Monitoring mental health and suicide prevention reform

National Report

2021

Australian Government
National Mental Health Commission

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Joint Foreword

We are pleased to present the National Mental Health Commission's 2021 National Report on mental health and suicide prevention in Australia. In 2021, we saw encouraging steps towards mental health reform and stronger mental health and suicide prevention systems, where all Australians feel heard and supported. We have seen that more Australians than ever are prioritising their mental health and wellbeing, and recognising the importance of seeking help to improve their mental health. Meanwhile, governments and the sector are united in their commitment to meet this need. However, we still have a long way to go.

This year, the Commission farewelled two Commissioners: Professor Helen Milroy and Professor Maree Teesson AC. The Commission is grateful for the tremendous service and contribution both Commissioners have made during their time on the Advisory Board. We are pleased to welcome Dr Marshall Watson as an incoming Commissioner. Dr Watson is a descendant of the Noongar people of the southwest of Western Australia. He is a consultant psychiatrist who brings with him dual training in child and adolescent psychiatry and forensic psychiatry.

The Commission and its Advisory Board remain committed to driving transformational change through mental health reforms that will help achieve an Australia where all people can lead contributing lives in socially and economically thriving communities.

Collaboration and connection are vital to making sure all voices are heard in mental health reform, and consultations are a key part of our work at the Commission. Throughout the year, we have aimed to create many opportunities to engage with, and listen to, those with lived experience and people across the sector who lead service provision or deliver on the frontline.

In 2021, we delivered the National Children's Mental Health and Wellbeing Strategy to the Australian Government; the National Disaster Mental Health and Wellbeing Framework to the Minister for Health and Aged Care and the Minister for Emergency Management, National Recovery and Resilience; and we continue to progress work on the National Mental Health Research Strategy. We launched the first *Mental Health Safety and Quality Engagement Guide*, which includes practical information for consumers and carers, service providers and health leaders who would like to improve their processes. We have continued our work on the National Workplace Initiative and released the Blueprint for Mentally Healthy Workplaces in collaboration with the Mentally Healthy Workplace Alliance, defining a vision of mentally healthy workplaces that can be shared by all organisations and businesses across Australia.

The mental health and suicide prevention sectors welcomed an investment of $2.3 billion in mental health and wellbeing in the 2021–22 Budget delivered in May 2021. This is the first Budget that responds to the recommendations from the Productivity Commission Inquiry into Mental Health and the National Suicide Prevention Final Advice.

An important investment in the Budget for suicide prevention reform is the creation of a National Suicide Prevention Office. The office will be a critical national driver of the work towards zero suicides by ensuring a whole-of-government approach that is informed by lived experience, and creates opportunities to respond early and effectively to distress.

The 2021-22 Budget presents the sector with an opportunity to take a unified approach to building a strongly coordinated mental health system, including the potential to fully realise a whole-of-governments approach that is coordinated, connected, compassionate, and free from stigma and discrimination. However, realising such an approach will require significant follow-through from governments in the form of coordinated implementation, and ongoing monitoring and evaluation of

outcomes, prioritising input from those with lived experience. To achieve coordinated, integrated services, we will need to adopt new ways of working across all jurisdictions and in partnership with all stakeholders.

As we approach the Commission's 10-year anniversary in 2022, we are taking the opportunity to reflect on just how far we have come and how we can best continue to act as a catalyst for change going forward. As we continue to grapple with the impacts of the COVID-19 pandemic and recent bushfires, floods and droughts, awareness of mental health and wellbeing has never been greater. We have made significant progress, but there is more to be done.

Now is the time to act to implement meaningful and sustained change across all governments, using the tools, knowledge and insights that the growing reform agenda has provided. We are grateful to every individual, and the agencies, communities, non-government organisations and governments that have shared their wisdom to get us to this point. We look forward to continuing our work together to ensure that strategic, coordinated action is achieved across the reform agenda.

Lucy Brogden AM,
Chair of the National Mental Health Commission Advisory Board

Christine Morgan,
Chief Executive Officer of the National Mental Health Commission

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 systems, and acts as a catalyst for change to achieve these improvements. This includes increasing accountability and transparency in mental health and suicide prevention 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 Commissioners in the financial year 2020–21 were Mrs Lucinda Brogden AM, Professor Ngiare Brown, Associate Professor Mathew Coleman, Ms Kerry Hawkins, Ms Niharika Hiremath, Rabbi Mendel Kastel OAM, Ms Christina McGuffie, Associate Professor Elizabeth-Ann Schroeder, Dr Marshall Watson, 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 systems 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 systems that still require reform.

The Commission wishes to acknowledge that, because of our commitment to act as a catalyst for change in the mental health and suicide prevention sectors and the nature of our work in the past year, 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, emotive and at times contested. People make sense of their experiences in different ways, and there is no consensus on preferred terminology. The Commission has been conscious to use terminology throughout this report that is respectful of those whose experiences we are describing and well understood by the audience reading this report.

