this inquiry.

Integrating mental health and substance use services

The use of alcohol and other drugs (AODs) can interact with mental health in ways that create serious adverse effects on many areas of functioning, including work, relationships, health and safety.[62] Comorbidity—that is, the co-occurrence of an alcohol, tobacco or other drug use disorder with one or more mental health conditions—complicates treatment and services for both conditions.[62] These conditions can also co-occur with physical health conditions (for example, cirrhosis, hepatitis, heart disease, diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain.[62]

Given the strong relationship between mental health and alcohol, tobacco and other drugs, it is imperative to improve collaboration and coordination between services.[63] Clinicians can struggle to differentiate symptoms, resulting in misdiagnosis and delays in treatment. Many people with comorbidities have to seek support from separate mental health and AOD services,[62] adding an additional layer of complexity when navigating the service system.

The National Drug Strategy 2017–2026 is the national framework for preventing and minimising alcohol, tobacco and other drug–related health, social and economic harm to individuals, families and communities.[62]

The strategy advises that collaboration and coordination between mental health and AOD services needs to be improved to ensure that the most appropriate treatment and support are being made available to the individual.

The integration of mental health and AOD services has been on the reform agenda for some time in Australia. Historically, there have been significant problems with management of people with comorbidity, partly due to a lack of specialist services, particularly for AOD treatment. However, even where specialist mental health and AOD services are available, they are usually separated physically, administratively and philosophically.[64] A 2006 Senate inquiry into mental health found that the separation of mental health and AOD administrations made operational coordination of services difficult. The inquiry also found that these difficulties were consistently raised as one of the greatest service limitations for consumers.[65]

The role of PHNs in commissioning AOD treatment services at the local level complements their role in coordinating Australian Government–funded mental health programs, as well as building linkages with primary care. The Fifth Plan recognises the importance of jointly considering substance use comorbidities in system and service planning at a regional level.[66] Through the Fifth Plan requirement for PHNs to undertake joint regional planning with LHNs and Aboriginal Community Controlled Health Organisations, PHNs are in a good position to influence the integration of AOD, mental health and primary care services.[67] Some PHNs are already developing integrated regional plans—for example, the North Western Melbourne PHN region's Blueprint for Better Health (integrating mental health, AOD and suicide prevention services)[68] and the Brisbane South PHN region's Mental Health, Suicide Prevention and Alcohol and Other Drug Foundation Plan 2020–2022.[69]

Multicultural mental health

At the national level, attention to multicultural mental health in Australia has been lacking. No national prevalence data on mental illness in migrant and refugee populations in Australia is collected. Further, an absence of key culturally and linguistically diverse variables in existing data collections[70] means that there is a clear need for the mental health sector to actively do more in this space.

In its 2014 Contributing Lives review, the Commission recommended the widespread adoption of the Framework for Mental Health in Multicultural Australia: Towards Culturally Inclusive Service Delivery as a tool to help organisations identify what they can do to improve their cultural responsiveness. Adoption of the framework has also been supported by other organisations, such as the Queensland Mental Health Commission and the PHN Advisory Panel on Mental Health. Redeveloped in collaboration with Mental Health Australia, the Federation of Ethnic Communities' Councils of Australia and the National Ethnic Disability Alliance, and funded by the Australian Government Department of Health, the framework has the potential to improve mental health service delivery for people from culturally and linguistically diverse backgrounds on a broad scale.

Through the framework, organisations and individual practitioners are able to evaluate and improve the cultural responsiveness of their services using self-assessment against cultural competency standards, and accessing guidance and supporting resources.

Online modules and self-reflection tools that are self-paced, and guide ongoing and sustainable action are also incorporated into the framework.[71] The framework guides a comprehensive quality improvement process by identifying where improvements are required, and how to implement and assess them.

By increasing the cultural responsiveness of services on a wide scale, the framework is working to address the lack of access to mental health services and information often faced by culturally and linguistically diverse communities. The Commission recommends continued support for further widespread uptake of the framework. Specifically, a mandatory requirement (or contracted obligation, where applicable) for adoption of the framework would assist widespread uptake. Adoption of the framework should be the minimum requirement for an organisation to meet the mental health needs of people from culturally and linguistically diverse backgrounds.

Organisations and mental health services should strive to embed cultural inclusivity and responsiveness into their services in a manner that suits their particular contexts. This should be done through co-design of services with people from culturally and linguistically diverse backgrounds with lived experience of mental health challenges.

Improving the physical health of people with mental illness

The Commission's National Report 2019 noted evidence that the life expectancy gap is widening for people with severe mental illness, and that people across the continuum of severity of mental illness are experiencing poorer physical health outcomes than the general population.[72]

In 2017–18, 58% of people with mental illness also had a long-term physical health condition, compared with 37% of people without mental illness.[73] These physical conditions include asthma, arthritis, cancer, diseases of the circulatory system, diabetes, back problems and chronic obstructive pulmonary disease.[73]

In 2017, the Commission launched Equally Well, the National Consensus Statement on improving the physical health and wellbeing of people living with mental illness. All jurisdictions committed to implementing Equally Well and embedded this commitment in the Fifth Plan, which identifies improving the physical health of people living with mental illness and reducing early mortality as a priority area. PHNs and LHNs are jointly working on regional planning and coordination activities to address this priority area.

More than 50 organisations pledged their support to Equally Well for improving the physical health of people living with mental illness in Australia when it was launched in July 2017. This included all state and territory governments, professional colleges and associations, consumer and carer organisations, community organisations and peak organisations, all mental health commissions, and 14 PHNs. An additional[40] organisations have since committed their support.

Equally Well aims to bridge the life expectancy gap between people with mental illness and the general population, and improve the quality of life of people with mental illness by providing equal access to health care.

It includes 48 actions aimed at delivering person-centred, effective, equitable and coordinated health care. Equally Well aims to reduce variation in care, address the often siloed approach to treatment and care, improve service effectiveness and efficiency, and improve health outcomes for people living with mental illness and their families and carers. The Equally Well website provides a range of resources to help with improving physical health and highlight the importance of keeping healthy.

The Commission monitors and reports on the implementation of the National Consensus Statement by all governments through the annual Fifth Plan Progress Report. The 2020 Fifth Plan Progress Report will report on the progress of the National Consensus Statement between 1 July 2019 and 30 June 2020.

Implementation of Equally Well has the potential to lead to significant improvement at the primary healthcare–acute care interface. The Productivity Commission's final report has acknowledged the potential of Equally Well by recommending that all governments implement all its actions and release clear statements on how they intend to implement the initiatives, including time frames and outcomes against which progress can be measured.

Medicare Benefits Schedule Review

The MBS Review was established in 2015 to consider how more than 5,700 items on the MBS can be better aligned with contemporary clinical evidence and practice, to improve health outcomes for patients.[74] Various specialised committees, reference groups and working groups have been established as part of this review to consider and advise on MBS items. These include a reference group on MBS items for primary mental health care, and another for psychiatrists to advise on all mental health–related MBS aspects.[75] The MBS Review Taskforce has recently finalised its recommendations regarding mental health–related MBS items, and the Australian Government is currently considering its response.

The Australian Government's response to the recommendations in the review has the potential to transform existing measures within the MBS, such as the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative; a stepped care approach to MBS mental health services; increased flexibility of MBS mental health services; and incorporation of the latest evidence. The Commission looks forward to the release of the Australian Government's response so that these improvements can be implemented.

Suicide prevention

Suicide has a significant impact on families, communities and society, prompting multiple governments to commit themselves to specific reduction targets—some towards a target of zero suicides. Australia's suicide rate has increased over the past 10 years. In 2019, 3,318 people died by suicide in Australia, making it the 13th leading cause of death.[76]

In 2019–20, multiple government and nongovernment suicide prevention reform activities were underway. These included the work of the National Suicide Prevention Adviser and Taskforce (see **Box 8**), development of the National Suicide and Self-harm Monitoring System, implementation of the National Suicide Prevention Trial sites, and establishment of a National Commissioner for Defence and Veteran Suicide Prevention.

The National Suicide and Self-harm Monitoring System (see Box 5) consolidates the suicide evidence base by bringing together existing data, as well as a range of new data from across states and territories, on a publicly available website. This information will help governments, service commissioners and the community to better understand the burden and impact of suicide risk, suicidal behaviours and self-harm. It will play a key national role in better informing public conversations about suicide prevention.

Chapter 3: Current mental health and suicide prevention reform activities

Twelve National Suicide Prevention Trial sites have been implemented across Australia, using various models. In addition, there are 12 local area suicide prevention trials in Victoria, four Black Dog Institute LifeSpan trials in New South Wales and one Black Dog Institute LifeSpan trial in the Australian Capital Territory.[77] These trials have different time frames, but the combined results will provide valuable information about the various approaches to suicide reduction.

The past 12 months have also seen investment in suicide prevention research and suicide prevention projects reflecting all governments' commitment to preventing and reducing suicides.[77]

See **Appendix 4** for further details of suicide prevention activities.

The establishment of a National Commissioner for Defence and Veteran Suicide Prevention in 2020 to look into suicides of veterans and serving Australian Defence Force members (see **Chapter 1**),[78] and the completion of the Productivity Commission inquiry into compensation and rehabilitation for veterans were welcomed.[79] The Australian Government responded to the Productivity Commission's inquiry recommendations made in the final report A Better Way to Support Veterans by releasing the new Veteran Mental Health and Wellbeing Strategy[80] in May 2020, and the Veteran Mental Health and Wellbeing National Action Plan 2020–2023 in August 2020.[81] Although the role of the Commissioner has been welcomed, there have been calls for a Royal Commission to investigate veteran suicides.

There has been a renewed focus on Aboriginal and Torres Strait Islander participation, partnership and leadership in preventing and reducing suicide. The new National Agreement on Closing the Gap (see 'Collaborative partnerships in system reform', above) includes for the first time a target to reduce Indigenous suicides.

Gayaa Dhuwi (Proud Spirit) Australia was established in March 2020 as the national leadership body for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health and suicide prevention. It is governed and controlled by Indigenous experts and peak bodies working in these areas, promoting collective excellence in mental health care.[82] Gayaa Dhuwi (Proud Spirit) Australia has started renewing the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, in consultation with stakeholders and community members, which aligns with recommendations from the Commission's National Report 2019.

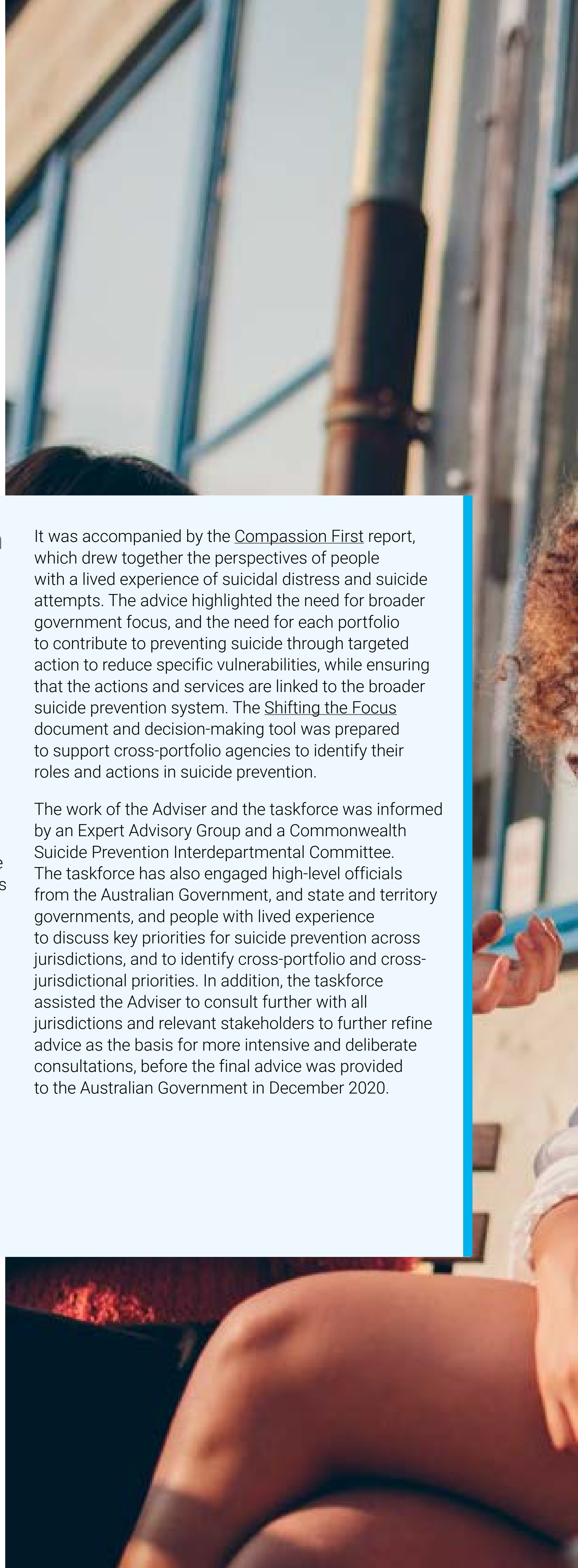
A number of states and territories have increased investment in suicide prevention approaches (details on state and territory initiatives are provided in **Appendix D**). For example, the New South Wales Government has identified suicide prevention as a Premier's Priority with the Towards Zero Suicides initiatives, as part of the Strategic Framework for Suicide Prevention in New South Wales 2018–2023. Victoria has introduced the Hospital Outreach Post-suicidal Engagement (HOPE) initiative, which provides enhanced engagement and support for people leaving the emergency department or medical ward following treatment for a suicide attempt.

Nongovernment organisations have been taking an active role in 2020, especially in addressing the impacts of COVID-19 and the bushfires (activities related to the bushfires and COVID-19 are outlined in **Section 2** and **Appendix C**). For example, the Suicide Prevention Research Fund has provided funding to support Australian research in suicide prevention and identify gaps in current research. The fund aims to support world-class Australian research, and facilitate the rapid translation of knowledge into more effective services for individuals, families and communities. The fund is managed by Suicide Prevention Australia, with Australian Government funding provided for three years.[83] Suicide Prevention Australia also released the State of the Nation in Suicide Prevention: a survey of the suicide prevention sector report, which provides valuable insights from the suicide prevention sector.

In particular, it examines the impact of COVID-19 on an already strained mental health sector, with 78% of organisations surveyed experiencing an increase in demand, and 65% needing greater funding and support to cope.[84]

The Black Dog Institute's white paper, released in October 2020,[85] explores existing data that relates to suicide prevention and how it can assist with prevention initiatives. Roses in the Ocean has been working with workplaces to develop greater awareness of how an organisation's culture can respond and support staff who are experiencing the impacts of suicide. Drawing from these experiences allows workplaces to develop better practices, and provide input into suicide prevention and postvention initiatives.

Suicide prevention initiatives currently being undertaken in Australia may have a significant impact on the future direction of planning and investment for suicide prevention. Ongoing monitoring of these initiatives will be important to determine how well proposed initiatives are taken up and whether they are effective in reducing Australia's suicide rate.



Box 8: National Suicide Prevention Taskforce update

To support the work of the National Suicide Prevention Adviser (the Adviser), a National Suicide Prevention Taskforce was established in August 2019 in the Australian Government Department of Health. Joint governance is provided by the Australian Government Department of the Prime Minister and Cabinet.

The Adviser reported directly to the Prime Minister on the effectiveness of design, coordination and delivery of suicide prevention activities.

In November 2019, the Adviser provided the Prime Minister with initial findings and some emerging advice to inform and complement the Australian Government's Towards Zero Suicides initiatives. The initial advice outlined the need for a fundamental shift to a broader approach that places the needs of people at the centre of all strategies and initiatives.

The interim advice was publicly released in November 2020. It focused on the key actions required and made recommendations about how a whole-of-government approach can be best implemented within Australia's system of governments, highlighting the proposed enabling structures and strategic approach needed. The interim advice emphasises the importance of incorporating understanding of suicidal behaviour from those with a lived experience of suicide.

It was accompanied by the Compassion First report, which drew together the perspectives of people with a lived experience of suicidal distress and suicide attempts. The advice highlighted the need for broader government focus, and the need for each portfolio to contribute to preventing suicide through targeted action to reduce specific vulnerabilities, while ensuring that the actions and services are linked to the broader suicide prevention system. The Shifting the Focus document and decision-making tool was prepared to support cross-portfolio agencies to identify their roles and actions in suicide prevention.

The work of the Adviser and the taskforce was informed by an Expert Advisory Group and a Commonwealth Suicide Prevention Interdepartmental Committee. The taskforce has also engaged high-level officials from the Australian Government, and state and territory governments, and people with lived experience to discuss key priorities for suicide prevention across jurisdictions, and to identify cross-portfolio and cross-jurisdictional priorities. In addition, the taskforce assisted the Adviser to consult further with all jurisdictions and relevant stakeholders to further refine advice as the basis for more intensive and deliberate consultations, before the final advice was provided to the Australian Government in December 2020.

Section 2

2020 and its impact on Australia's mental health

Chapter 1:
A season of natural disasters

Even before the COVID-19 pandemic reached Australia, the communities on the east coast of Australia and in South Australia were experiencing some of the largest bushfires (in scale and duration) in Australian history.

Many of these rural communities were still in the midst of an extended severe drought when the bushfires occurred. Following the fires, many were impacted by floods and hailstorms.

The effects of acute natural disasters on mental health are well documented, but chronic natural disasters—such as the prolonged drought experienced by communities across Australia—bring unique challenges. Unlike natural disasters that often pose a contained acute stress and crisis period, the nature of drought is such that it continues long term, resulting in sustained chronic stress and a prolonged impact on communities.

Drought significantly impairs the ability of many people in rural communities to live a contributing life, given the sustained impact on their homes, relationships and communities, and income and employment—all key social determinants of mental health.

The summer bushfires caused significant damage to life, homes, natural bushland and businesses across Australia. The financial impacts of the bushfires were estimated to exceed $10 billion; however, the mental health impacts on communities have not been quantified. This gap in the data needs to be addressed both to ensure that mental health need is being met and for better planning.[20] As mentioned in **Section 1, Chapter 1**, the Royal Commission into National Natural Disasters Arrangements highlighted the need for consistent measurement of the impacts of natural disasters and better data sharing.

Research released by the Australian Institute of Health and Welfare on 25 November 2020 shows that, following the introduction of the Medicare Benefits Schedule (MBS) mental health items for bushfire-affected people, the number of services accessed each week rose throughout the year, peaking at around 650 in mid-June, and averaged 498 services accessed per week. However, it is difficult to know how many people may have accessed services through general MBS mental health items for problems related to the bushfires.[86]

Evidence from previous fires in Australia indicates that a range of psychological factors result from the processing of trauma after bushfires, especially for those directly impacted, such as first responders and communities living in fire-ravaged areas. Common mental health impacts include anxiety, depression, substance abuse and post-traumatic stress disorder. Others may also experience increased suicide risk, acute stress or poor sleep quality.[87] These past studies on previous significant bushfires in Australia are a useful reference to understand the impacts that are likely to be felt by affected communities.

The Beyond Bushfires Study was a six year study into the impacts of the 2009 Victorian bushfires by the University of Melbourne, which contributed to the evidence base on the short- and long-term impacts of disasters. Although most people recover over time, a sizeable group of people experience mental health problems for months or even years after the initial trauma. Five years after the 2009 bushfires, 22% of people in high-impact communities were reporting symptoms of mental health disorders at twice the rate of the general population.

The University of Wollongong has prioritised a number of research projects to understand the impacts of these fires and floods, and the pandemic on the communities in the Wollongong region.[88] Researchers will consider the extent of the mental health impact of the fires, and the interaction and influence of community resilience, self-care of older Australians, disability inclusion and stories for healing.[88]

These projects, along with the research projects discussed below, undertaken through the Medical Research Future Fund, will be instrumental in informing our understanding and our response in the future.

Evidence indicates that the uptake of mental health services following emergencies is suboptimal and that we need to better understand why this is the case, to ensure that appropriate services are being provided to communities. The study into the 2009 bushfires showed that only 25% of those identified as severely distressed actually sought help.[89]

For those who have disconnected from services, proactive outreach continues to be vital to re-engagement. In regions suffering the long-term impacts of droughts, floods and fires, it is clear that outreach in the form of regular mental health and wellbeing checks can play a number of roles, including undertaking nonmedical screening, helping people connect to services if and when they need to, supporting families and carers, and strengthening community connections.

Bushfire and drought response: what has been done?

Australian Government response

By early January 2020, it was evident to governments that a coordinated response to the bushfires needed to address mental health needs in both the short and longer terms. On 12 January 2020, the Australian Government announced a mental health package to support the provision of coordinated mental health services to meet the needs of the broader community, including first responders and communities directly affected by the fires. The government announced a further mental health package on 11 May 2020 to support locally led mental health supports in regions severely impacted by the 2019–20 bushfires. The flexibility, change and cooperation achieved during the year have shown how innovation and collaboration can work well—for example, in the development of digital services, the broader benefits of telehealth and innovative community models, including support by peer workers.

The lessons learned need to be harnessed to inform the ongoing response to the events of 2020 and to strengthen the system in the future. The National Bushfire Recovery Agency was established on 6 January 2020 to lead and coordinate a national response to rebuilding communities affected by bushfires across large parts of Australia. The agency administers the National Bushfire Recovery Fund ($2 billion over two years), which is supporting recovery efforts across Australia.[90] Priorities for the fund include a mental health package for first responders and communities.

The National Mental Health Commission (the Commission) is leading the development of the National Disaster Mental Health and Wellbeing Framework to guide a national coordinated response. The framework is intended to improve coordination arrangements for mental health and wellbeing, and allow governments to foster and enable participative, localised responses following disasters; it is expected to be released in June 2021. The framework is being developed in consultation with people in areas affected by disasters, state and territory governments, people with lived experience of mental illness, local governments, nongovernment organisations involved in disaster support, and mental health and disaster management researchers.

Further research is being funded by the Medical Research Future Fund to better understand the physiological impacts of prolonged exposure to bushfire smoke and the mental health impacts of bushfires on affected communities. Grants awarded under the mental health stream in May 2020 included research into the mental health impacts on children, first responders and affected communities.[91]

State and territory government responses

The states and territories are primarily responsible for mental health during a disaster, and have a number of programs and arrangements in place to assist communities and individuals. At a state and territory level, governments responded individually to the summer bushfires in their jurisdiction, either expanding existing local mental health services or introducing new programs. Some examples are provided in **Box 9**.

Box 9: Government responses

The Victorian Government provided case management support to people living in Gippsland and north-east Victoria via the Victorian Bushfires Case Support Program. The program provides a support coordinator as a single point of contact to link people directly with supports, such as information and advice, mental health support and financial counselling.[92]

In New South Wales, the Rural Adversity Mental Health Program's team of 20 coordinators provided assistance in affected communities by:

- attending evacuation centres to link distressed individuals to mental health services and provide resources
- participating in disaster recovery committees and activities
- deploying a media and social media communications strategy to promote normal emotional responses to disasters and advise when a person should seek professional support
- developing dedicated evidence-based bushfire resources, including webpages and hard-copy fact sheets for those without internet access.[93]

The Queensland Government delivered a recovery package to support the mental health and resilience of communities impacted by the bushfires. This included:

- addressing risks to the mental health and wellbeing of impacted communities
- employing community development officers
- establishing a community mental health program to provide specialist mental health support and emotional wellbeing for individuals, families, volunteers and communities impacted by the bushfires.[94]

The South Australian Government provided a mental health and recovery package for targeted supports to aid long-term recovery in the Adelaide Hills, Yorketown and Kangaroo Island communities.[95]

Inquiries into natural disasters

The Royal Commission into National Natural Disasters Arrangements collected evidence from many communities affected by the fires, and the organisations and services that provided support to them. Many were critical of the level of support and leadership provided following the bushfires, stating that this had left people still living in tents with mental health issues increasing.[96] Some called for mental health to be a key component of all disaster planning by governments.[97]

> There have also been calls to increase the training of local health and support services (such as GPs) in trauma and mental health so that communities are better prepared for natural disasters.[98]

More robust and long-term investment in mental health supports for communities was also seen as key to community resilience, particularly for children.[99]

State inquiries highlighted the longer-term impact on mental health, especially on first responders, following such a long and arduous fire season. The final report of the New South Wales Bushfire Inquiry recommended that the New South Wales and Australian governments work to provide firefighters access to mental health support through GPs, including free mental health screenings following bushfires.

The Inquiry into the 2019–20 Victorian Fire Season has released its Phase 1 report. Mental health does not feature significantly in the report, although an observation made in the report indicated that the emergency management sector had in place multiple mental health and wellbeing initiatives for staff that were available before, during and after emergencies. The Phase 2 report, expected by 30 June 2021, will consider the emergency relief and recovery response.

In November 2019, a Senate inquiry into the Australian Government's response to the drought, and the adequacy and appropriateness of policies and measures to support farmers, regional communities and the Australian economy was referred to the Rural and Regional Affairs and Transport References Committee.
In its submission to the inquiry, the Commission highlighted a number of mental health–related items for specific consideration in relation to the Australian Government's response to the drought. These included:

- development of a long-term national program that promotes mental health, improves service access and coordination, and links farming communities to more effective local responses to emerging mental health needs
- a specific response to suicide prevention, including evidence-based community awareness training and resources such as community gatekeeper training (where connected community members are trained to recognise and respond to people who are at risk of suicide) and the involvement of peer workers; access to services (including aftercare); and postvention support
- a specific response for young people in drought-affected communities
- a specific response for Aboriginal and Torres Strait Islander people in drought-affected communities.

The committee's final report is due in February 2021.

Chapter 2: The COVID-19 pandemic

Impact of COVID-19 on mental health

In the early stages of the COVID-19 pandemic, it was important for governments to understand not just the health impacts of the virus itself but the economic and mental health impacts for the whole population, particularly vulnerable groups. This understanding supported governments both to respond to the short-term impact of COVID-19 and to ensure that longer-term consequences were addressed and planned for. National data agencies adopted a number of measures to provide rapid data, including:

- flexible approaches to collecting and analysing data within existing data collections to ensure that they were responsive to the needs of decision makers[100]
- establishing collaborations with each other and with mental health researchers to ensure that coordinated information was produced in a timely fashion[100]
- providing the Australian Government with weekly updates on Australia's mental health and use of mental health services, including use of crisis helplines[100]
- establishing new data collections to measure the impact of the COVID-19 pandemic and the associated restrictions on Australian households[101]
- establishment by Australian mental health and suicide prevention researchers of platforms to track and share research protocols, measures and results for COVID-19-focused research, in an effort to minimise duplicated effort and produce the strongest possible research.[102,103]

The Australian Government announced $2.4 million for collection of up-to-date evidence and modelling of the mental health impacts of COVID-19.[104] **Box 10** gives an overview of COVID-19 mental health–related data in Australia.

Box 1: Sources of COVID-19 mental health–related data

The Commission prefers data that is nationally representative, with appropriate sample sizes and statistical power. While other data sources may have interesting findings, we are unable to make statements about the general Australian population from data that is not nationally representative or has sample bias. Together, the following sources of information provide a national picture of the impacts of COVID-19 on mental health.

Australian Bureau of Statistics (ABS) Household Impact on COVID-19 Rapid Surveys[101]

This multi-wave survey provides insights into the prevalence and nature of impacts from COVID-19 on households. The ABS Rapid Survey was conducted fortnightly until August 2020, and now monthly, and is based on a random sample of 1,000–3,400 households with an adult aged 18 years or over.

Australian National University (ANU) Monitoring the Impacts of COVID-19 (ANU Poll)[105]

A COVID-19 impact monitoring survey held in April, May, August and October, including mental health–related questions, was developed by the ANU Centre for Social Research & Methods. It uses a longitudinal sample of 2,500–3,000 people aged 18 years and over from the Life in Australia panel.

Melbourne Institute (University of Melbourne) Taking the Pulse of the Nation survey[106]

This survey provides insights on how Australians are adapting to various changes in Australian, state and territory government policies as the pandemic evolves. It asks about feelings of depression or anxiety as a measure of general mental distress, rather than attempting to measure mental illness. On a weekly basis, 1,200 people aged 18 years and over are surveyed.

Royal Children's Hospital National Child Health Poll[107]

This survey was conducted in June 2020 and asked Australian parents about the health behaviours of their children and themselves in relation to the COVID-19 pandemic. The survey included questions about lifestyle, mental health, the use of health services and family finances. This was a one-off online survey of 2,018 parents.

The Royal Children's Hospital National Child Health Poll is an ongoing survey whose topic changes from poll to poll.

Australian Broadcasting Corporation (ABC) COVID-19 Monitor survey[108]

The purpose of this multi-wave survey was to reveal how people were feeling during the COVID-19 lockdown and provide insights into what Australians think about governments' responses to the pandemic. A total of 2,297 participated in this survey.

Digging Deeper: Exploring the Effects of Coronavirus project

The Commission engaged the ANU National Centre for Epidemiology and Population Health to review findings of pandemic research in Australia and compare them with international data, and data from previous pandemics and disasters. The research, which is due to be completed in mid-2021, is exploring the effects of quarantine and self-isolation on people's mental health. It will dig deeper into people's experiences through qualitative interviews.

Other key sources of information for impacts of COVID-19 on mental health

The longer-term mental health impacts of COVID-19 are being explored through a range of studies and research. The Open Science Framework, run by the Matilda Centre for Research in Mental Health and Substance Use and ANU, has collected information on a number of Australian studies on mental health and COVID-19 with a view to collaboration and data sharing.[102]

The mental health impacts of COVID-19 are likely to be unevenly experienced because they are affected by individual social and economic circumstances.[109] Many researchers have collected evidence since February 2020 to better understand how the direct experiences of COVID-19, such as social isolation, loss of employment, concern about contracting COVID-19 (or loved ones contracting COVID-19), or major disadvantage due to COVID-19 restrictions, have impacted the mental health of people in Australia.[110] To date, more than 100 mental health–related research studies on COVID-19 have been initiated. With Australia officially entering an economic recession in September 2020, based on past experiences, it is expected that the associated job losses, mortgage pressure, house repossessions and relationship stress will impact longer term on the mental health of many Australians.[111] A number of economic measures have been introduced, both nationally and at the state and territory level, to financially assist businesses and individuals during the COVID-19 lockdowns.

Economic and health concerns

From the outset of the pandemic, it was evident that not only would the national economy be impacted by the massive disruption to usual economic functioning, but that communities, families and individuals would be directly impacted. Estimates by the Australian Bureau of Statistics (ABS) indicate that almost 2.7 million people were affected by either losing their job in the first two months of the pandemic in Australia (April and May 2020) or working significantly reduced hours.[112] The official unemployment rate reached 7.5% in July 2020 and dropped in the next month to 6.8%.[113] An additional 3.5 million people were assisted through the Australian Government's JobKeeper program, which generally meant receiving a reduced income; however, it maintained a crucial employment connection.[114] Others worked reduced hours, with underemployment reaching a high of 13.7% in April 2020 and decreasing to 11.2% in July 2020.[115]

The impact on people's daily lives was varied as work, school and home life merged in an unprecedented way, affecting all in our communities—millions were adjusting to working from home, often at the same time as their children were studying from home. Other workers such as essential services were being pushed to their limits, with longer work hours, higher demands and an increased threat to their own health.

At the end of July 2020, 77% of those surveyed in the Melbourne Institute's Taking the Pulse of the Nation survey indicated that they would prefer to stay at home to minimise the risk of infection than continue with usual activities. The surveys, conducted each week, also indicated an increasing vulnerability to mental illness and a higher level of pessimism about the longer-term impacts of COVID-19.[116]

Social isolation, loneliness and mental distress

During COVID-19, many people have struggled with fear and uncertainty about their own health and that of their loved ones to varying degrees.[117]

In addition, increased social isolation and loneliness is a major adverse consequence of COVID-19, and is strongly associated with anxiety, depression, self-harm and suicide attempts across the lifespan.[118–120]

Around one in five people across Australia in an October survey by the ABS reported experiencing loneliness (see **Figure 10a**). Significantly higher rates (33%) of loneliness were reported by Victorians compared with other locations, especially by Victorian women (42%).

An Australian National University (ANU) study found that, in May, August and October, females had higher l evels of anxiety and worry about COVID-19 than males, and younger people had higher levels than older people (see **Figures 11a** and **11b**).

According to the Melbourne Institute's Taking the Pulse of the Nation survey, 15–21% of people reported feeling depressed or anxious most of the time from May to October. The proportion of people who felt anxious or depressed most of the time in October varied by state. During mid-October, Victoria had the highest proportion (27%), followed by South Australia (26%), Queensland (20%), Western Australia (20%) and New South Wales (19%). This survey asks about feelings of depression or anxiety as a measure of general mental distress, rather than an attempt to measure mental illness.

Figure 10a: Selected personal stressors, by location, October 2020

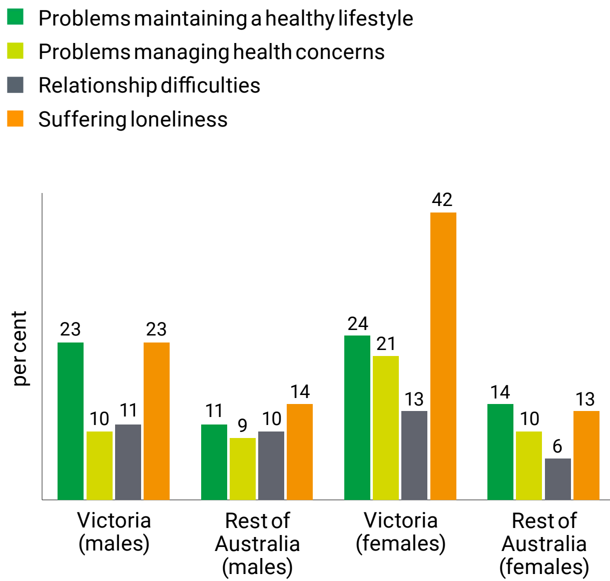
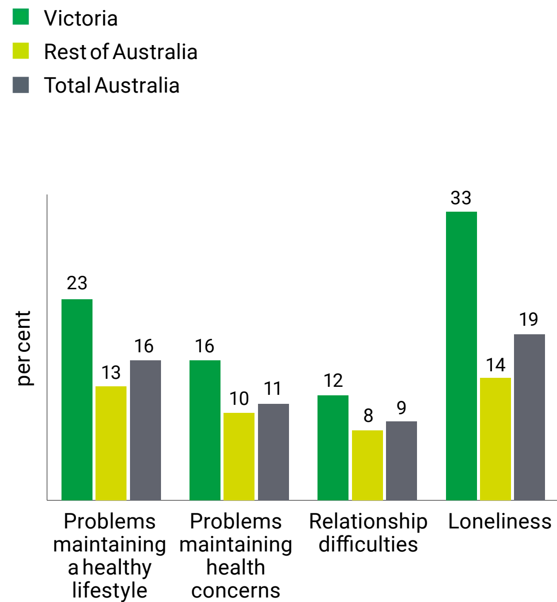


Figure 10b: Selected personal stressors in Victoria compared with the rest of Australia, by sex, October 2020



Source: ABS Household Impacts of COVID-19 Survey, October 2020

Figure 11a: Percentage of people who reported worry and anxiety due to COVID-19, by sex

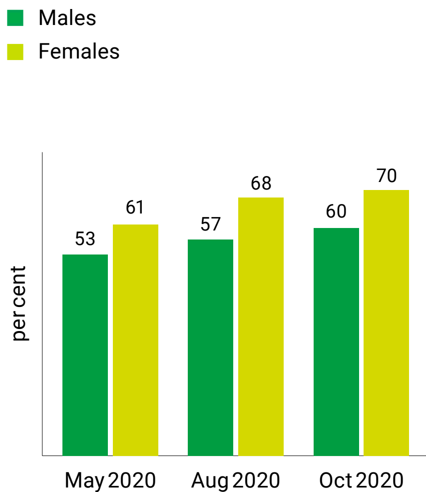
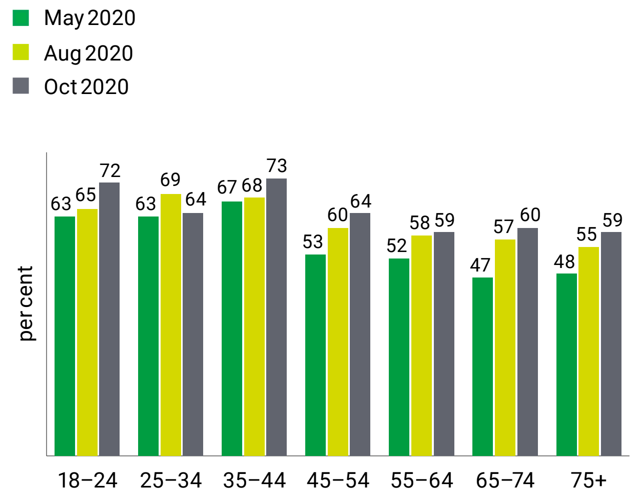


Figure 11b: Percentage of people who reported worry and anxiety due to COVID-19, by age group



Source: ANU Poll, May, August, October 2020

Domestic violence

For many, the pandemic coincided with the onset or escalation of violence and abuse.[121] Social isolation and lockdowns can compound this situation, by reducing access to support services for victims of domestic violence, child abuse and neglect; as well, increased financial insecurity limits accommodation options. By late March 2020, Google searches for domestic violence help were at the highest level in five years, with an increase of 75%.[122] A survey by the Australian Institute of Criminology also revealed that, of those women who reported experiencing domestic violence in the three months before the survey, one in three said this was the first time their partner had been violent towards them.

For women who had experienced physical or sexual violence before the COVID-19 crisis, more than half said the violence had become more frequent or severe since the start of the pandemic (from February to April 2020) (**see Figures 12a and 12b**).[121]

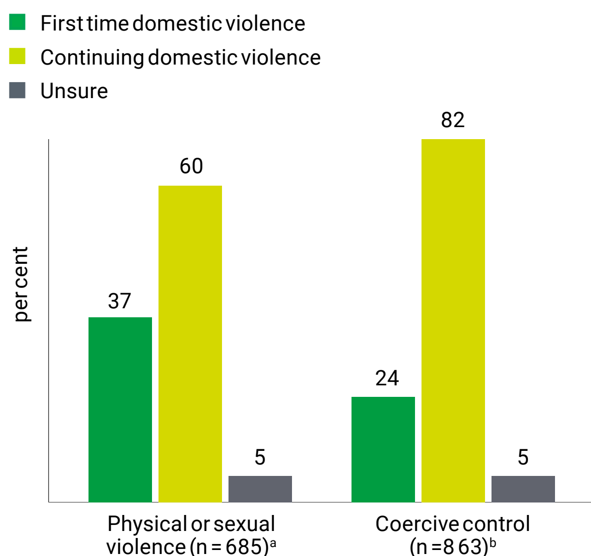
Although a significant proportion (two-thirds) of women did seek help from police, government agencies, or nongovernment agencies and informal sources, many were unable to because of safety concerns.[121] This is consistent with the concerns raised by many in the domestic violence sector that they found it difficult to engage with women during the periods of lockdowns. It also helps to explain why the number of domestic violence incidents reported to police has not increased.[123]

In March 2020, the Australian Government announced a $150 million domestic violence emergency response package.[122] Of this, $130 million will go to states and territories to strengthen family and domestic violence support services and accommodation options.[124] An additional $3 million was announced in July to provide more counselling and support services for women and their children who have experienced family violence.

A national parliamentary inquiry into family, domestic and sexual violence was announced in June 2020. This included an investigation into the impact of natural disasters and other significant events such as COVID-19, including health requirements such as staying at home, on the prevalence of domestic violence and provision of support services. This inquiry will inform the next National Plan to Reduce Violence against Women and their Children.

- Among women who had experienced physical or sexual violence from their current or former cohabiting partner prior to February 2020, half (53.1%) said the violence had increased in frequency or severity (**Figure 4**). One in three women (33.1%) reported that the violence had stayed the same, and a minority said that it had decreased (13.9%). Further, 47.0 percent of women who experienced coercive control before and after February 2020 said the abuse had increased in frequency or severity, 39.3 percent said it had remained the same and 13.7 percent said it had decreased.
- 1.5 percent of all women and 2.9 percent of women in cohabiting relationships had been a victim of physical or sexual violence by a current or former cohabiting partner for the first time in the last three months.
- 2.8 percent of all women and 5.4 percent of women in cohabiting relationships experienced emotionally abusive, harassing or controlling behaviour by a current or former cohabiting partner for the first time in the last three months.
- 1.1 percent of all women and 2.2 percent of women in cohabiting relationships experienced coercive control by a current or former cohabiting partner for the first time in the last three months, meaning they had not experienced emotionally abusive, harassing or controlling behaviour prior to February 2020.

Figure 12a: Prior domestic violence, by type of violence experienced in the three months prior to May 2020 (weighted data)



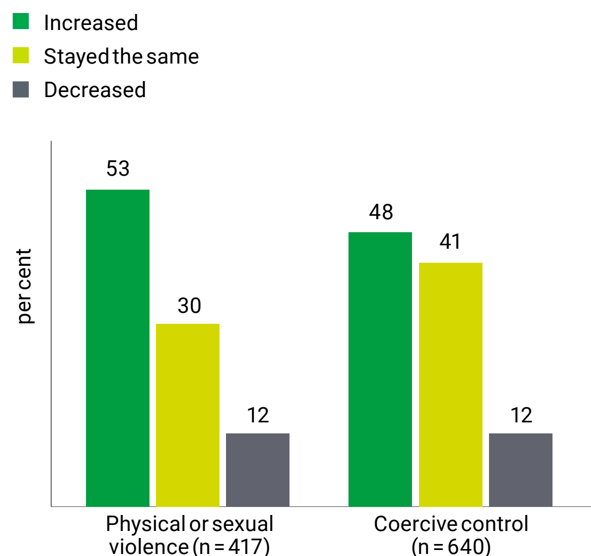
Note: Limited to women who were in a cohabiting relationship and reported that they had experienced domestic violence in the three months prior to the survey. Percentages may not total 100 due to rounding of weighted figures.

a: Total includes 41 women who were unsure whether they had experienced physical or sexual violence prior to February 2020.

b: Total includes 51 women who were unsure whether they had experiences emotionally abusive, harassing or controlling behaviour prior to February 2020.

Source: Australian Institute of Criminology, May 2020

Figure 12b: Changes in the frequency or severity of physical or sexual violence or coercive control, by type of violence experienced in the three months prior to May 2020 (weighted data)



Note: Limited to women who were in a cohabiting relationship in the past 12 months, had experienced domestic violence in the three months prior to the survey and had experienced violence or abuse from their partner prior to February 2020. Respondents could report experiencing both physical or sexual violence and coercive control.

Use of substances, alcohol and other drugs, and gambling

The significant changes to daily living due to the pandemic affected substance use in varied ways (noting that not all substance use is considered problematic). As part of the population health response to COVID-19, we need to monitor patterns of substance use (including alcohol and other drugs) associated with the COVID-19 pandemic, because substance use is a risk factor for mental ill-health and may exacerbate existing mental illness.[125]

An increase in alcohol consumption during the lockdown period is evident for both males and females. A study released by the ANU in June 2020 showed that the main reason for increased drinking in both males (67.3%) and females (63.7%) was more time at home. However, increased stress was the second biggest driver for females (41.9%) and boredom for males (49%).[126]

To understand any changes to drug use due to the pandemic, the Australians' Drug Use: Adapting to Pandemic Threats (ADAPT) Study surveyed those who used illicit drugs on a monthly basis in 2019, and compared their previous use to use in the first few months of the pandemic. The responses were specific to drug type and did not seem to address whether access to specific drugs affected patterns of use:

- More than half (56%) of respondents reported an increase in cannabis use, while 15% reported a decrease.
- Around two in five (43%) reported an increase in alcohol consumption, one-third reported a decrease, and one in four said it was stable.
- Almost half of people who used MDMA reported a decrease in use; likewise for people who used cocaine (39%) and ketamine (42%).
- More than half who used pharmaceutical opioids, benzodiazepines and gamma-hydroxybutyric acid (GHB) reported that their use was stable (56%, 53% and 50%, respectively).
- Only 4% had accessed drug treatment, and 2% reported they had tried but were unable to access drug treatment, in the previous four weeks.[127]

As part of its pandemic response package, the Australian Government provided funding to a range of services to provide online and telephone services for people affected by substance use.[128] These services play an important role in counselling services and were even more essential when face-to-face counselling was limited during lockdowns.

Evidence on changes to gambling practices during the pandemic indicated some increased activity, especially among young men. The Gambling in Australia during COVID-19 survey collected information from more than 2,000 people who gambled. It indicated that the number of survey participants who gambled four or more times a week increased from 23% to 32% during June–July 2020.[129]

The biggest spike in frequency and monthly gambling spend was seen in young men aged 18–34 years, increasing from a median of $687 to $1,075. This group was also most likely to sign up for new online gambling accounts, making up 79% of new account holders.[129]

Suicide and suicidal behaviours

Despite concern about a possible increase in suicides due to increased risk factors related to COVID-19, available data suggests that, as of September 2020, there has not been an increase in suicide deaths.[130-133]

A significant increase since COVID-19 in the use of mental health services and an increase in psychological distress reported, particularly among young people, is evident from data from the new National Suicide and Self-harm Monitoring System (see **Section 1, Chapter 2**).

In the recent State of the Nation report by Suicide Prevention Australia, people were asked to nominate what they thought would be the greatest risk to suicide rates over the next 12 months. Social isolation and unemployment were seen as the highest risk.[84]
The report provides insight from suicide prevention support providers on the current situation in the sector. Nearly 80% of respondents said they had seen an increase in demand across all support services in the past 12 months. Many services reported a shift to online services during the COVID-19 restrictions, which increased the reach of online platforms.

Governments have responded to COVID-19 pandemic concerns by announcing a range of initiatives aimed at reducing suicide risk and improving suicide prevention systems; these are outlined in **Appendix B**. Further work is anticipated from the release of the final report from the National Suicide Prevention Adviser.

Impacts of reimposition of restrictions

Victoria experienced a second wave of COVID-19 over five months from June to October 2020, peaking in August. Research has indicated that longer periods of quarantine and social isolation can be associated with worse mental health outcomes.[134] In the four weeks to 11 October, numbers of people accessing items under the MBS Better Access initiative were 31% higher in Victoria than in the rest of Australia.[135] Various mental health helplines also experienced increased use during this time, including the Beyond Blue Coronavirus Mental Wellbeing Support Service, Lifeline and Kids Helpline.[135]

In August 2020, as part of the Australian Government $31.9 million announcement, 15 mental health clinics, called HeadtoHelp, were created across Victoria to further enhance essential support during the COVID-19 pandemic.[136] The Victorian Government provided $59.7 million to support these clinics, by boosting the capacity of clinical and community mental health services. The clinics opened on 14 September, primarily targeting mild to moderate mental health issues. They are located at various GP clinics and community centres, where health care is generally accessed. The HeadtoHelp model of care was co-designed with Primary Health Networks (PHNs), the Australian Government and the Victorian Government. Funding is committed to monitor and evaluate this new model, so that we can learn from the implementation and operation of this surge capacity response to the pandemic.

Further restrictions were declared in Adelaide and the Northern Beaches, New South Wales, in the later part of the year. On 18 December 2020, the Northern Beaches local government area of Sydney was declared a COVID hotspot due to discovery of a cluster of cases in the suburb of Avalon, resulting in new restrictions and border controls for people living in this area and eventually Greater Sydney.

National response

Public mental health messaging

Across the sector, it was recognised that a universal public mental health strategy was required to reach the whole population, as everyone was affected by the pandemic to some extent.

The Commission collaborated with mental health organisations, experts and leaders across the country to develop and launch #InThisTogether —a national online campaign with evidence-based practical mental health and wellbeing tips.

Six months on, research confirmed the impacts of pandemic lockdowns and restrictions on at-risk groups and the broader community, and a further stage of this campaign was launched in August 2020.

#GettingThroughThisTogether built on the success of #InThisTogether, acknowledging the continuing challenges for many people, as we navigate the compounding impacts of the pandemic. Ten new practical tips were made accessible online; these were developed in collaboration with more than 20 mental health and social service organisations to help everyone to get through these extraordinary times. In addition, Head to Health, the digital mental health platform, has a dedicated page updated regularly for COVID-19 with mental health tips, resources and support services.

National Mental Health and Wellbeing Pandemic Response Plan

On 15 May 2020, National Cabinet endorsed the National Mental Health and Wellbeing Pandemic Response Plan as a response to the national public health emergency. The plan was based on stakeholder consultations, which received approximately 102 submissions of feedback, advice, commentary or revision from 75 stakeholders representing government, nongovernment organisations and individuals.

The plan was developed under the co-leadership of Victoria, New South Wales and the Commission and has been informed by all governments. All jurisdictions agreed to provide funding and implement the plan's actions. The Australian Government committed $48.1 million to support the plan.

The plan includes priorities for both the response and recovery periods, with flexibility for jurisdictions to respond to the needs of different communities. The plan identified three areas in which all jurisdictions could immediately act to fundamentally alter the trajectory of mental health impacts of COVID-19 and limit adverse downstream outcomes:

- data and modelling—immediate monitoring and modelling of the mental health impact of COVID-19
- outreach—adapting models of care to changing sites of service delivery
- connectivity—improving service linkage and coordination.

The plan is a testament to a unified commitment, by governments and the sector, to support all Australians' mental health and wellbeing during the response to, and recovery from, the COVID-19 pandemic. The plan reflects the need for timely data to inform suicide prevention responses through one of its three priority commitments.

The Commission is monitoring and analysing information on proposed and announced actions and programs that address the immediate actions and priority areas of the plan.

Mentally healthy workplaces during COVID-19

The Commission, in conjunction with the Mentally Healthy Workplace Alliance, has recently released a series of evidence-based, easy-to-use guides to support the mental health and wellbeing of Australian workers and to encourage mentally healthy workplaces during COVID-19.

These guides have been created by experts to provide practical tips and advice on helping employers and employees to look out for the signs that someone may need support, and assist them to find help when they need it. Resources have been developed for sole traders, small business, and medium to large business.

The National Workplace Initiative (NWI) provides a nationally consistent approach to workplace mental health (see **Box 11**). Although the NWI is managed by the Commission, the Mentally Healthy Workplace Alliance continues to guide the NWI and provide expert advice on its implementation.

Box 11: The National Workplace Initiative[137]

The National Workplace Initiative (NWI) aims to help bring about national consistency in how organisations and workplaces support their employees. It aims to create an evidence-based framework for creating mentally healthy workplaces; connect organisations to the right resources via a digital platform; amplify and strengthen exemplar programs already underway; and highlight gaps in research, resources or services.

The Australian Government provided $11.5 million over four years in the 2019–20 Budget to deliver the NWI, which is being developed with input and guidance from a wide range of stakeholders. Having acquired an understanding of the challenges facing business, the Commission is now working to identify solutions that will support organisations in creating mentally healthy workplaces. The first version of the NWI digital platform, and a roadmap for how this will grow and expand over time, is expected to be available in 2021.

Mental health items under the Medicare Benefits Schedule

COVID-19 has led to substantial changes in the delivery of mental health services, most notably an expansion and increase in use of telehealth and digital health services. There was a significant uptake in the use of telehealth and digital health services during the COVID-19 pandemic (see **Box 12** for usage data by service).

The announcement of new MBS telehealth items to help reduce the risk of community transmission of COVID-19, and provide protection for patients and healthcare providers, was welcomed by the mental health sector. These MBS telehealth items were initially available, until September 2020, to a range of health services, including clinical psychologists, psychologists, social workers and occupational therapists. In November 2020, with more than 40 million telehealth consultations since March 2020, the Australian Government announced its intention to make telehealth an enduring feature of Australia's health system and will work with the sector to co-design what this will look like.[138,139]

On 2 August 2020, the Australian Government announced an additional 10 subsidised psychological therapy sessions for people affected by restrictions in areas impacted by the second round of COVID-19 lockdowns.[140] In the 2020–21 Budget, the Australian Government announced the extension of this measure nationwide under the MBS Better Access initiative.[141]

Telehealth items provided safe options for people —particularly those with chronic health concerns— to continue to access mental health services. A significant increase in telehealth consultations over face-to-face sessions was seen (see **Box 12**). During the peak of the pandemic, Australia-wide telehealth MBS Better Access items were being accessed by nearly 50% of people using the services. By October, nearly two-thirds of services had returned to being delivered face to face.[142]

Box 12: Data on use of telehealth and digital health services

Note: Direct comparisons between organisations are not appropriate because of differences in populations being serviced, service models, funding envelopes, workforce availability and information systems. Comparisons with 2019 should be made with caution because historical trends may be affected by a range of events, including planned awareness-raising campaigns.

Figure 13: MBS mental health services processed (weekly)

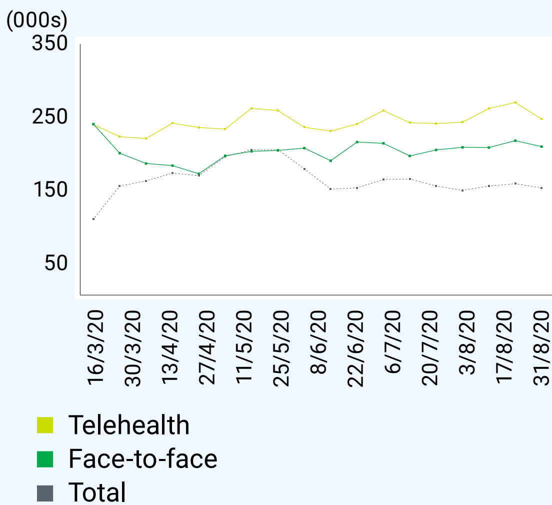


Figure 14: Lifeline contacts (number of calls per month)

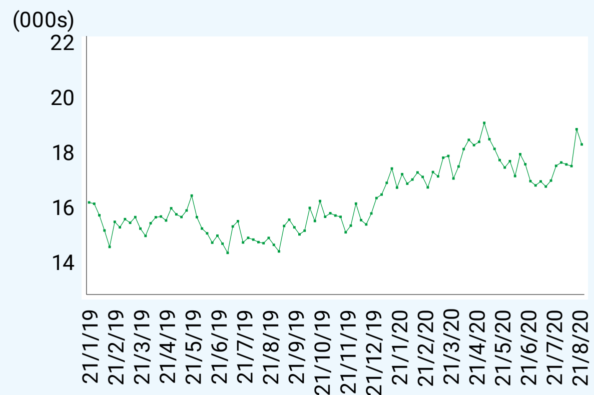
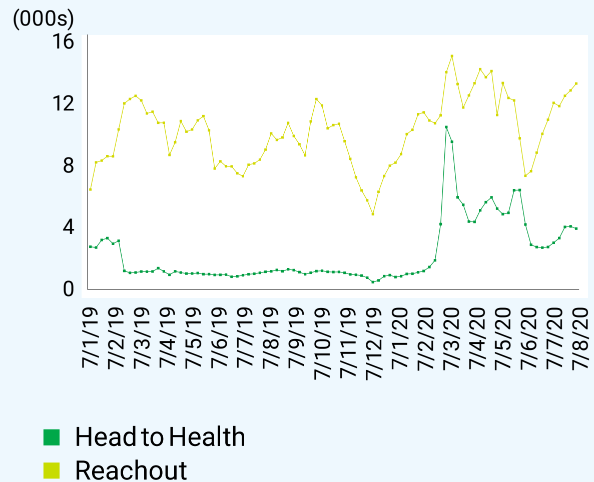


Figure 15: Beyond Blue contacts (calls, webchats and emails)

Figure 16: Digital health (Head to Health and Reachout) users per day (weekly averages)



Responses to specific impacts on diverse population groups

Although the events of 2020 have affected all people Australia-wide, some groups are more vulnerable to the economic, social, physical and mental health impacts of COVID-19 as a result of pre-existing inequities in access to health care, housing, income and social supports. Responses by governments need to target the specific needs of particular population groups, because how they respond to the impacts of the pandemic will be influenced by their own experiences of a range of adverse social, economic and health outcomes, including homelessness, unemployment and incarceration.

Older people

From the outset of the pandemic, older people, whether living in the community or in an aged care facility, were identified as the most at-risk population. The risk of severe illness from COVID-19 increases with age; people aged over 60 years are at high risk.[143] Some chronic medical conditions that are more prevalent in old age weaken the immune system, thereby increasing the risk. Older people are especially vulnerable to respiratory diseases.

Anxiety for older people may also have been increased by regular media reports detailing a higher rate of infection and mortality among older people. Lower digital literacy of some older people, less access to technology and issues such as hearing loss have meant that digital avenues commonly used to mitigate social isolation have been less accessible for older people. This is reflected in the Families in Australia study conducted by the Australian Institute of Family Studies. People over the age of 70 reported having significantly less contact with family during the pandemic. Only 23% of people aged over 70 reported having daily contact with family living elsewhere, compared with 40% of people aged under 40.[144]

Older people living in aged care facilities were disproportionately affected by COVID-19. As at 23 October 2020, more than 2,000 COVID-19 cases had been reported in residential aged care facilities. A total of 904 deaths as a result of COVID-19 had been reported, of which 682 were people living in residential aged care facilities, mostly in Victoria. The Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) noted that COVID-19 was the greatest challenge experienced by the aged care sector in Australia, with the pandemic exposing systemic weaknesses in the system.

> The Aged Care Royal Commission launched an investigation of the response to COVID-19 in aged care. Expert witnesses during the investigation pointed to the fundamentally flawed approach of treating aged care and health care, including mental health care, as two separate industries.[145]

The COVID-19 crisis in aged care highlighted the need for better collaboration and communications between the health (and mental health) system (especially hospitals, general practice and ambulances) and aged care. In late July 2020, a collaborative approach was implemented jointly by the Australian and Victorian governments with the formation of the Victorian Aged Care Response Centre, which has set a national standard for the delivery of emergency support.[146]

Although many residents of aged care facilities have not experienced a COVID-19 outbreak at their facility, they have endured social restrictions for most of 2020 that go beyond those of the general community.

The Aged Care Royal Commission's COVID-19 hearing, conducted in August 2020, considered the balance between managing risks posed by a future pandemic or infectious disease outbreak and the importance of mental health, wellbeing and quality of life of aged care residents. Family and friends shared with the Aged Care Royal Commission the profound impact of visitation restrictions, as visits have an integral role in care and support for residents.[147]

Based on its findings, the Aged Care Royal Commission recommended that the Australian Government provide funding to people in aged care during the pandemic. This recommendation included ensuring adequate staff to allow continued visits, and allowing for the creation of MBS items to increase access to allied health professions, including mental health services.[147] The Australian Government accepted all six recommendations made by the Aged Care Royal Commission, including implementing measures to support mental health care for residents.[148]

In May 2020, the Australian Government announced a $6 million package intended to prevent loneliness and isolation in senior Australians. This included almost $5 million to significantly expand FriendLine, a national telephone support service for older Australians. It also included $1 million in grants to 215 local community organisations to provide at-risk seniors with digital devices such as mobile phones and laptops.[149]

The Australian Government has also allocated $19 million under the National Mental Health and Wellbeing Pandemic Response Plan for PHNs to commission additional mental health nursing services or equivalent support for older people who are experiencing social isolation or loneliness as a consequence of the COVID-19 pandemic. Services will be available for 12 months to people aged over 65 who live in residential aged care facilities or in the community.[150]

Aboriginal and Torres Strait Islander communities

Aboriginal and Torres Strait Islander communities experience some of the worst health outcomes worldwide. This is often due to existing health inequities such as a high burden of chronic disease, poor nutrition, overcrowding, systemic racism and poor socioeconomic situations. Aboriginal and Torres Strait Islander communities are at heightened risk of mortality from COVID-19 compared with non-Indigenous people.[151] However, in comparison with the devastating incidence of COVID-19 in Indigenous communities abroad, the number of COVID-19 cases among Aboriginal and Torres Strait Islander people is six times lower than if the population were affected at the same rate as the rest of Australia.[152]

> The low proportion of COVID-19 cases in Aboriginal and Torres Strait Islander people has been attributed to the swift health response from the Aboriginal community-controlled health sector, led by the National Aboriginal Community Controlled Health Organisation (NACCHO) and other peak organisations. [153]

In response to the pandemic, NACCHO called for protection and support in restricting access to rural and remote Aboriginal and Torres Strait Islander communities, to reduce the risk of contact with nonresidents. Local planning was led and informed by the local needs and requirements of local communities, with an assessment of the need for rapid employment of additional health workers, and access to physical infrastructure to enable quarantine of COVID-19 patients. This response protected and prepared communities for lockdown, developed local communication strategies, and united diverse sectors such as health, education, land councils and government agencies.

People living with mental illness

People with a pre-existing mental illness are particularly at risk of severe impacts on their mental health as a result of COVID-19. In addition, the COVID-19 emergency has the potential to increase the number of avoidable deaths of people living with mental illness. Already, people living with mental illness have significantly higher prevalence of preventable physical diseases such as heart disease, diabetes, respiratory diseases and cancer, and are particularly vulnerable to morbidity and mortality due to COVID-19.[154,155]

Evidence suggests that people living with mental illness are more likely to be affected by emotional reactions to COVID-19. This can exacerbate symptoms of mental illness or cause relapse, thereby worsening conditions and increasing the risk of delayed diagnosis and treatment of other conditions, including highly infectious diseases such as COVID-19.[156]

Disruptions in mental health care and supports due to physical distancing restrictions may contribute to worsening mental health, because not everyone has access to online and telehealth services. Data indicated that some people living with mental illness were disconnecting from services in the initial phase of the COVID-19 pandemic.[157]

Consumers responding to a survey by the New South Wales lived experience peak group, BEING, in April 2020, reported the negative impact on their mental health of the loss of their support worker visits. They also reported that trips to the shops required them not just to be responsible for their own emotions but to deal with heightened emotions of the broader community. Some reported that the sheer volume of distress—with the compounding impact of droughts, bushfires and COVID-19—meant that it was more challenging to rely on their usual coping strategies. Suggestions from consumers on effective programs during COVID-19 included lower-intensity online support or opportunities for social connection, such as peer support telephone and online programs.[158]

The National Mental Health and Wellbeing Pandemic Response Plan identified as one of its ten priorities addressing the complex needs of those living with mental illness by promoting best-practice care. This includes assertively providing outreach for those who are in crisis, including suicide crisis, or have disengaged from their services. It also includes increased community-based services, thereby reducing emergency department presentations and reliance on inpatient services, and physical health screening for people who had a pre-existing mental health issue and were treated for COVID-19 in hospital.[157]

People with disability

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability published a Statement of Concern in March 2020 and a report in November 2020 on findings of the experiences of people with disability during COVID-19. The report was critical of the Australian Government for not engaging with the disability sector earlier in the pandemic. It highlighted evidence of a number of barriers faced by people with disability during COVID-19 and that many experienced:

- stress and anxiety related to fear of contracting COVID-19 because of exposure to different support staff
- distress, particularly among people with cognitive disability, due to the lack of clear and consistent information about the pandemic and the measures taken to control it
- a sense of being forgotten and ignored, particularly when isolated from family, friends and social networks.[159]

The report made 22 recommendations, including involvement of disability representatives in all future planning for natural disasters and emergencies, and establishment of a dedicated unit within the Australian Government Department of Health to plan for the safety and wellbeing of people with disability during these events.

A Disability Information Helpline, the Disability Gateway, was established for people with disability, and their families and carers, who need information that is free, private and fact checked for COVID-19-related assistance.[160] The Australian Government Department of Health also established a COVID-19 Health Professionals Disability Advisory Service telephone line to provide specialised advice for health professionals involved in the care of people with disability diagnosed with COVID-19 or experiencing COVID-19 symptoms.[161]

In April 2020, the Australian Government announced the development of a Management and Operational Plan for People with Disability, which would form part of the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19). The plan is intended to ensure that the healthcare needs of people with disability, and their families and carers are met during the pandemic,[162] and emphasises the need for continuity of quality mental health care. Although the plan has been welcomed, criticisms have arisen that it should have been prioritised earlier, because of the additional risks to people with disability.[163]

The National Disability Insurance Agency has been consulting widely with providers and other key stakeholders to understand the issues that have arisen during the COVID-19 pandemic. For participants with psychosocial disability, key concerns include the difficulties faced in moving to telehealth approaches for service delivery.[164]

The Australian COVID-19 Vaccination Policy includes disability support workers and people at higher risk of infection as priority groups for vaccination. It also includes a commitment that all Australian Government and state and territory governments will consider the needs of residential aged care and residential disability settings.[165]

Young people

Evidence that more than 75% of mental health issues develop before the age of 25 highlights the need to ensure that young people experiencing mental distress as a result of COVID-19 receive access to timely support and treatment.[166] An annual youth survey by Mission Australia noted that young people identified the most important issues in Australia as equity and discrimination (40.2%), COVID-19 (38.8%) and mental health (30.6%).[167] Findings from headspace's 2020 National Youth Mental Health Survey of 3,575 people aged 12–25 indicate that three-quarters of participants reported that their mental health was a little worse (47%) or a lot worse (27%) since the outbreak of COVID-19. Psychological distress is high, with one in three reporting high to very high levels of distress; an increase of about ten percentage points was seen since 2018 for young men aged 15–17.[168]

Young people's education has been significantly disrupted during the pandemic. Those transitioning from school at this time are at particular risk of increased stress, depression, isolation and use of unhealthy coping mechanisms.

The National Mental Health and Wellbeing Pandemic Response Plan identified the need for educational responses, including long-term education supports for students who may have fallen behind in their learning or disengaged with education, to get them back on track.[157]

Year 12 students of 2020 also faced a historically unprecedented challenge as disruption to their year affected many school milestones. These impacts include disruptions to study, 'Schoolies' and formals being cancelled, gap years being abandoned and youth unemployment reaching almost 13.9%.[169]

The impacts of COVID-19 on international students are addressed in the National Mental Health and Wellbeing Pandemic Response Plan. These students face new challenges relating to travel restrictions, study implications and visa concerns. These are in addition to longstanding challenges, including being away from traditional family supports, adapting to a different culture, financial stresses, study pressures and loneliness.

The Australian Government made a commitment of $509 million in the 2019–20 Budget towards the Youth Mental Health and Suicide Prevention Plan, including expansion of the national headspace network, tailored initiatives with a focus on Aboriginal and Torres Strait Islander young people, and investment in early childhood and parenting support.[170]

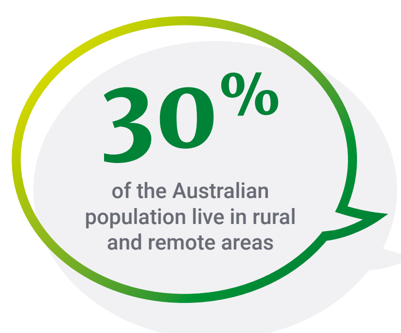
Regional and remote communities

At the time the pandemic was declared, many rural communities were coming to terms with the long-term stress, and social and economic impacts of years of drought and the recent devastating bushfires. Thirty per cent of the Australian population live in rural and remote areas. These people often have poorer health outcomes due to their geographic isolation, lifestyle differences, and a level of disadvantage related to education and employment opportunities and poorer access to health services, especially mental health services.[171] Frequently, mental health care in rural and remote communities is provided through community health centres, hospitals in major regional centres and a small number of GPs.

> Many communities have no resident mental health services and must rely on visiting services, or travel to communities where services are available. People requiring services often have to travel away from their families and communities, which becomes an additional stressor and denies them an important source of social support.[172]

During the COVID-19 pandemic, this travel was even more restricted. For many remote communities, such as remote Aboriginal communities in Western Australia that rely heavily on fly-in fly-out (FIFO) services, the strict and multilayered travel restrictions resulted in significant practical, administrative and financial challenges to local service provision.[173] For example, although mental health services were covered by exemptions allowing the entry of essential services, FIFO staff had to be provided with accommodation and allowances while in quarantine, often in private accommodation; costs were often higher as a result of inadequate quantities and qualities of staff housing in some communities.[173] As a result, many Aboriginal Community Controlled Health Services were paying for staff yet unable to work to full capacity, making it even more difficult for communities to access mental health support when it was most needed.

The development and implementation of new technologies such as telehealth (see **Box 12** for data on telehealth use) that overcome issues of distance and isolation have been essential in providing continuing mental health care for rural and remote communities. Internet technologies also enable opportunities to provide information about mental health and mental distress, and to connect people living in rural and remote communities with support groups.[174]



Refugee and migrant communities

The need for all communities to access clear public health information is crucial during a pandemic. It is not enough to just provide translated information: governments need to ensure that the meaning and intent, especially for government announcements in relation to COVID-19, are clear and accessible. The National COVID-19 Health and Research Advisory Committee, in its report on risks of a resurgence of COVID-19, indicated that migrants may experience particular barriers to infection control, such as not understanding that testing is free, not having access to all available information in their language, past medical trauma and wariness of government, and labour exploitation limiting access to health care (such as a lack of sick leave).[175]

In April 2020, the National Refugee-led Advisory and Advocacy Group held national community consultations on COVID-19.

> For many groups within the refugee community, closing the digital divide to enable equitable access to online resources and services was reported as an issue. Digital literacy and costs of digital platforms could also be challenges for home schooling and online learning for refugee children and youth, and their parents.

The consultation noted the importance of community safety and wellbeing during the pandemic—misinformation and panic had been seen in refugee communities due to inadequate, decentralised and limited translated audiovisual information.

> Stories of communities coming together to support each other emerged as a reminder that, given the opportunity and resources, affected communities can devise the most effective and efficient solutions to their own challenges.[176]

Charities that support refugees and asylum seekers have called for the Australian Government[177] to extend income support payments to these groups as they see increases in demand for assistance in their communities. Temporary visa holders have not been eligible for income support, such as the Australian Government JobSeeker and JobKeeper payments. This has left many people without income during the restrictions, as casual positions have decreased and businesses have closed. This loss of income has placed many in financial stress and led to concern about their temporary status.

Lesbian, gay, bisexual, transgender, intersex and queer people

Social isolation can significantly add to existing mental health issues for young LGBTIQ+ people. Without the support of friends and the school environment during lockdown, those who are experiencing tensions in the home may find that these intensify, increasing the risk of mental illness.[178] In response to COVID-19, the MindOUT project, a suicide prevention initiative, has provided PHNs with access to an existing online module introductory lesbian, gay, bisexual, trans, and intersex mental health and suicide prevention training.[179]

Rainbow Health Victoria[179] recommended the sharing of messages about community resilience and increased initiatives to provide community support through adaptive means. Consistent with the broader population, connection to community and peer support have an important protective effect for LGBTIQ+ people.

Section 3

Where to from here? Emerging issues and priorities in mental health and suicide prevention reform

Chapter 1: Improving wellbeing

The single most effective means of reducing the burden and impact of psychological distress, mental illness and suicide is to avoid people becoming mentally unwell in the first place.[21]

This means that an effective system should address the full spectrum of wellbeing by building good mental health, while also responding to distress, mental health issues and severe mental illness. A strong mental health system does this by recognising the complexities of mental health, including the social and economic drivers of wellbeing.

The principles of working together, harnessing information, facilitating access, building community-based care, and delivering quality, personalised care will help to improve wellbeing for people who interact with the mental health system. However, improving wellbeing is also about promoting mental health, building protective factors and mitigating risk factors. This means taking a systems approach to building good mental health, with a focus on the broader context, including prevention and early intervention, addressing social and economic disadvantage, addressing increasing levels of loneliness, and addressing comorbidities such as substance use.

Early intervention and prevention

The National Mental Health Commission (the Commission) has always taken a strong stance on the importance of prevention and early intervention approaches.[180] The National Children's Mental Health and Wellbeing Strategy (see **Box 13**) highlights opportunities for preventive actions in early childhood; however, a preventive approach should span across the life course. Supporting population mental health and wellbeing, and intervening early when individuals are at risk reduces distress, disadvantage and disability over the lifetime.[181]

Evidence shows that policies that focus on early intervention and prevention have positive flow-on effects, particularly for the most disadvantaged in our society.[181,182] Such policies also reduce the likelihood of contact with more costly supports and services, including the child protection and justice systems, acute hospital-based care, and social support payments.[21]

According to the Productivity Commission, early intervention and prevention can help to maintain and expand the proportion of the population (an estimated 60%—5.2 million people) who are not at risk of, or do not have, a mental disorder.[21] Early intervention and prevention are at the core of a person-led mental health system that aims to help people maintain and improve their mental health. To achieve this, the Productivity Commission recommends taking action to improve social and emotional wellbeing of children and their families, increase youth economic participation, and increase social inclusion. Reducing stigma and workforce training have also been identified as important actions to address the cultural and social barriers to improving mental health and wellbeing.[21] These issues are discussed in **Section 3, Chapter 3.**

Box 13: National Children's Mental Health and Wellbeing Strategy

The National Children's Mental Health and Wellbeing Strategy will guide the Australian Government's investment in the health and wellbeing of children and their families. The strategy provides a framework to proactively promote child wellbeing, support families and communities, and help those who are struggling as early as possible to minimise any long-term impacts of poor mental health.

The strategy describes the importance of prevention and investment in early intervention, as the foundations for lifelong health and wellbeing commence long before school. It has four focus areas; each focus area contains objectives and actions that should be taken to achieve the required reform:

- **Family and community**—highlights the importance of empowering families to promote mental health and wellbeing as part of routine parenting, and making it easier for families to connect with services when required. The importance of community-based approaches to health is also emphasised.
- **Service system**—recognises that the current mental health service system is in need of major reform, and that it is crucial that we make it easier for families and service providers to navigate the system. The strategy also recommends incentivising collaborative care and having a system built to cater for complexity.
- **Education settings**—emphasises the important role that educational settings play in promoting mental health and wellbeing in children, and discusses the additional supports that may be required for educators to build positive wellbeing cultures.
- **Evidence and evaluation**—speaks to the importance of improving data collection and use, and embedding a culture of evaluation to enable an optimal system of programs and services that provides consistently high-quality supports for children and families. Importantly, the principles of co-design are central to ensuring that services meet the needs of all children and families.

The Commission held consultations in January and February 2020 with professional colleges and peak bodies to capture perspectives, current issues and gaps within systems supporting children's mental health and wellbeing. The Commission has also consulted with expert groups to capture input across mental health, early childhood and primary education, clinical and social services, parent and carer roles, Aboriginal and Torres Strait Islander children, families and communities.

The strategy entered a final consultation stage in December 2020. This is a public consultation that allows anyone to view and provide feedback on the strategy through the Commission's website. It is anticipated that consultation on the draft strategy will conclude in March 2021, and that the strategy will be finalised and launched in mid-2021.

Addressing increasing levels of loneliness

An emerging issue with significant potential to affect wellbeing is the increasing levels of loneliness found throughout society, both in Australia and internationally. This is considered an emerging public health issue as loneliness has been associated with poorer physical and mental health outcomes.[183] For example, lonely Australians are 15% more likely to be depressed and 13% more likely to be anxious about social interactions than people who are not lonely.[184] Recent evidence suggests that the impact of COVID-19 has exacerbated feelings of loneliness, as discussed in **Section 2**. However, increasing loneliness was evident well before the COVID-19 pandemic.[185]

Findings from a survey conducted in 2018 by the Australian Psychological Society found one in two (51%) Australians felt lonely for at least one day in a week, and more than one in four (28%) felt lonely for three or more days.[184] The Young Australian Loneliness Survey, conducted in Victoria in 2019, found that one in four (28%) young people reported problematic levels of loneliness.[186]

Loneliness has been found to impact different groups of people more than others—in particular, older people, younger adults, people with disability who have mental health issues, people with poor health, people living alone, carers, and people from some culturally and linguistically diverse communities.[183]

Addressing social and economic disadvantage

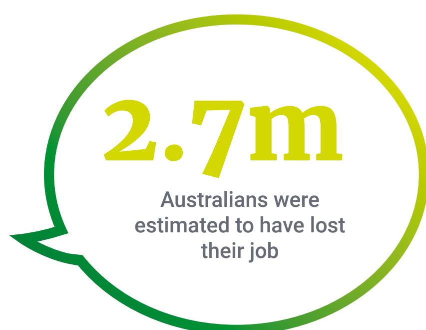
A system that improves wellbeing will help those who are most at risk of mental health issues. It is well established that some of the most powerful root causes of inequities in mental health are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape the conditions of daily life.[181] People living with mental illness are also more likely to experience a range of adverse social, economic and health outcomes, including homelessness, unemployment, incarceration and poor physical health.[155,187-190] This reciprocal 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. For example, various programs preventing discharge from acute mental health care into homelessness, examined by the Productivity Commission, demonstrated a return on investment ranging from $1.24 to $9 per dollar invested.[21]

Many determinants of health and wellbeing need to be addressed at population, community, family and individual levels.[191] Particularly relevant now is the impact of loss of income and work as a result of the COVID-19 pandemic. It is estimated that almost 2.7 million Australians lost their jobs, or were working reduced hours, during the pandemic's peak in March and April 2020.[192] Economic disadvantage, including low income, high levels of debt and relative poverty, have clear associations with risk of mental disorders.[181] There is evidence that, when income inequality increases, distress levels among groups of lower socioeconomic status tend to increase.

In particular, associations have been shown between financial hardship and depression, suicide, drug dependence and psychotic disorders.[193-198] Strategies and policies that provide sufficient income for healthy living, such as social protection and minimum wage policies, therefore act as protective factors.[181]

Integrating mental health and substance use

Section 1 outlines the case for integration of mental health services, alcohol and other drug (AOD) services, and supporting frameworks such as the National Drug Strategy 2017–2026 and the Fifth National Mental Health and Suicide Prevention Plan. Despite a clear case for integration, there have been challenges in implementing these national strategies. Specifically, the different approaches by state and territory governments in addressing substance use comorbidity add a further layer of complexity in coordinating services, and funding structures can be a barrier to service integration. Funding structures that implement rigid eligibility criteria mean that people with comorbid substance use issues can often be turned away from mental health or AOD services.[21] Services have attempted to provide integration—for example, headspace for youth and the Adult Mental Health Centres that are currently under development. However, clinicians are primarily trained in mental health, so that services tend to be approached via this lens.



To address these longstanding challenges, the Productivity Commission has recommended that all governments integrate commissioning and provision of mental illness services and substance use services for people with both conditions.[21] The Productivity Commission has also recommended that mental health and AOD services should jointly develop and implement operational guidelines covering screening, referral pathways, training guidelines, and other resources for mental health and AOD workers to improve outcomes for people with substance use comorbidities.

Innovation in prevention of mental ill-health and AOD comorbidity has also shown potential for improving wellbeing. Results from a trial of an online school-based prevention program targeting substance use, depression and anxiety in adolescence found that increased knowledge about alcohol, cannabis and mental health reduced the likelihood of drinking and reduced symptoms of anxiety over a 30-month period.[199] An opportunity exists for the wider use of such prevention programs that have demonstrated their effectiveness to promote good health, while addressing issues that contribute to mental distress. The Commission encourages strengthening of the evidence base behind prevention programs that address comorbidities and improve wellbeing to promote wider use of these kinds of innovations.

Chapter 2: Working together

To achieve significant change, the responsibility for mental health must be across governments, sectors, services and communities. This has been highlighted during the COVID-19 pandemic. There has been an urgent need for governments to access timely, reliable data on the effects of COVID-19 and the mental health system's capacity, so that they can make swift, evidence-based decisions.[157]

Government agencies and the research sector have responded by establishing new collaborations and data collections, or pivoting existing collections to rapidly produce relevant data.[200] This coordinated response demonstrates the capacity for greater collaboration in system and data processes when the impetus is there.

As discussed in **Section 1**, to effectively address mental health and suicide prevention in Australia, a national approach is required to improve strategic oversight and coordination of mental health policy and investment.

This approach views mental health and suicide prevention as a whole-of-government priority, across portfolios and beyond the traditional focus on health. This will ensure that mental health is consistently and fairly prioritised.

A strong, coordinated suite of national governance structures is required, including formal agreements between the Australian Government and state and territory governments, and consistent national and state-based legislation and policies.

The Commission welcomes the establishment of the Mental Health National Cabinet Reform Committee, which will establish a new National Mental Health and Suicide Prevention Agreement by November 2021. It has long been known that the mental health and suicide prevention system is complex and fragmented, with a lack of clarity around roles and responsibilities. The new agreement will be the first step in strengthening the fundamental building blocks of funding and governance in the mental health system.

Working together is more than establishing agreements between governments. Recent inquiries and reports, as well as information gathered through Vision 2030 consultations, have highlighted the benefits of working together to establish responsibilities; harnessing information through the collection and sharing of data, monitoring and evaluation; and facilitating a partnership approach to systems improvement. For example, the final report of the Productivity Commission inquiry into mental health has recommended a number of actions to enhance consumer and carer collaboration, and strengthen the funding, monitoring, reporting and evaluation of mental health and suicide prevention policies, services and programs.[21]

Governance structures can and should ensure that consumers and carers participate fully in the design of policies and programs that affect their lives.

Chapter 3: Facilitating access

A consistent message from people with lived experience of mental illness, and their carers and families is the difficulties that they have with accessing and navigating the mental health and suicide prevention system.[21,201,202] Of particular concern are the many inconsistencies within the gateways and pathways to mental health treatment.

A range of possibilities have been proposed to assist with navigation and coordination to improve existing entry points, and to build additional consumer-preferred entry points to the mental health system.[21,203]

Both Vision 2030 and the Productivity Commission have proposed a person-led system that responds to the needs of people seeking assistance, and allows people to choose how they interact with the system and the type of services that they need.[21] Technology and the workforce have been identified as key enablers of a system that facilitates access and navigation regardless of whether a person enters the system through a general practitioner, the emergency department or other means. Accessing and navigating the mental health system is also an issue for particular cohorts, including people living in rural and remote communities, and the older population.

This chapter discusses opportunities for facilitating affordable access to mental health services and treatment through innovation in digital mental health, addressing workforce issues, and strengthening the system response to rural and remote mental health. Emerging issues for rural and remote mental health and older people, including those accessing aged care services, are also discussed.

Digital mental health

Digital mental health services are offering new and innovative ways for people with lived experience, and their carers and families to access services.[21] Digital services provide an opportunity to significantly increase access to care by transcending geographic, stigma, privacy and financial barriers. Specifically, there are opportunities for technology to be used across all levels of care, including:

- provision of information
- assessment and screening
- online provision of self-guided programs and clinician-supported interventions
- virtual general and specialist psychological interventions
- connection and navigation of services
- crisis supports
- integration of self-directed interventions with clinician-led treatment approaches
- provision of virtual tertiary consultation and coordination of virtual team care.

Research has found that:

- digital mental health interventions in the workplace can improve employee psychological wellbeing and increase work effectiveness[204]
- digital mental health services enable effective outcomes for Aboriginal and Torres Strait Islander people,[205] non-English-speaking migrants,[206] and older cohorts[207]
- digital mental health services create an access point for carers to receive training, establish social networks with other carers, learn from peer and expert advice, and engage in interactive problem solving.[208]

Although there are clear benefits to the use of technology, there are also issues that need to be considered and addressed as digital mental health services expand. Concerns have been raised about accessibility to the internet and other digital technologies, and related considerations such as digital literacy—in particular, for people in regional and remote locations, and older Australians.[209,210]

Lack of access to technology, devices and the internet, and low digital literacy can result in increased vulnerability for people who may have limited access to face-to-face options, or for those who may not have the technical skills to participate in the digital world or use health-related technology to its fullest potential.[211, 212] It is also important to understand and address the ways in which digital services integrate with face-to-face technology and how information is managed, including self-management by people with mental health concerns. In addition, we need to ensure that the evolution of digital technology does not exacerbate the deprivation of people experiencing poverty and inequality.

As highlighted in **Sections 1 and 2**, new technology is changing the way mental health services are delivered. With the introduction of new health technology tools such as wearables, apps and devices, connecting to and integrating mental health services is increasingly attractive and efficient. However, at present, awareness of the broad range of digital mental health services is not uniform among the mental health workforce, despite sites such as Head to Health that identify services suited to specific patient needs. Furthermore, for many clinicians, digital mental health services are limited to applications.[213]

Continued research and evaluation are important to understand the effectiveness of digital mental health services, including specific services and modes of delivery, for the general population and different cohorts.

Online services need to be evidence based, and national coordination and oversight are needed to ensure that digital services are aimed at known gaps to minimise duplication, and ensure that the system remains consistent and accessible for people who need it.

The Commission recommends that a National e-Mental Health Strategy is developed after the National Digital Mental Health Framework is in place and mature, to help fill any gaps that may be found. Such a strategy will focus on the e-mental health ecosystem requirements for the use of digital platforms and applications, including examination of issues around privacy, ethics, artificial intelligence, predictive technologies, disruptive technologies, global reach and participation, and protection of risk.

Workforce

A theme throughout the Commission's Connections consultation in 2019 was that the current workforce does not have the capacity to deliver quality mental health services to the diverse communities in Australia and does not offer the breadth of services needed. This was attributed to a wide range of systemic issues, including inadequate training available for frontline workers, insufficient staffing levels, low retention of trained workers and lack of support for diversity in professional roles.[203] The future challenge for the mental health workforce is to rethink its composition from what is traditionally considered a multidisciplinary mental health team comprising mental health professionals (such as psychiatrists, mental health nurses, social workers and psychologists).

Recommendation:

The Commission recommends that the Australian Government develop a National e-Mental Health Strategy to complement the National Digital Mental Health Framework.

Vision 2030 identifies a robust and multidisciplinary workforce as being a key performance enabler to implementing a successful mental health and wellbeing system. Such a system requires integration of services that address mental health, physical health and social needs.

A multidisciplinary workforce should extend beyond the clinical disciplines to appreciate the contributions from a wide range of professionals across all types of care in the stepped care model, from frontline prevention and identification through a range of treatments to recovery support and research. This workforce includes a wide range of clinicians (psychological, allied health, general practice and medical), recovery support workers, lived experience workers, counsellors, psychotherapists, frontline or emergency responders, and people working in community institutions more broadly, including sporting, cultural and religious organisations.[203]

The Commission considers that the success of a multidisciplinary workforce depends on:

- clearly identified roles and responsibilities that encourage professional recognition, with flexibility in scope, and a culture of collaborative practice and team approaches
- recruitment and career pathways in mental health specialisation across all aspects of the workforce
- appropriate mental health training, from primary qualifications to ongoing or specialised professional development and in-role training
- retention of trained workers and incentives to take up mental health specialisations
- resourcing to enable professions to work to their full scope of practice.[203]

All jurisdictions in Australia have shown a commitment to the mental health peer/lived experience workforce, through either mental health plans and strategies, the development of peer workforce or lived experience frameworks, or standards and guidelines (see **Appendix F** for details).

Meaningful employment of designated lived experience roles is increasingly understood as contributing to best practice in service transformation, particularly in moving towards more recovery-oriented, person-directed service delivery.[214] Lived experience contribution to the ongoing national reform agenda underpins the significance of the national peer/lived experience workforce. A well-supported lived experience workforce results in benefits for people accessing services, families, social networks, organisations and the broader community. The relationships made possible through lived experience work strengthen connection, resiliency, choice and hope, improving the lives of individuals and helping to transform services.[215]

Following the completion of the National Mental Health Workforce Strategy (see **Box 14**), a critical next step will be developing an implementation plan to ensure that these improvements are realised. This will involve highlighting priority actions, and identifying measurable milestones and realistic time frames.

Recommendation:

The Commission recommends that the Australian Government develop a National Mental Health Workforce Strategy Implementation Plan.

Box 14: National Mental Health Workforce Strategy 2020–2030

Due for completion by late 2021, the National Mental Health Workforce Strategy is being developed to consider the quality, supply, distribution and structure of the mental health workforce, and identify practical approaches for ensuring that the workforce can meet the demands of the mental health system over the next 10 years.[216] A taskforce was established to oversee the development of the strategy. Some of the key mental health workforce challenges identified are the need to define the mental health workforce, diverse and changing population needs and consumer expectations, workforce shortages, rural and remote service provision, the need for the workforce to be responsive and flexible to changing circumstances, and measurement of progress.

The strategy's five priority areas are:

- attracting and retaining the mental health workforce for rural and remote areas, which requires consideration of structural, professional and personal factors
- supporting and valuing Aboriginal and Torres Strait Islander leaders across the system
- valuing and resourcing of the peer and lived experience workforce
- training and education across the career journey
- a whole-of-government approach to ensure that funding agreements and policy strategies relating to the workforce are interdependent and mutually reinforcing.[217]

The strategy is undertaking data analyses to estimate the current workforce supply and compare this with workforce targets (demand) produced by the National Mental Health Service Planning Framework. It is also identifying data gaps for nonregistered mental health practitioners and how to address them. Additionally, the strategy is considering an analysis of capacity of educational institutions in the tertiary, vocational and community education sectors to respond to increased demand for mental health workers.[218]

Rural and remote communities

Although the prevalence of mental illness in rural and remote areas is similar to that in metropolitan areas, people living in rural and remote areas face greater challenges in accessing appropriate support services. These difficulties are driven by the distribution of the mental health workforce, which is skewed towards urban areas.[21,219]

One of the biggest issues in relation to the mental health workforce across professional streams and geographical areas is high staff turnover. Contributing factors include stress and burnout, an aging workforce, excessive workloads, insecure tenure, limited career paths, and reduced time for training, mentoring and supervision. Mental health professionals operating in rural and remote areas, and in private practice, may also experience isolation.[220]

It is also important to recognise that the skill set required for the rural and remote mental health workforce often needs to allow workers to work across the primary, secondary and tertiary spectrum of care. Training packages that reflect this are crucial in supporting staff working outside major cities.

Digital technology can be useful for remote service provision and as an adjunct to the workforce in regional and remote areas, including as a method of providing distance education and training, and e-supervision to health professionals. However, digital mental health services should not be a substitute for face-to-face care unless that is what consumers want.

A range of opportunities exist to better meet the mental health needs of those living in regional and remote locations around Australia. Knowing the pivotal role that social connection and community participation play in wellbeing, programs that increase community connectedness and participation, build resilience and prevent mental distress should be prioritised. Such programs should be considered both in mental health services and more broadly, while acknowledging that each community has its own identity and culture. This embraces a holistic approach that acknowledges the key role of community and social connection as a preventive mental health measure.

Recommendation:

The Commission recommends that the Australian Government develop a National Regional and Remote Mental Health Strategy that looks holistically at the issues faced across diverse communities in regional and remote Australia.

Mental health initiatives under the Stronger Rural Health Strategy and the forthcoming National Mental Health Workforce Strategy will help to address key challenges, including strengthening the rural and regional mental health workforce, and improving availability of, and access to, mental health services. The aim of the Stronger Rural Health Strategy is to build a sustainable, high-quality health workforce that is distributed across the country according to community need, particularly in rural and remote communities. The strategy includes a range of incentives, targeted funding and bonding arrangements, and will give doctors more opportunities to train and practise in rural and remote Australia.

Older people

The COVID-19 pandemic has highlighted the need to break down the siloed approach between aged care, hospitals, general practice, ambulance services and the whole health system, and develop cross-sector partnerships.[221] The increasingly complex care needs of older people frequently require multidisciplinary services drawn from across the aged care and healthcare systems. The final report of the Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) will include significant reforms to address the funding and jurisdictional boundaries and professional silos that negatively affect access to care and the care experience for the older person. It will also address the inequities of access between people in aged care facilities and older people in the community.

Reform in aged care should address the provision of care in its broadest sense, such as social and emotional health, psychological wellbeing, and biomedical and psychiatric considerations of a person's mental wellbeing.

The Commission's submission to the Aged Care Royal Commission recommends an approach based on implementing the Contributing Life Framework for older people. The approach needs to address current gaps in the mental health and aged care systems, and improve the overall wellbeing of older people, with the aim of reducing prevalence rates across the spectrum from mental distress to mental illness.

This holistic approach to care and planning includes delivery of mental health supports for older people across the spectrum of care: promotion, prevention, crisis intervention, treatment and recovery.

It should also include greater interaction between aged care service providers and the wider service networks and community supports, addressing issues such as grief and loss, family relationships, loneliness and social isolation, AOD addictions, and spirituality.

Examples are expansion of programs, outside of clinical services, to contribute to the mental health and wellbeing of older people, such as 'befriending' programs, and a greater role for peer workers in both community and residential aged care settings. This would require further exploration of how the peer and lived experience workforce could contribute to mental health support, and act as a conduit between older people and mental health services.

Chapter 3: Facilitating access

Key reform areas for the interaction between the aged care and mental health systems include the following:

- Improvement within the aged care system should include workforce capacity and training, enhanced data and reporting, and greater early access to specialist mental health care for older people.
- Further national policy focused on improving older people's mental health and wellbeing in both aged care and mental health policy is needed.
- A coordinated approach is required across the mental health and aged care sectors —that is, remove the silos.
- Any new national aged care strategy, planning and funding framework, workforce strategy, regulation and monitoring processes should explicitly consider mental health, given the high rates of mental health issues among aged care residents.

There is currently no overarching approach to support the mental health of older people, which can be very different from the general population, due to declining health and frailty, bereavement, isolation and residential settings. There is a need to focus on promoting older people's mental health and ensure that mental health conditions are identified, and that coordinated support is provided early and in an accessible way.

Recommendation:

The Commission recommends that the Australian Government develop a National Older Persons Mental Health and Wellbeing Strategy.

Chapter 4:
Delivering quality,personalised care

To deliver high-quality care, providers must understand and respect people's needs, attitudes and concerns. There is growing evidence that, by personalising care and involving people in decisions about their health and care, we will improve health and wellbeing, improve quality of care, and ensure more informed use of healthcare resources.

It is well documented that the health and social care system is facing unpredicted demands due to demographic and financial pressures, technological advances, and changing attitudes towards people wanting to be more in control of their health and wellbeing.[222]

Issues affecting quality of care extend beyond the delivery setting and include personal, social and cultural factors. Research highlights the benefits of addressing client perspectives on quality of care, since it leads to improved client satisfaction, continued and sustained use of services, and improved health outcomes. This chapter discusses meeting the needs of specific groups where existing gaps are not being addressed, such as men and boys; women and girls; and lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) people.

Access to gender-specific services

Increasingly over the past 15 years, a focus on the mental health needs of men has encouraged the expansion of organisations that support and work with men to improve their mental health and wellbeing. The Australian Bureau of Statistics reports that, of the 3,318 registered suicide deaths recorded in Australia in 2019, 2,502 (75.4%) were of males and 816 (24.6%) were of females.[223] Additionally, according to the Australian Institute of Health and Welfare, 10.7% of Australians received Medicare-subsidised mental health–specific services in 2019–20, an increase from 6.2% in 2009–10; 12.8% of Australian females accessed these services, compared with 8.5% of Australian males, in 2019–20. Australians aged 18–24 years had the highest rate of use of such services(15.3%).[142]

Research has indicated that the system needs to provide access to gender-specific services if it is to improve mental health among men.[224] The impact of COVID-19 means that some targeted services have been expanded, including increased funding provided to the Men's Referral Service and MensLine Australia. MensLine Australia provides phone and online counselling support for men with emotional and relationship concerns, alongside its Help is Here campaign.[225] Services such as The Men's Table, Mates in Construction, Men's Sheds and Man Walk have adapted service provision to meet the needs of men by focusing on goals and solutions rather than talking about emotions.

To better understand and hear directly from men on mental health and suicide prevention, the Men's Health Connected Online Summit facilitated a recent national discussion in June 2020. Where men are not using traditional face-to-face sessions, flexible and innovative services should be considered, including online and telephone service delivery, which may provide greater access for men living in rural and remote Australia.

Critical life points experienced by women and girls, such as puberty, pregnancy, motherhood and menopause, can result in poor mental health. In addition, situations typically associated with women can lead to anxiety and depression, including infertility and perinatal loss, being a primary caregiver, relationship breakdowns, violence or abuse, discrimination, unemployment or underemployment, isolation and socioeconomic disadvantage.[226]

It is estimated that approximately one in five women in Australia will experience depression, and one in three women will experience anxiety during their lifetime.[190] The Australian Longitudinal Study on Women's Health (also known as Women's Health Australia) is a population-based survey that explores the factors contributing to the health and wellbeing of more than 57,000 Australian women in four age cohorts: those born in 1989–95, 1973–78, 1946–51 and 1921–26. The 1989–95 cohort had a higher percentage of conditions identified over their lifetime (51.2%) than older cohorts.[227]

Mental health is a priority health issue in the national gender-specific health strategies for males and females (see **Box 15**). Each strategy embodies an understanding of how gender intersects with social, economic, environmental, political and cultural determinants of health, influencing exposure to risk factors and interactions with the health system.

Research is needed to examine the differences in how men and women engage with, and respond to, psychological treatment, as there is limited research reporting on intervention effectiveness by gender.

Box 15: National gender-specific health strategies

The National Men's Health Strategy 2020–2030 and the National Women's Health Strategy 2020–2030 aim to address the different biological and societal factors that impact in different ways on women's and men's health and wellbeing. They aim to strengthen and improve national approaches for men and women by working in tandem with each other, and with other national, state and territory policies and strategies.

Mental health is a priority health issue in both strategies, with a life course approach for specific intervention points to increase the effectiveness of health education, intervention and service delivery. The National Women's Health Strategy 2020–2030 has five priority areas, including mental health. Within the mental health priority area, five key areas for action have been identified to improve mental health outcomes for women and girls in Australia. These are enhancing gender-specific mental health awareness, education and prevention; focusing on early intervention; and investing in service delivery and multifaceted care.

Acknowledging the unique needs of different population groups is a key element of each strategy; priority populations are recognised, and targeted interventions are identified to improve health outcomes. The population groups that experience a relatively high burden of adverse health outcomes (such as those living in rural and remote areas, Aboriginal and Torres Strait Islander communities, people from lower socioeconomic backgrounds, people affected by the criminal justice system, veterans, and members of the LGBTIQ+ community) may also differ for men and women. To improve health equity, each strategy has targeted interventions to address the complex, multidimensional needs of these priority population groups.

The Million Minds Mental Health Research Mission is funding research into projects on suicide prevention for boys and men, including interventions to assist with help seeking, online and telephone services, and suicide prevention (specifically in new fathers).[29] In addition, mental health professionals require education on the role of gender and its implications on mental health treatment practices.[224]

The Commission supports the conclusions in both the National Men's Health Strategy 2020–2030 and the National Women's Health Strategy 2020–2030 of the importance of monitoring and reporting on progress in implementing actions over the ten year lifespan of the strategies. Of particular importance is reporting on the success factors that support gender-based activity, focusing on equity and access to mental health care for women and men at greater risk of poor mental health outcomes. These include people who are homeless, people with low financial security or financial literacy, people living in rural and remote areas, Aboriginal and Torres Strait Islander people, veterans transitioning from service, migrant and refugee people, and the LGBTIQ+ community.

Lesbian, gay, bisexual, transgender, intersex and queer communities

Services are needed that ensure safety for those who identify as LGBTIQ+, and provide supported outreach within this population and enable appropriate care regardless of the service accessed. As a minority group, LGBTIQ+ people disproportionately face negative mental and physiological health outcomes compared with the general population.[179] LGBTIQ+ people continue to experience routine discrimination, prejudice, stigma and exclusion in the community.

It is difficult to determine suicide mortality rates for LGBTIQ+ people because sexuality and gender identity may be unknown. A recent study by La Trobe University indicates alarmingly high rates of suicide distress facing LGBTIQ+ people—they reported suicidal thoughts over the past 12 months at a rate 20 times higher than the general population.[228] A number of studies have found that members of LGBTIQ+ communities are more likely to experience mental distress, such as anxiety, depression, thoughts of suicide, suicide attempts and self-harm than their non-LGBTIQ+ peers, as a result of negative social experiences such as homophobia and bullying.[179]

Early interventions must aim to reduce known psychosocial risk factors for this population while enhancing protective and resilience factors. The La Trobe University study recommends research and evaluation of interventions and programs around suicide ideation, homelessness, AOD issues, and intimate partner and family violence in relation to people from the LGBTIQ+ community.

The Productivity Commission's report recognised the need to improve access to appropriate services, and to have a well-trained workforce to provide high-quality and culturally safe services for all Australians.

Some LGBTIQ+ people underutilise health services and delay seeking treatment because of actual or anticipated experiences of stigma and discrimination from service providers.[179] It is crucial that services are affirming of sexuality and gender identity, and attentive to the particular pressures experienced by LGBTIQ+ people.

The Commission believes that the specific needs of LGBTIQ+ people who have experienced stigma and discrimination in the community and while accessing health services should be addressed as part of the National Stigma and Discrimination Reduction Strategy.

Concluding statement

This National Report 2020 highlights that mental illness and suicide continue to be significant public health issues in Australia and internationally. Poor mental health and wellbeing has substantial personal, economic, productivity and social impacts.

Complex challenges continue to face the Australian Government, state and territory governments, the private sector and the community to achieve better-coordinated and integrated support across a range of sectors and systems, and to ensure that all services are person and family centred. Timely access to quality mental and physical health treatment and care is important. However, to prevent mental health difficulties and enable recovery, individuals and their loved ones also need timely access to the right type of social, economic and community-based supports
as a coordinated response.

As the health sector responds to radical changes in demand for services, the unprecedented events of 2020 have forced health care to be more innovative. Digital technology has enabled people to stay connected during the crisis, while the rapid expansion of virtual health care has meant that long-awaited efficiencies, workplace flexibility and improvements in access to care are beginning to be realised. However, with these innovations comes the need to address the digital divide within Australia to enable equitable access. Addressing stigma and discrimination is also critically important, as well as addressing employment, education, housing, justice, income support, early childhood and family support, aged care, psychosocial services, the needs of Aboriginal and Torres Strait Islanders, and the needs of culturally and linguistically diverse communities.

During the past 12 months, Australia's mental health system has continued to be the focus of the reform agenda, including the Productivity Commission inquiry into mental health, the Royal Commission into Victoria's Mental Health System, the Aged Care Royal Commission, the Disability Royal Commission, and the Natural Disasters Royal Commission.

Along with Vision 2030, the Fifth Plan, the National Mental Health Research Strategy, and the National Children's Mental Health and Wellbeing Strategy, these inquiries will provide a significant national reform program in the years to come. However, there will need to be continued research and evaluation in mental health to understand progress with these existing reforms and support the case for future reforms.

The past 12 months have been particularly challenging for Australians as a result of the health and financial impacts of COVID-19, and recent bushfires, floods and drought. The COVID-19 pandemic is posing significant health, social and economic challenges for all Australians, with a number of at-risk groups likely to be impacted due to vulnerability or existing mental illness. Evidence from previous pandemics and broader research on the economic impact of recessions suggests the likelihood of increased mental illness, including new presentations of mental distress and illness; increased substance use; an increased incidence of interpersonal, generational and family violence; impacts from trauma; and increased risk of suicide in the longer term.

The Commission will continue to provide independent policy advice and evidence on ways to improve Australia's mental health and suicide prevention system. In addition, the Commission will continue its role as a catalyst for change within the mental health system.

Throughout this report, the Commission has identified a number of areas where improvements can be made to ensure that all Australians achieve the best possible mental health and wellbeing. The Commission views these as priority items within the context of the past 12 months. The list below compiles the recommendations made throughout the report.

Recommendations

1. The Australian Government should develop a National Older Persons Mental Health and Wellbeing Strategy

The COVID-19 pandemic, as well as the Aged Care Royal Commission, have highlighted the mental health needs of older people, in both residential aged care facilities and the community, and the need for national consistency in service delivery of mental health supports for older people. To ensure that older people with a mental health issue can live a contributing life, and participate in their communities, a national coordinated response is needed to address the mental health crisis in aged care, as well as broader mental health impacts on older people living in the community.

The strategy should ensure a holistic approach to planning and delivery of mental health supports for older people, across the spectrum of care: promotion, prevention, crisis intervention, treatment and recovery.

2. The Australian Government should develop a National Mental Health Workforce Strategy Implementation Plan

With the development of the National Mental Health Workforce Strategy, due to be completed in mid-2021, there is an opportunity to significantly improve the mental health workforce, particularly in regional and remote areas, by improving training and education, incorporating fully the peer and lived experience workforce, and developing a whole-of-government approach to funding and policy directions.

A critical next step will be developing an implementation plan to highlight the priority actions, with measurable milestones and realistic time frames, to ensure that these improvements are realised.

3. The Australian Government should develop a National e-Mental Health Strategy

As we move to greater use of digital supports, it is vital that digital services are consistent in their quality of care, are accessible to all who would benefit from them and, most importantly, operate within a strategic and coordinated e-mental health ecosystem. To complement the National Safety and Quality Digital Mental Health Standards and upcoming National Digital Mental Health Framework, an e-Mental Health Strategy should be developed.

4. The Australian Government should develop a National Regional and Remote Mental Health Strategy

The National Mental Health Workforce Strategy currently in development will consider the quality, supply, distribution and structure of the mental health workforce, and identify ways of improving recruitment and retention in regional and remote locations.

Although this work is welcome, there have been calls for a National Regional and Remote Mental Health Strategy that looks holistically at the issues faced across diverse communities in regional and remote Australia. In 2018, the Senate's Community Affairs References Committee published the Accessibility and Quality of Mental Health Services in Rural and Remote Australia final report, which recommended a national strategy on rural and remote mental health to address the low rates of access to mental health services, and the tragically high
rate of suicide in Australia's rural and remote communities.

Once the National Mental Health Workforce Strategy has been finalised, it is recommended that the Australian Government develop a National Regional and Remote Mental Health Strategy that looks holistically at the issues faced across diverse communities in regional and remote Australia.

Glossary of terms and acronyms

Burden of disease	A measure of the impact of a disease or injury on a population.
Carer	In this document, 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 support	Nonclinical 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 National Disability Insurance Scheme (NDIS) aimed at providing specialised support to participants living with 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 accessed support under the National Psychosocial Support Transition measure and have been assessed as ineligible for the NDIS.
COVID-19	The term used for the disease caused by the virus SARS-CoV-2, as established by the World Health Organization, the World Organisation for Animal Health, and the Food and Agriculture Organization of the United Nations. COVID-19 is also known as '2019 novel coronavirus', '2019-nCoV' or 'coronavirus'.
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.
Digital divide	The gap that exists between individuals who have access to modern information and communication technology and those who lack access.
Digital health	An overarching term to describe the use of information and communications technology in support of health and health-related fields, including healthcare services; health surveillance; health literature; and health education, knowledge and research.
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.

headspace
An Australian non-profit organisation for youth mental health established by the Australian Government in 2006.

JobKeeper
The Australian Government describes the JobKeeper payment as a payment made to eligible businesses and not-for-profits affected by COVID-19 to support them in retaining employees.

JobSeeker
The Australian Government describes the JobSeeker payment as a payment made to eligible individuals seeking employment.

Justice system
In this report, all aspects of the investigative, adjudicative and correctional processes that deal with crime, including policy making and law reform; policing; courts and tribunals; dispute resolution; penalties and fines; prisons, corrections services and parole; legal assistance; and victim support.

LGBTIQ+
The collective term for people who identify as lesbian, gay, bisexual, transgender, gender diverse, intersex, queer and questioning. Many subgroups form part of the broader LGBTIQ+ movement.

Note that there are multiple variations of this term (for example, LGBTQIA).

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.

Medicare Benefits Schedule (MBS)
A listing of the Medicare services subsidised by the Australian Government. The Schedule is part of the wider Medicare Benefits Scheme managed by the Australian Government Department of Health and administered by Services Australia.

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 health problem
A mental health problem that reduces a person's cognitive, emotional or social abilities, but not to the extent that it meets the criteria for a mental illness diagnosis. These problems can result from life stressors, and often resolve with time or when the individual's situation changes. A mental health problem may develop into a mental illness if it persists or increases in severity.

Mental ill-health
The Life in Mind National Communications Charter defines mental ill-health as a broad term that includes both mental illness and mental health problems.

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 disorder' and 'mental health disease'.

National Disability Insurance Scheme (NDIS)
The NDIS provides individualised support packages for eligible people with permanent and significant disability, and their families and carers.

National Psychosocial Support measure
Provides psychosocial support to people with severe mental illness who are not currently receiving supports through other Australian Government, state and territory programs or the NDIS.

National Workplace Initiative (NWI)
A nationally consistent approach to workplace mental health. The NWI aims to bring about national consistency in how organisations and workplaces support their employees. It aims to create an evidence-based framework for creating mentally healthy workplaces; connect organisations to the right resources via a digital platform; amplify and strengthen exemplar programs already underway; and highlight gaps in research, resources or services.

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

Pandemic
The World Health Organization defines a pandemic as an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.

Partners in Recovery
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 Partners in Recovery 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.

Poor mental health
When our mental health is not what we would want it to be. Finding it difficult to manage how we think, feel and act with respect to daily stresses could be a sign of poor mental health.

See also **mental health** and **mental health problem**.

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.

Prevention
In this report, approaches that work to reduce incidence, prevalence and recurrence of mental ill-health.

Primary Health Network (PHN)
An administrative health region established to deliver access to primary care services for patients, as well as coordinate 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 choice. Patients are charged fees for accommodation and other services provided by the hospital, and relevant medical and paramedical practitioners.

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

Psychosocial disability
An impairment or restriction arising due to mental illness that can limit an individual's ability to function, think clearly and enjoy full physical health, or manage their social and emotional welfare. Although not everyone who has a mental health issue will experience psychosocial disability, those who do can experience severe effects and social disadvantage.

Psychosocial support
Processes, interventions and services that aim to support an individual to maintain their best possible level of independence. Psychosocial support assists people to mend and rebuild emotionally, cognitively, practically and socially, and helps people to develop or regain skills necessary to be able to fully participate in society.

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 usually 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.
Socioeconomic disadvantage	Reduced access to material and social resources, and subsequent reduced 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 areas of society.
Substance use disorder	A category of mental illnesses that relate to problems arising from the use of alcohol or other 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, and develop the skills necessary to understand and implement their plan. Where necessary, it provides additional targeted support to participants in highly complex or high-risk situations.
Vision 2030	A blueprint for mental health in Australia that outlines the goals and objectives for mental health, and the systems or services that may meet these goals and objectives.

Appendix A
National Report 2019 recommendations update

Recommendation	Progress update

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.

The Australian Government has committed $89.5 million to implement the Intergenerational Study of Health and Mental Health, beginning with the National Study of Mental Health and Wellbeing (NSMHWB), scheduled to go into the field from January 2021 (subject to COVID-19). Initial findings are expected from late 2021.

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.

Discussions between the Australian Bureau of Statistics (ABS), the Australian Government Department of Health and the National Indigenous Australians Agency (NIAA) have identified a range of issues with regard to including Aboriginal and Torres Islander–specific mental health and wellbeing data in the Intergenerational Health and Mental Health Study (either the NSMHWB or subsequent modules):

- The survey instrument, incorporating a diagnostic interview similar to that used in the NSMHWB, needs to be both culturally appropriate and able to adequately capture relevant social and cultural determinants of mental health for Aboriginal and Torres Strait Islander people.
- Consultation needs to be conducted with Aboriginal and Torres Strait Islander people, health services and other key stakeholders before undertaking any national survey, particularly on a sensitive topic such as mental health. In particular, issues related to informed consent, data linkage, and requirements for ethics approvals and/or privacy impact assessment would need to be discussed with stakeholders and the community.
- Managing respondent burden requires careful-consideration in terms of the impact on individuals who may require access to appropriate support.

Recommendation	Progress update

Recommendation 2 continued	- Consideration of timing of such a survey is important in terms of:
	  - the sequence and potential clash with other important Indigenous-specific surveys from the ABS and the survey burden on the population
	  - whether comparability with the mainstream mental health survey is a priority; if so, a comparable time period would be needed.
	- The collection approach for Aboriginal and Torres Strait Islander surveys needs to be enhanced, including communication and engagement practices.
	
	The Australian Government Department of Health will continue to work closely with the ABS, the NIAA and other stakeholders to plan for future collection of Aboriginal and Torres Strait Islander mental health data, informed by further research.
	
	The National Aboriginal and Torres Strait Islander Health Survey (2018–19) included various data items relating to mental health and wellbeing, including:
	- whether the respondent has ever been diagnosed with a mental health condition
	- type of diagnosed mental health condition
	- whether the respondent has psychological disability
	- whether the respondent has accessed/used health services for a mental health condition
	- whether the respondent has been to a counselling service in the past 12 months
	- reason(s) they did not go to a counsellor in the past 12 months
	- whether the respondent consulted a psychologist in the past two weeks
	- social and emotional wellbeing.

Recommendation 3 The Australian Government supports the ongoing inclusion and further development of psychosocial risk factor analysis in the routinely published deaths data collection.	The ABS has released the results of a pilot study into the psychosocial risk factors associated with suicide deaths in 2017. The ABS Causes of Death, Australia, 2019 publication extended this analysis and published psychosocial risk factors from 2017, 2018 and 2019 data. The Commission is currently seeking further information regarding an ongoing commitment to analysis of psychosocial risk factors in the routinely published deaths data collection. The ABS has worked with the National Coronial Information System and data custodians to embed psychosocial risk factors in future national mortality datasets. Supporting work is published by the Australian National University and the ABS on psychosocial risk factors as they relate to coroner-referred deaths in Australia.

Recommendation	Progress update

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.	Following release of the final report of the Productivity Commission's inquiry into mental health in November 2020, the Australian Government has indicated that it will consider the report and respond as part of the 2020–21 Budget.

Recommendation 5

The Australian Government produces a clear implementation plan to accompany the development and release of the National Mental Health Workforce Strategy.	A National Mental Health Workforce Strategy Taskforce has been established. It is anticipated that the taskforce will provide initial recommendations to the Australian Government by December 2020. A final report will be provided to the Australian Government by late 2021.

Meeting the needs of consumer and carers

Recommendation 6

The National Mental Health Commission 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.	YES survey data for 2018–19 was published in October 2020. At this time, only three jurisdictions—New South Wales, Queensland and Victoria—contributed to YES data collection. In 2018–19, New South Wales consumers were offered the YES survey during every hospital stay or community episode of care. In Queensland and Victoria, consumers were offered the YES survey at a particular time of the year.

Recommendation 7

The National Mental Health Commission suggests that state and territory governments investigate the feasibility of implementing the Mental Health Carer Experience Survey.	New South Wales implemented the survey in 2018, and Queensland implemented it in 2019. Victoria implemented the survey in 2020. Data from these jurisdictions has not yet been aggregated into a routinely published, publicly available report.

Recommendation	Progress update
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 National Mental Health Commission 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.	The Australian Government invested in the development of the Living in the Community Questionnaire (LCQ), which is now available for use. The LCQ has been designed to explore aspects of a consumer's life in the community, including social activities, participation in employment or study, living situation and physical health care. The summary form of the LCQ (the LCQ-S) has been created and can be used within services to support consumer–clinician dialogue and care planning. Primary Health Networks (PHNs) are required to provide data about the delivery of commissioned mental health services to the Australian Government Department of Health through the PHN Primary Mental Health Care Minimum Data Set. PHNs are also able to collect any other data appropriate for evaluation and performance improvement.

Social determinants

Recommendation	Progress update
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.	Following release of the final report of the Productivity Commission's inquiry into mental health in November 2020, the Australian Government has indicated that it will consider the report and respond as part of the 2020–21 Budget.
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.	Following release of the final report of the Productivity Commission's inquiry into mental health in November 2020, the Australian Government has indicated that it will consider the report and respond as part of the 2020–21 Budget.

Recommendation	Progress update

Primary Health Networks

Recommendation 11

Recommendation	Progress update
In consultation with PHNs, the Australian Government establishes an overarching entity to govern, support and build PHN capacity on a national scale.	The Australian Government has advised that it does not consider that an additional organisation is required. In 2014, the Review of Medicare Locals recommended that the Australian Government should not fund a national alliance for Primary Health Organisations, now known as PHNs. The Australian Government Department of Health provides national support for the PHN program through national direction and leadership, performance setting and monitoring, including facilitating opportunities for knowledge sharing and learning, engagement and communications, and financial management of the program. In addition to the department's role, the 31 PHNs have formed the PHN Cooperative, which serves as a single point of contact for the PHNs, and provides a forum for PHNs to shape and inform shared agendas. There are also a number of state- and territory-based alliances among PHNs that optimise the collective capabilities of PHNs as a sector, proactively align efforts and advance primary care reform with a jurisdictional purview. They also shape, strengthen and sustain primary health care through partnerships and strategies that improve people's access and health outcomes. The Productivity Commission has recommended that the Australian Government support state and territory governments that choose to establish regional commissioning authorities to administer mental health funding as an alternative to PHN–Local Health Network groupings.

Recommendation 12

Recommendation	Progress update
The Australian Government responds to the 17 recommendations in the PHN Advisory Panel Final Report.	The mental health policy landscape has evolved considerably since this report was delivered, and future policy and programs will be informed by this report and other significant reviews, such as the Productivity Commission inquiry into mental health.

Recommendation 13

Recommendation	Progress update
The Australian Government endorses the implementation of the Five-Year Horizon for PHNs	The mental health policy landscape has evolved considerably since these reports were delivered, and future policy and programs will be informed by these reports and other significant reviews, such as the Productivity Commission Inquiry into mental health.

Recommendation	Progress update
Recommendation 14	
The report on the performance of the PHN Program to be released by the Australian Government include baseline data about how the PHN Program is meeting outcomes under the new PHN Performance and Quality framework.	The Australian Government Department of Health's 2018–19 PHN Program Performance and Quality Framework report, which includes baseline data, was published on 1 October 2020. This was the first PHN program-wide performance report conducted under the PHN Program 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.	The Australian Government has committed to providing the PHN program with performance-based three year contracts to support longer-term service planning and system improvement. The Australian Government Department of Health has highlighted that it expects that PHNs will pass on longer-term funding certainty to service providers who meet performance expectations, where the underlying funding is available, and where the commissioning cycle indicates that a new approach to market is not needed. It is not always appropriate for PHN-commissioned service providers to be placed on three year contracts. For example, PHNs may put in place surge arrangements or offer additional support for a limited period, such as during COVID-19 lockdown periods. In such cases, it may be more suitable for PHNs to offer a shorter contract length. The Productivity Commission recommends that the Australian Government should require PHNs to enter into longer contracts when commissioning psychosocial services.
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.	The PHNs and Aboriginal Community Controlled Health Organisations (ACCHOs) *Guiding Principles* document recognises the commitment by PHNs and Aboriginal Community Controlled Health Services (ACCHSs) to work together to improve access to health services and improve health outcomes for Aboriginal and Torres Strait Islander people. The Guiding Principles acknowledge and respect the essential role that ACCHSs play in delivering culturally safe, holistic models of care, including comprehensive primary health care for Aboriginal and Torres Strait Islander people, and the important leadership role of the sector in improving the health and wellbeing of Aboriginal and Torres Strait Islander people. The Guiding Principles were developed in consultation with ACCHO peak bodies and are publicly available.

Recommendation	Progress update
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.	Recent improvements to access for people with psychosocial disability, such as the recovery coach, have recently been implemented, and the psychosocial framework is expected to be completed in 2021. As of 30 September 2020, 40,508 participants with a primary psychosocial disability had accessed the National Disability Insurance Scheme (NDIS).
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.	The Australian Government Department of Health continues to carefully monitor the transition of clients from ceased Commonwealth community mental health programs (Partners in Recovery, Day to Day Living, and Personal Helpers and Mentors) to accessing support through National Psychosocial Support Transition measure arrangements from 1 July 2019. Additional funding of $28.4 million is being provided in 2020–21 to continue support for 12 months from 1 July 2020 to 30 June 2021 for clients who are yet to test eligibility for the NDIS. An evaluation of the National Psychosocial Support measure and Continuity of Support program commenced in February 2020 and is due to be completed in December 2020. The findings of this evaluation, as well as the findings from other reviews such as the Productivity Commission inquiry into mental health, will inform broader policy and funding reforms, including access to services and integration with state and territory services. The Australian Government has implemented three programs to help with the transition of people from a number of Australian Government–funded mental health programs that have ceased due to the transfer of funding to the NDIS. Unfortunately, not all people from these programs have access to the NDIS, because they do not meet the eligibility criteria or choose not to apply. *Continuity of Support* In the 2018–19 Budget, the Australian Government announced that it had committed $109.8 million from 1 July 2019 for the Continuity of Support (CoS) measure. This measure provides psychosocial supports to former clients of ceased Commonwealth community mental health programs (Partners in Recovery, Support for Day to Day Living, and Personal Helpers and Mentors Service) who were receiving services at 30 June 2019 and are ineligible for supports under the NDIS. CoS will provide ongoing funding, ensuring that CoS clients continue to have access to responsive support as needed.

Recommendation	Progress update
Recommendation 18 continued	*National Psychosocial Support Transition measure (NPS-T)* The NPS-T program provides targeted support to people who were previously accessing psychosocial services through ceased Commonwealth community mental health programs (Partners in Recovery, Support for Day to Day Living, and Personal Helpers and Mentors Service) on 30 June 2019 to test their eligibility for the NDIS. Clients in NPS-T can also access psychosocial supports while they undertake this process. Clients of NPS-T who are found ineligible for the NDIS will be able to access psychosocial support through the CoS program. On 29 March 2020, the Australian Government announced that it would invest a further $28.4 million in NPS-T from 1 July 2020 to 30 June 2021, to extend support for the 2,709 remaining clients (from 15,484 clients at 1 July 2019) to test eligibility for the NDIS. *National Psychosocial Support measure (NPS-M)* In the 2017–18 Budget, the Australian Government committed $80 million over four years for the NPS-M. The states and territories have matched funding for this measure, and the Australian Government has bilateral agreements in place with each jurisdiction to support coordinated delivery of these services. The NPS-M is designed to: • support people with severe mental illness and associated psychosocial functional impairment who are not more appropriately supported through the NDIS • reduce the avoidable need for high-intensity, acute health services and promote effective use of the health system.

Recommendation	Progress update
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	The National Disability Insurance Agency (NDIA) has implemented projects to support PHNs and provider organisations to support people transitioning to the NDIS from Commonwealth mental health programs. The NDIA is improving linkages and referrals to mainstream mental health supports and the community mental health sector for people not eligible for the NDIS, with new arrangements commencing from March 2020. To improve access for prospective participants, the NDIA has implemented a number of improvements: • new streamlined access processes that support prospective participants to begin their access request verbally with a support worker or another trusted person • new resources to clarify information needed to demonstrate evidence of disability for people with psychosocial disability • enhanced role of Partners in the Community to undertake outreach activities to increase access to the NDIS for people with psychosocial disability, with role specifications completed by April 2020, after which new information and marketing strategies will be rolled out • additional $20 million for the Community Connector program, which will be expanding into urban and rural settings. The additional funding will be targeted to culturally and linguistically diverse communities, people experiencing psychosocial disabilities, aging parents or carers of people with disability, and Indigenous communities. The NDIA plans to have the program in place by April 2020 • strengthened information sharing between Australian Government and state and territory governments and the NDIA, including a six monthly NDIS data report on psychosocial disability so that jurisdictions can monitor developments. On 9 October 2019, disability ministers under the Disability Reform Council committed to improving access and experiences for participants with psychosocial disability.

Recommendation	Progress update
Recommendation 19 continued	The NDIA is working collaboratively with the Australian Government Department of Social Services and Department of Health, and state and territory health department representatives on the following key initiatives: • undertaking a joint examination of access and eligibility • improving linkages and referral to mental health supports for people not eligible for the NDIS • undertaking assertive outreach to increase access to the NDIS for people with psychosocial disability • implementing a psychosocial disability recovery approach • implementing a national approach to concurrent supports. A Stakeholder Reference Group of sector peak bodies and representatives with lived experience has been established to provide input into priority areas, including development of the NDIS Psychosocial Disability Recovery Framework.
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.	On 29 May 2020, National Cabinet agreed to reconsider the structure of the Council of Australian Governments and the supporting councils. A decision on the restructure is pending. The Disability Reform Council is the forum for member governments to discuss matters of mutual interest and progress key national reform in disability policy, including the NDIS. The council has continued to guide work on the NDIS. The council noted at its March 2020 meeting that the priorities during the COVID-19 pandemic were to: • ensure the ongoing delivery of core NDIA services as part of the NDIA's Pandemic Plan, including a shift from face-to-face planning to telephone planning, and redirecting NDIA staff and partners to priority service delivery roles that support participants in responding to COVID-19 • ensure that appropriate plans are in place to respond to any workforce shortages that may arise as a result of COVID-19 • ensure that providers are supported to remain viable during the period of impact of COVID-19 and beyond • ensure the continuation of services to NDIS participants through extension and increased flexibility of NDIS plans, where necessary, so that the NDIA can focus on reviewing plans that may require amendment in response to the impact of COVID-19. At its July 2020 meeting, the council agreed to continue monitoring the NDIS support market, and work to finalise an NDIS workforce plan later in 2020 in light of COVID-19.

Recommendation	Progress update
Recommendation 21 The NDIA includes support coordination as a standard item in all plans for people with psychosocial disability.	From 1 July 2020, greater flexibility will be introduced into plan funding to allow participants to use their funding across all aspects of the plan. This means that participants will be able to use the funding for support coordination or recovery coach support. The recovery coach role provides a greater level of support for participants with psychosocial disability. Participants can choose from two streams of recovery coach: those with lived experience and those with learned experience.
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.	In June 2019, the NDIA published a report on participants with psychosocial disability, providing information about plan funding, numbers of participants, client satisfaction and outcomes. The NDIS publishes a quarterly report of data on NDIS participants. The quarterly report provides basic figures on how many new participants with psychosocial disability have accessed the scheme. The National Mental Health Sector Reference Group is also provided with more detailed information at its quarterly meeting.

Suicide prevention

These recommendations are pending the final report of the National Suicide Prevention Taskforce.

Recommendation	Progress update
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.	The Australian Government is working towards zero suicides. It appointed the first National Suicide Prevention Adviser, who reports directly to the Prime Minister. The National Suicide Prevention Adviser will work with relevant ministers to drive a whole-of-government approach to suicide prevention activities. The National Suicide Prevention Taskforce supports the National Suicide Prevention Adviser. Interim advice and in-principle recommendations were released in November 2020, following consultation with almost 2,000 people with lived experience, experts in suicide prevention and government representatives. The interim advice will be used to consult further with government representatives on implementing the recommendations. The final advice is due to the Australian Government in December 2020.

Recommendation	Progress update
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.	In the 2019–20 Budget, the Australian Government allocated $4.5 million to support the establishment of a national independent and inclusive Indigenous social and emotional wellbeing, mental health and suicide prevention leadership body: Gayaa Dhuwi (Proud Spirit) Australia. Gayaa Dhuwi (Proud Spirit) Australia has commenced renewing the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy in consultation with stakeholders and community members, and is working closely with the National Suicide Prevention Adviser and Taskforce.
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.	The New South Wales Government has introduced 20 new services across the state that provide an alternative to emergency presentations as part of the Towards Zero Suicides initiatives. The centres are based on the United Kingdom Safe Haven cafes that have shown positive reductions in emergency admissions. The Safe Haven model is also being trialled in Victoria. The Australian Government is trialling eight Adult Mental Health Centres, one in each state and territory, to assist in reducing presentations to emergency departments. The centres will be established and led by PHNs from 2020–21, and service delivery will commence in 2021–22. An evaluation framework will assist in understanding the trials' effectiveness and informing their potential for future expansion.
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.	Under the Fifth National Mental Health and Suicide Prevention Plan Implementation Plan, the Safety and Quality Principal Standing Committee of the Mental Health Principal Committee is to work with the Australian Commission on Safety and Quality in Health Care to develop the mental health supplement to the National Safety and Quality Health Service Standards (second edition). A National Safety and Quality Community Mental Health Standards (NSQCMHS) advisory group, comprising representatives from key sectors (including the Australian Government Department of Health), has been established and has had its initial meeting. The department will ensure that guidance on the care required by people at risk of suicide is included in the NSQCMHS through its representation on the advisory group.

Recommendation	Progress update
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.	On 29 May 2020, National Cabinet agreed to reconsider the structure of the Council of Australian Governments and the supporting councils. A decision on the restructure is pending. As part of the role, the National Suicide Prevention Adviser will develop options to improve the whole-of-government coordination and delivery of suicide prevention activities across portfolios, to address the complex issues contributing to Australia's suicide rate and find community-led, person-centred solutions. The interim advice was provided to the Prime Minister in August 2020 and made public in November 2020, outlining in-principle recommendations. The key recommendations focus on a whole-of-government approach, and the need for ongoing engagement with people with lived experience in the development and design of services. The interim advice will be used for further consultations with governments to inform the final report and recommendations, which will be provided to the Prime Minister in December 2020.
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.	The Australian Government has committed $15 million from 2019–20 to 2021–22 to establish a new national system for collection and coordination of information on suicide and self-harm. Bringing together region- and demographic-specific information on the incidence of suicide and suicidal behaviour, this system will ensure that governments and communities will be able to rapidly deliver the right type of services when and where they are needed most, to prevent suicides and suicide clusters. The Suicide and Self-harm Monitoring website was launched on 29 September 2020. Data will continue to be released over the course of the project. Coronial suicide registers capable of timely data have been established in Victoria, New South Wales, Queensland, Western Australia and Tasmania. The Australian Institute of Health and Welfare is working with the Australian Capital Territory, South Australia and the Northern Territory to establish suicide registers. The Productivity Commission recommended that relevant data should be shared and the Commission should assess evaluations of current suicide prevention activities.

Recommendation	Progress update
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.	PHNs receive Australian Government funding to commission suicide prevention activities at the local level, responding to regional need. In addition, through the National Suicide Prevention Leadership and Support Program, the Australian Government provides funding for a range of national activities that contribute to reducing deaths by suicide across the Australian population and among at-risk groups, and reducing suicidal behaviour. Projects include research, anti-stigma and awareness campaigns, face-to-face support for individuals in need, and training for frontline services. The Australian Government has committed a further year of funding for the program to June 2022. There is still no clarity around roles and responsibilities for suicide prevention activities. Whole-of-government engagement is needed to ensure that outcomes can be achieved.
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 evaluation of the National Suicide Prevention Trial has now been finalised. There has been significant investment in suicide prevention trials across the country (Victoria, LifeSpan in New South Wales and the Australian Capital Territory, and Australian Government trials). The Australian Government is providing funding to gather and analyse findings from evaluations of the suicide prevention trials to improve the evidence base available at the national level. The Australian Government Department of Health has engaged a consultant to progress this initiative. This work supports the recommendation of the National Suicide Prevention Adviser for "enhanced coordination of all suicide prevention trial site evaluations to enhance understanding of effective interventions and inform future decisions".

Appendix B

Government announcements relating to COVID-19, bushfires and mental health

Jurisdiction	Announcement extract	Date	Website
Australian Government	The Australian Government will establish a new agency with an initial $2 billion for a National Bushfire Recovery Fund to coordinate a national response to rebuild communities and livelihoods after the devastating firefront has passed.	6 January 2020	View here
Australian Government	Immediate mental health services deployed into fire-affected communities. $76 million will fund free counselling sessions, extra Medicare and telehealth consultations, an expansion of headspace services for young Australians, and community recovery initiatives.	12 January 2020	View here
Australian Government	$64 million for suicide prevention and mental health initiatives. Initiatives will focus on: • Australians who have been discharged from hospital after a suicide attempt • families and carers who have lost a loved one to suicide • young Australians, particularly in Aboriginal and Torres Strait Islander communities, and in regional and rural areas • Australians in crisis, and in need of immediate assistance.	30 January 2020	View here
Australian Government	Announcement of National Commissioner for Defence and Veteran Suicide Prevention.	5 February 2020	View here
Australian Government	$74 million will be provided to support the mental health and wellbeing of Australians, including: • awareness and prevention measures, including a communications strategy on maintaining mental health during the pandemic • early intervention measures, including $10 million to establish a COVID-19 support line and additional funding to expand existing support services • expansion of the Community Visitors Scheme for our older Australians • expansion of headspace Digital Work and Study Service for our young Australians • development of mental health and wellbeing resources for Indigenous Australians through Gayaa Dhuwi (Proud Spirit) Australia • continued support for a further 12 months for people with severe mental illness seeking to transition to the National Disability Insurance Scheme.	29 March 2020	View here
Australian Government	COVID-19: Whole-of-population telehealth for patients, general practice, primary care and other medical services—expansion of telehealth Medicare Benefits Schedule (MBS) items.	29 March 2020	View here
Australian Government	Immediate response plan to focus on people with disability during coronavirus.	4 April 2020	View here

Jurisdiction	Announcement extract	Date	Website
Australian Government	Boost for bushfire recovery—as part of the Regional Bushfire Recovery and Development Program, bushfire-affected communities will share in $448.5 million from the Australian Government to support the delivery of local recovery plans, with priority given to the most severely impacted regions, drawing on local voices and local governments in close partnership and as part of cost-sharing arrangements with states. This includes Community Wellbeing and Participation ($13.5 million)—backing Primary Health Networks with additional funding to provide critical, localised emotional and mental health support for bushfire-affected individuals.	11 May 2020	View here
Australian Government	Appointment of Deputy Chief Medical Officer for mental health.	13 May 2020	View here
Australian Government	$48.1 million announced to support the National Mental Health and Wellbeing Pandemic Response Plan.	15 May 2020	View here
Australian Government	$54 million in grants for mental health research.	20 May 2020	View here
Australian Government	$20 million additional funding for research to improve mental health care and reduce suicide rates in Australia.	25 May 2020	View here
Australian Government	$690,000 to Medical Deans Australia and New Zealand to support mental health first aid training for all medical students.	27 May 2020	View here
Australian Government	Supporting isolated senior Australians to stay connected: • $6 million communications package supporting senior Australians through two new initiatives to prevent loneliness and social isolation • almost $5 million to significantly expand FriendLine, a national telephone support service for older Australians, to answer 60,000 calls a year • $1 million in grants to 215 local community organisations to provide at-risk seniors with digital devices such as mobile phones and laptops.	28 May 2020	View here
Australian Government	$24.2 million to reduce wait times—fast-tracking access to mental health services for young people aged 12–25 seeking headspace appointments.	9 June 2020	View here
Australian Government	Investment of almost $35 million in 42 key research projects in areas such as ending avoidable Indigenous deafness, ending avoidable Indigenous blindness, and helping to eradicate chronic kidney disease. Three of these projects are in Indigenous mental health (approximately $4.3 million worth of the total investment amount).	14 June 2020	View here

Jurisdiction	Announcement extract	Date	Website
Australian Government	COVID-19 support for children and young people—$550,000 over two years to support children and young people who have a parent or guardian with a mental illness.	17 June 2020	View here
Australian Government	$8 million for two projects that will use artificial intelligence to improve mental health treatments for Australians.	29 June 2020	View here
Australian Government	$27 million to boost research in preventive and public health projects through the landmark $20 billion Medical Research Future Fund. This funding will enable research teams across Australia to look at new ways to prevent people from getting ill. Telehealth will have a key role in a number of these projects.	27 July 2020	View here
Australian Government	121 Men's Sheds across Australia will share in $500,000 in the latest funding round of the National Shed Development Programme.	27 July 2020	View here
Australian Government	The Australian Government will provide 10 additional Medicare-subsidised psychological therapy sessions for people subjected to further restrictions in areas impacted by the second wave of the COVID-19 pandemic. The $7.3 million in additional support recognises that many people in areas impacted by the second wave of the pandemic will be facing increased emotional and mental stress.	2 August 2020	View here
Australian Government	An additional $12 million to ensure that people in Victoria can access 24/7 mental health support through digital and telephone counselling services. This package includes: • $5 million for headspace to increase outreach services to young people in the community who are in severe distress • $2.5 million for Beyond Blue to expand capacity, extend counsellor webchat hours to operate 24/7, and boost the ability to refer people with severe and complex needs for five additional sessions • 2.5 million for Lifeline to deal with increased call volumes from Victoria • $2 million for Kids Helpline to increase its call answer rate and service responsiveness, deal with additional demand for services, and link to further support.	6 August 2020	View here
Australian Government	An additional $31.9 million to create 15 mental health clinics across Victoria and further enhance essential support during the COVID-19 pandemic. This was in recognition of the ongoing impact of Victorian restrictions on the mental health of individuals and communities. The clinics are now located at various general practice clinics, headspace and community centres, where health care is generally accessed. Nine are established in Greater Melbourne and six in regional Victoria. The clinics provide multidisciplinary mental health treatment and care in communities to anyone struggling with their mental health.	17 August 2020	View here

<table>
<tr><th>Jurisdiction</th><th>Announcement extract</th><th>Date</th><th>Website</th></tr>
<tr><td>Australian Government</td><td>$2 billion to extend critical health services across Australia.

Millions of Australians will continue to receive medical care and support in their own homes, with the Australian Government investing more than $2 billion to extend a range of COVID-19 health measures for a further six months, to 31 March 2021. Patients will continue to have access to Medicare-subsidised telehealth for general practitioner, nursing, midwifery, allied health and allied mental health services, where and when they need them.</td><td>18 September 2020</td><td>View here</td></tr>
<tr><td>Australian Government</td><td>Additional changes made by the National Disability Insurance Agency to support participants and providers during COVID-19 restrictions, including:

• temporarily broadened what assistive technology (AT) items can be purchased so all participants are able to spend up to $1500 on AT items, such as smart phones and laptops, from their existing budgets
• information packs tailored to COVID-19, including
    • psychosocial disability—this pack is designed to help people with psychosocial disability and their carers get the most out of their NDIS plan during the COVID-19 pandemic
    • mental health and wellbeing—this pack is designed to help participants, and their families and carers to look after their mental health and wellbeing during the COVID-19 pandemic.</td><td></td><td>View here</td></tr>
<tr><td>Australian Capital Territory</td><td>$4.5 million COVID-19 mental health support package to help Canberrans.

An additional $200,000 for the Way Back Support Service to support people who have attempted suicide or are experiencing suicidal crisis, and $341,843 to establish two Safe Haven cafes.</td><td>6 May 2020</td><td>View here</td></tr>
<tr><td>New South Wales</td><td>$73 million to support mental health and wellbeing during the COVID-19 pandemic. This includes more than 180 additional mental health workers, expanded virtual mental health programs and increased capacity of the 1800 NSW mental health line.</td><td>24 April 2020</td><td>View here</td></tr>
<tr><td>New South Wales</td><td>The NSW Government will invest a further $310 million in emergency drought relief in recognition of the ongoing drought conditions in regional New South Wales, extending emergency drought measures to help farmers and communities make it out of the worst drought in living memory.

This investment includes the continuation of health and wellbeing programs, including the Farmgate Counsellors program, Aboriginal wellbeing services and the Royal Flying Doctors Far West Drought Support program.</td><td>May 2020</td><td>View here</td></tr>
</table>

Jurisdiction	Announcement extract	Date	Website
New South Wales	$800,000 to set up a 'warm line' that will enable people who may be experiencing distress to connect quickly with peer workers.	20 May 2020	View here
Northern Territory	The Worker and Wellbeing Fund will: • help people access wellbeing and other counselling or support services • help people navigate the welfare system, and access income and other financial support • help workers who have lost their job find new employment opportunities fast—for example, guiding people to job-matching services such as the Territory Jobs Hub • assist Territorians who require access to accommodation and other essentials.	3 April 2020	View here
Northern Territory	TeamHEALTH launched TeamTALK—a phone-based support service, where any Northern Territorian can quickly access an experienced, locally based mental health recovery professional for a judgement-free, confidential chat.	9 April 2020	View here
Queensland	The Queensland Government is delivering a $14 million recovery package to support the mental health and resilience of communities impacted by the bushfires.	24 January 2020	View here
Queensland	$28 million fund to support community-based health services groups as part of the fight against the COVID-19 pandemic.	14 April 2020	View here
Queensland	Queensland's economic recovery plan.	27 May 2020	View here
South Australia	The South Australia Health website includes a number of resources on mental health during COVID-19, including: • a mental health support line for South Australians concerned about the COVID-19 pandemic, with Lifeline counsellors to provide a call-back support service for people in distress or in need of additional support • a mental health fact sheet • a mental health triage service.	2020	View here

Jurisdiction	Announcement extract	Date	Website
Tasmania	The Social and Economic support package includes $4 million to support those experiencing mental health difficulties as a result of the challenges associated with coronavirus, including: • $875,000 to establish a dedicated 1800 phone number to allow the Tasmanian community to call in and receive psychosocial support, and provide a reach-out service for older Tasmanians and industries that are significantly impacted • $360,000 for increased capacity to provide mental health advice, support and referral for vulnerable Tasmanians living in rural areas • $450,000 supporting providers to use technology to keep vulnerable Tasmanians connected • $120,000 for targeted support for Tasmania's migrant community regarding the COVID-19 pandemic • $600,000 for increased capacity to provide mental health support for Tasmanians living in supported accommodation • $250,000 to adapt Tasmania's pharmacotherapy program to the challenges of COVID-19.	26 March 2020	View here
Tasmania	A new campaign has been launched to encourage Tasmanians to 'check in' with themselves and those around them following the impacts of COVID-19.	22 July 2020	View here
Victoria	The Victorian Government has announced a $59.4 million funding boost to support Victoria's mental health system and ensure that Victorians get the care they need, as demand for services spikes during the coronavirus crisis.	12 April 2020	View here
Victoria	$19.5 million in funding to deliver essential reform recommendations from the interim report of the Royal Commission into Victoria's Mental Health System and to help flatten a potential second curve of mental ill-health.	15 May 2020	View here
Victoria	Bushfire mental health assistance $8.75 million to bolster mental health services provided by Albury Wodonga Health and Latrobe Regional Health, which offer specialist early intervention advice to general practitioners and community clinicians. The investment includes $6.6 million for practical mental health support programs delivered by organisations such as Gippsland Lakes Community Health Consortium, Alpine Health in partnership with NESAY, Corryong Health Service, Tallangatta Health Service and Beyond Blue. Another $3 million is dedicated to Aboriginal Community Controlled Health Organisations to establish social and emotional wellbeing programs, in line with the recommendation from the Royal Commission into Victoria's Mental Health System.	8 July 2020	View here

Jurisdiction	Announcement extract	Date	Website
Victoria	$59.7 million in new funding will strengthen the surge capacity of clinical and community mental health services across Victoria to cope with additional presentations and reduce pressure on hospital emergency departments—ensuring that Victorians can get the care they need, even as demand for services spikes. This funding will also fast-track delivery of more new public acute mental health beds, as recommended by the Royal Commission into Victoria's Mental Health System, boost community mental health services and accelerate the statewide roll out of the Hospital Outreach Post-suicidal Engagement (HOPE) program.	9 August 2020	View here
Western Australia	$1 billion support package for households, small businesses and frontline health staff.	31 March 2020	View here
Western Australia	$56 million investment to provide mental health, and alcohol and other drug support to at-risk and vulnerable groups. Funds go to: • $25 million for a new 20-bed adult community care unit • $25 million development of a new 16-bed youth mental health, and alcohol and other drug homelessness service • $6 million to support vulnerable cohorts and community wellbeing, and support an increase in demand for community mental health services.	9 June 2020	View here
Western Australia	Appointment of a Chief Medical Officer, Mental Health, within the Mental Health Commission to help strengthen its leadership role in the sector.	7 July 2020	View here
Western Australia	$20 million funding to create specialist mental health hub as part of WA Recovery Plan: • $20 million for 20 more mental health beds at Fremantle Hospital • adds to the commitment for a new 20-bed secure mental health unit at the hospital, which has also received additional funds of $4.4 million • creates the South Metropolitan specialist mental health hub.	7 July 2020	View here
Western Australia	New Emergency Telehealth Service launched to support children and young people experiencing a mental health crisis. Provides an alternative to attending a metropolitan hospital emergency department for mental health assessment, thereby limiting time spent in hospital. Supports other health professionals and community-based staff to provide children and young people with mental health support.	13 July 2020	View here

Jurisdiction	Announcement extract	Date	Website
Western Australia	The Western Australian Government announced nearly $15 million for: • developing and implementing a region-by-region approach to Aboriginal suicide prevention • providing aftercare support following a suicide attempt through a peer-based approach • providing support and meeting the needs of those affected by a suicide death • increasing capacity of services that provide long-term support to children who have been bereaved by a suicide death • improving community-level data collection for suicide prevention.	23 July 2020	View here

Mental health measures in the 2020–21 Federal Budget

Jurisdiction	Announcement extract	Date	Website
Australian Government	Extracts relating to mental health measures outlined in the 2020–21 Federal Budget are listed below (noting that some items were announced before release of the Budget). **COVID-19 Response Package—additional mental health and crisis support for Victoria** The government will provide $47.3 million over two years from 2020–21 in additional mental health and crisis support services for people experiencing mental illness and distress as a result of the COVID-19 pandemic in Victoria, including: • $26.9 million in 2020–21 to establish 15 enhanced mental health clinics within six Primary Health Networks, to provide immediate coordinated mental health care • $7.0 million for Beyond Blue, Lifeline and Kids Helpline to expand capacity to manage increased demand for crisis support services in Victoria • $5.0 million in 2020–21 to support digital and telephone services for vulnerable populations, including new and expecting parents, people with eating disorders, and culturally and linguistically diverse communities • $5.0 million in 2020–21 for headspace to increase outreach services to young people in the community who are in severe distress • $3.4 million over two years from 2020–21 to undertake an evaluation of these initiatives, and to provide additional support to the Victorian Mental Health Taskforce. **COVID-19 Response Package—supporting mental health** The government will provide $100.8 million over two years from 2020–21 to provide up to 10 additional individual psychological therapy sessions each calendar year nationally under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative.	6 October 2020	View here

Jurisdiction	Announcement extract	Date	Website
Mental health measures in the 2020–21 Federal Budget continued			
Australian Government	**Prioritising mental health—continued support** The government will provide an additional $62.1 million over four years from 2020–21 (including $0.6 million per year ongoing) to improve access to mental health services, including: • $45.7 million over four years from 2020–21 to expand the Individual Placement and Support program under the Youth Employment Strategy to assist vulnerable young people with mental illness to participate in the workforce • 6.9 million over two years from 2020–21 to support digital mental health services, including the Australian Government's mental health gateway Head to Health • $5.0 million in 2020–21 to provide parents, guardians and carers with mental health and career information for students in the context of the COVID-19 pandemic • $2.3 million over four years from 2020–21 to enhance the national headspace network by upgrading the Mount Barker service in South Australia to a full centre • $2.1 million in 2020–21 for the Prevention Hub led by the Black Dog Institute and Everymind to continue to advance research that targets people at heightened risk of mental ill-health and suicide. **Supporting Our Hospitals—simpler and more affordable private health cover for all Australians** The government will also make home and community-based care more accessible through private health insurance, commencing with mental health and general rehabilitation services. Formal consultation on the implementation will commence with the sector in October 2020. COVID-19 Response Package—BusinessBalance—supporting the mental health of Australians in small businesses The government will provide $7.0 million in 2020–21 to support the mental health and financial wellbeing of small businesses impacted by COVID-19, including: • $4.3 million to provide free, accessible and tailored support for small business owners by expanding Beyond Blue's NewAccess program in partnership with the Australian Small Business and Family Enterprise Ombudsman • $2.2 million to expand a free, accredited professional development program that builds the mental health literacy of trusted business advisers so that they can better support small business owners in times of distress, delivered through Deakin University.	6 October 2020	View here

Jurisdiction	Announcement extract	Date	Website
Mental health measures in the 2020–21 Federal Budget continued			
Australian Government	**Implementation of the 2019 Monsoon Trough: a Strategy for Long-Term Recovery** • $2.0 million over four years from 2020–21 for preventive mental health measures for children in flood-affected areas. **Supporting families impacted by stillbirth** The government will provide $7.6 million over four years from 2020–21 (and $1.2 million per year ongoing) to address inconsistencies in the support provided for families affected by stillbirth or by the loss of a child before their first birthday, irrespective of whether it is their first or subsequent claim. **Mental health support for veterans and their families** The government will provide $101.7 million over four years from 2020–21 for veterans' mental health support and services. Funding includes: • a one-off increase to the fees paid to the Department of Veterans' Affairs mental health, social work and community nursing providers, and a simplified fee structure for these services • an additional 10 specialist psychiatry training places each year for psychiatrists to specialise in veterans' mental health care • expanding the Open Arms Veterans and Families Counselling Community and Peer program, in addition to developing and implementing an outcomes monitoring framework to monitor and assess Open Arms services • expanding digital mental health capabilities through a pilot of web-based forums for veterans and their families, improving access to support for those in regional and remote locations • extending the Coordinated Veterans' Care Program to eligible White Card holders with an accepted mental health condition.	6 October 2020	View here

Appendix C

Sector announcements relating to COVID-19, bushfires and mental health

Organisation	Announcement extract	Date	Website
Black Dog Institute	**TEN—The Essential Network**, an app supporting health professionals to manage life and work through COVID-19. 'TEN' is a mobile app that connects and provides fast, easy, anytime access to evidence-based tools, resources, programs and specialists. Developed by health professionals for health professionals, it's a one-stop resource and help centre, providing self-assessment, self-management and treatment for stress, anxiety and symptoms of depression. At the core is an online clinic screening tool designed to recommend relevant resources and online tools based on report outcomes.	2020	View here
Beyond Blue/Be You	**Bushfire Response Program**—support for schools and early learning services affected by bushfires. The Bushfire Response Program provides targeted mental health support to schools and early learning services affected by bushfires across Australia.	2020	View here
Everymind	The Life in Mind team at Everymind has worked with the suicide prevention and mental health sectors, and in collaboration with the National Mental Health Commission to provide a comprehensive list of resources to support those affected by bushfires and COVID-19.	2020	View here
SANE Australia	**Position statement** on the impact of COVID-19, advocating for various actions required as part of the COVID-19 mental health response.	2020	View here
Neami National	**Support during COVID-19** In response to the extraordinary circumstances across Australia, we are maintaining support, while reducing risks to the people who use our services, our staff and the community.	2020	View here
Beyond Blue	We have published a dedicated **'Coping with bushfires'** thread in our online forums. The thread provides a safe, understanding place to share how you are feeling about the bushfires and to offer support to those affected.	9 January 2020	View here
Mental Health Australia	**'Look after your mental health, Australia'** Over the next few weeks, we will be promoting a series of community-driven ideas to help people keep mentally well during this difficult time, and sharing the wonderful content so many of you have already begun producing.	March 2020	View here
Orygen	Responding to the COVID-19 outbreak.	March 2020	View here
Flourish Australia	New Health Action Plan in response to COVID-19.	20 March 2020	View here

Organisation	Announcement extract	Date	Website
Suicide Prevention Australia	**Impact of COVID-19 on the sector: survey report** In mid-April 2020, Suicide Prevention Australia launched a survey to help inform the National Suicide Prevention Adviser about the impact the COVID-19 pandemic is having on program and service delivery within the sector. The goal was to gather intelligence to inform the national response, as well as provide an opportunity to identify ways to build sector capacity during this challenging period.	April 2020	View here
Independent Community Living Australia/ Roses in the Ocean	Launch of **eFriend,** a virtual, peer-based mental health support platform. The platform connects Australians with peer workers who apply their personal lived experience of mental illness and recovery to support mental health consumers and carers.	April 2020	View here
Various	**#InThisTogether campaign** The Commission, together with mental health organisations, experts and leaders, has developed #InThisTogether—a national conversation sharing practical tips online to support the mental health and wellbeing of Australians during COVID-19. Contributors include Beyond Blue, Lifeline, Reachout, headspace, RUOK?, Orygen, the Black Dog Institute, SANE Australia, the Brain and Mind Centre, Apunipima Cape York Health Council and Smiling Mind.	1 April 2020	View here
Beyond Blue	**Coronavirus Mental Wellbeing Support Service** This includes a 24/7 phone support service, web chat support service, online community forum, and various other mental health and wellbeing support resources.	9 April 2020	View here
Everymind	Everymind jointly launches **Coronavirus (COVID-19) survey** to understand impact on Australian media, marketing and creative industries.	29 April 2020	View here
Save the Children	The Save the Children bushfire response acknowledged the role of families in children's recovery and provided a staged approach as needs shifted. The response provided: • 10 child-friendly spaces in evacuation relief and recovery centres in New South Wales, Victoria and South Australia to provide respite to recently evacuated families • mobile outreach teams that returned to communities after recovery centres had closed to deliver psychosocial support to children and families • engagement with schools and regional authorities to plan delivery of the Journey of Hope Program to help children cope with traumatic events.	12 May 2020	View here

Organisation	Announcement extract	Date	Website
Neami National	Neami National is launching a new service to support the more than 500 people who have moved from sleeping rough into local hotels and motels in response to the COVID-19 pandemic.	22 May 2020	View here
Suicide Prevention Australia	**Joint white paper:** Reducing distress in the community following the COVID-19 pandemic	June 2020	View here
	Turning the Tide: a six-point plan for change	March 2020	View here
	State of the Nation in Suicide Prevention: A survey of the suicide prevention sector	September 2020	View here
Various	**#GettingThroughThisTogether campaign** The Commission, together with mental health organisations, experts and leaders, has developed #GettingThroughThisTogether—a national conversation sharing practical tips and support for the mental health and wellbeing of all Australians as COVID-19 continues.	16 August 2020	View here

Appendix D

Suicide prevention activities

Government	Description	Date	Website
Australian Government	In November 2020, the National Suicide Prevention Adviser's interim advice and in-principle recommendations were released. The interim report and recommendations will be used to consult with the Australian and state and territory governments. The Commission will continue to monitor the Australian Government's response to additional recommendations made in the final report, due to be submitted by the end of 2020.	16 November 2020	View here and here
Australian Government	The Australian Government announced a further $19 million to extend leading national suicide prevention services.	10 September 2020	View here
Australian Government	In July 2020, the Australian Government announced that, for the first time, the national Closing the Gap agreement includes a target aimed at reducing Indigenous suicide rates.	July 2020	View here and here
Australian Government	The National Suicide Prevention Adviser presented initial findings to the Prime Minister in November 2019 (see **Box 8**). In response, the Australian Government announced a $64 million investment in suicide prevention and mental health initiatives in January 2020. These initiatives will focus on supporting some of the most vulnerable groups, including: • Australians who have been discharged from hospital after a suicide attempt • families and carers who have lost a loved one to suicide • young Australians, particularly in Aboriginal and Torres Strait Islander communities, and in regional and rural areas • Australians in crisis, and in need of immediate assistance.	30 January 2020	View here
Australian Government	The Australian Government announced $10.3 million distributed through the Million Minds Mental Health Research Mission, for three suicide prevention projects.	May 2020	View here
Australian Government	The Australian Bureau of Statistics released the results of a pilot study into the psychosocial risk factors associated with suicide deaths in 2017.	July 2019	View here
Australian Government	A number of trials under the National Suicide Prevention Trial are funded until 30 June 2021 at 12 sites across Australia, led by Primary Health Networks and supported by the Australian Government. The trials involve integrated, whole-of-system, local-area approaches to suicide prevention, each with different community needs, tailored models, time frames and funding. The trials were established in an attempt to address criticisms around the lack of coordinated, multilevel or multifactorial approaches in Australia that involve both health and non-health sectors, and government and nongovernment agencies. The evaluation was completed in December 2020.	Trials commenced 2016–17, cease 30 June 2021	View here
Australian Capital Territory	The Australian Capital Territory Government announced $342,000 to create two Canberra Safe Haven cafes. These cafes will provide a safe alternative to the emergency department and other treatment services for adults over 18 years of age experiencing loneliness or personal difficulties, or simply seeking social connection.	6 May 2020	View here

Government	Description	Date	Website
New South Wales	The New South Wales Government committed $87 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.	September 2020	View here
New South Wales	The New South Wales Government announced $2.8 million in funding to train more than 10,000 community gatekeepers over the next three years.	10 July 2020	View here
New South Wales	The New South Wales Government announced funding of $6.8 million for specialist counsellors to be deployed across rural New South Wales to help prevent suicide.	24 August 2020	View here
New South Wales	The New South Wales Government announced $7.7 million for community-led Aboriginal suicide prevention.	2 September 2020	View here
New South Wales	The New South Wales Government launched the Suicide Monitoring and Data Management System.	9 November 2020	View here
Queensland	Reducing Queensland's suicide rate is a Queensland Government priority under Our Future State: Advancing Queensland's Priorities. Every Life: the Queensland Suicide Prevention Plan 2019–2029 is a whole-of-government plan. $80.1 million has been allocated to the plan.	2019	View here
South Australia	A new Suicide Prevention Advocate was appointed.	22 September 2020	View here
Tasmania	The first Tasmanian Suicide Register report was released.	9 October 2020	View here
Victoria	Mental Health Support for Drought Affected Communities—suicide prevention trials—were announced.	26 February 2020	View here
Victoria	The Coroners Court of Victoria released its Victorian suicides of Aboriginal and Torres Strait Islander people report, which establishes the foundation for ongoing annual reporting on Indigenous suicides by the court, with a view to building a comprehensive public dataset over time. With this information, communities and organisations working to prevent Indigenous suicides will be able to effectively target resources and programs designed to reduce deaths.	June 2020	View here
Victoria	The Victorian Government continued the rollout of its Hospital Outreach Post-suicidal Engagement (HOPE) program, establishing programs in three new locations.	9 August 2020	View here

Government	Description	Date	Website
Western Australia	The Western Australian Government delivered its full response to the State Coroner's inquest into the deaths of 13 children and young people in the Kimberley Region, Western Australia, and the 2016 parliamentary inquiry, Learnings from the Message Stick: the report of the Inquiry into Aboriginal Youth Suicide in Remote Areas. The government announced $266.7 million for Aboriginal suicide prevention initiatives. Of the combined 86 recommendations included in both reports, in 2019, the Western Australian Government had fully accepted 22, accepted 33 in principle, had already implemented or started implementing 16, and was still considering the feasibility or implications of a further 11.	March 2020	View here View here
Western Australia	The Western Australian Government announced nearly $10 million to develop and implement a region-by-region approach to Aboriginal suicide prevention in Western Australia. The Western Australian Government also announced an additional $4.79 million for programs to provide additional suicide prevention support to all Western Australians as part of the WA Recovery Plan, including: • aftercare support following a suicide attempt through a peer-based approach • providing support and meeting the needs of those affected by a suicide death • increasing capacity of services that provide long-term support to children who have been bereaved by a suicide death • improving community-level data collection for suicide prevention	July 2020	View here
Western Australia	The Western Australian Government announced a suicide prevention taskforce to examine management of at-risk prisoners.	18 August 2020	View here
Western Australia	The Western Australian Suicide Prevention Framework 2021–2025 was released. The framework sets the direction for future action to reduce deaths by suicide in Western Australia.	21 October 2020	View here

Appendix E

Sector suicide prevention activities

Organisation	Description	Date	Website
Black Dog Institute	The Australian Government announced $2.5 million for phase two of the Black Dog Institute's Centre for Research Excellence in Suicide Prevention (CRESP II). CRESP II will focus on the early detection of Australians at risk of suicide.	November 2019	View here
Various	#YouCanTalk campaign The awareness campaign is a collaboration between several organisations taking place over the December 2019 to January 2020 holiday period, in recognition of how difficult this time of year can be for many Australians.	December 2019 – January 2020	View here
SANE Australia	Better Off with You campaign: a six-week campaign in partnership with Sydney North Health Network (Northern Sydney PHN). Better Off With You featured real stories told by people with experience of suicidal thoughts and attempts.	22 January 2020	View here
University of Sydney	The University of Sydney's Brain and Mind Centre has launched YOUTHe, a five year Centre of Research Excellence in suicide prevention for young people. The $2.5 million, five year National Health and Medical Research Council project is a collaboration between some of Australia's top mental health researchers.	April 2020	View here
SANE Australia	The You Are Not Alone website has been created by national mental health charity SANE Australia, together with research partners the University of New England and the University of Sydney.	25 May 2020	View here
Orygen	Parent suicide alertness training.	26 August 2020	View here
Beyond Blue	For World Suicide Prevention Day 2020, Beyond Blue has developed a range of free resources.	10 September 2020	View here
National LGBTI Health Alliance	National LGBTI Mental Health and Suicide Prevention Strategy.	21 October 2020	View here
Aboriginal and Torres Strait Islander Lived Experience Centre at the Black Dog Institute	The Black Dog Institute released a universal definition of lived experience experienced by Aboriginal and Torres Strait Islander communities.	December 2020	View here
Neami National	Neami National suicide prevention programs.	2020	View here
Black Dog Institute	Four Black Dog Institute LifeSpan trial sites have been implemented in New South Wales. LifeSpan combines nine strategies that have strong evidence for suicide prevention into one community-led approach incorporating health, education, frontline services, business and the community. The Australian Government has funded a summative analysis of the evaluations of the Victorian, LifeSpan in New South Wales and Australian Government suicide prevention trial sites. The evaluation of the LifeSpan trial in New South Wales will involve comparing rates of suicide deaths and attempts before and after the introduction of the model in each region and between regions. Primary outcomes of the trial will be available in 2022, and secondary outcomes in 2023.	2020	View here

Appendix F

Mental health peer workforce strategies and plans

All jurisdictions in Australia have shown a commitment to the mental health peer workforce, either through mental health plans and strategies, the development of a peer workforce or lived experience frameworks, or standards and guidelines.

Jurisdiction	Frameworks	Link
Australian Capital Territory	Office for Mental Health and Wellbeing Workplan 2019–2021	View here
New South Wales	Living Well Mental Health Reform Strategy 2014–2024	View here
	Living Well in Focus 2020–2024	View here
	Lived Experience Framework	View here
Northern Territory	Mental Health Strategic Plan 2019–2025	View here
Queensland	Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023	View here
	Mental Health Lived Experience Workforce	View here
South Australia	Mental Health Services Plan 2020–2025	View here
Tasmania	Rethink Mental Health Strategy 2015–2025	View here
	Peer Workforce Development Strategy	View here
Victoria	10-Year Mental Health Plan 2015–2025	View here
	Lived experience workforce strategies (Strategy for the Consumer Mental Health Workforce in Victoria; and Strategy for the Family Carer Mental Health Workforce in Victoria).	View here and here
Western Australia	Mental Health 2020 report	View here

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