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

For instances where using certain terminology may misrepresent the source being cited, the terminology used by the source has been used.

For a detailed list of definitions of terms used in this report, refer to the glossary of terms at the end of the report.

The Commission endorses the Mindframe *Guidelines on Media Reporting of Severe Mental Illness in the Context of Violence and Crime* and requests that media using this report do so in accordance with the guidelines.

Summary

The National Mental Health Commission's (the Commission's) National Report is one of the ways in which the Commission meets its core function: to provide independent, robust policy advice and evidence on ways to improve Australia's mental health and suicide prevention systems, and to act as a catalyst for change to achieve these improvements. The National Report provides an assessment of the progress of current reforms and their impacts on communities, the incidence and impact of any significant events during the period, and areas of the systems that still require focus.

This National Report reflects a period of significant change for the mental health and suicide prevention sectors. Events such as the COVID-19 pandemic, bushfires, floods and drought have exacerbated existing issues of mental ill health and suicide. There has been increased demand for mental health services and supports, resulting in increased pressures on an already stretched workforce. These events have also fostered a greater appreciation of the impact of social determinants by highlighting how the social, cultural and economic environments we exist within are inextricably linked with our mental health and wellbeing.

The impacts of the pandemic and other disasters have highlighted growing inequalities. Some population groups have been further disadvantaged as the impacts of the pandemic continue to unfold and we experience ongoing lockdowns. For Aboriginal and Torres Strait Islander people, the pandemic risks exacerbating existing health, social and economic inequalities. There is increasing concern for women and young people.

The 2021–22 Budget and the Australian Government's National Mental Health and Suicide Prevention Plan present a commitment to more preventive and person-centred mental health and suicide prevention systems.

But more still needs to be done. The systems are still inadequate to meet the needs of the full breadth of people experiencing mental illness and psychological distress.[1] The systems struggle to consider the interconnectedness of sectors that contribute to mental health and wellbeing, including housing, disability, health, education and justice.[2] This will require continued partnership with people with lived experience to ensure that reforms are being designed and implemented as needed.

The recent reform agenda in Australia has resulted in various recommendations. Although the measures outlined appear promising, we are yet to see how they will be rolled out and implemented, and what their impact on the sector will be. A key challenge for the mental health reform agenda is to bring all these pieces together and support implementation, ideally with ongoing assessment of outcomes against a monitoring and evaluation framework. In October 2020, National Cabinet announced a new Health National Cabinet Reform Committee tasked with delivering a new National Mental Health and Suicide Prevention Agreement (National Agreement) by November 2021. This is intended to guide whole-of-governments national reform. The potential for the National Agreement to drive improved coordination and better outcomes is significant.

National Report 2021 reporting period

As a result of disruptions from the COVID-19 pandemic, the reporting period for this year's National Report encompasses January to June 2021. The National Report 2022 will form the Commission's 10-year anniversary edition and will return to a 12-month reporting period.

Priority issues in mental health and suicide prevention

Similar issues, themes and advice have consistently emerged across the findings of recent inquiries. The Commission has identified 6 priority areas requiring greater and continued focus to work towards effective, connected and well-functioning mental health and suicide prevention systems. These 6 areas—prevention and early intervention, accessibility, integrated and coordinated care, lived experience participation, workplace and the workforce, and outcomes-driven systems—are also aligned with the key principles and approaches set out in Vision 2030, the Commission's blueprint for mental health in Australia.

Prevention and early intervention

The lack of a focus on prevention and early intervention across the general community and within Australia's mental health and suicide prevention systems has been consistently highlighted. This refers to prevention and intervention both early in life and early in the experience of distress. The National Suicide Prevention Final Advice emphasised the importance of early intervention in supporting people in distress and not waiting until they are in crisis. Although investment in early intervention is increasing, we are yet to see the same for prevention approaches, which must include social determinants such as education and housing.

Promising pieces of work in this area are emerging. They include the National Children's Mental Health and Wellbeing Strategy, which recognises the importance of supporting children from infancy, as well as empowering parents, carers and communities. A new network of up to 15 Head to Health Kids mental health and wellbeing centres is being developed in partnership with states and territories. There are also growing calls for an increased prevention and early intervention focus for violence against women and children.

An important aspect of shifting focus towards prevention of suicide and mental ill health is increasing awareness and improving metal health literacy across the whole population. This can be done by implementing programs and campaigns, such as #ChatStarter, that build connections and support the development of resilience, particularly among children and young people.

Accessibility

Accessing and navigating the mental health and suicide prevention systems is a persistent issue. Structural barriers mean that policies and practices in a range of settings disproportionately impact the lives of people with mental ill health, and prevent services responding appropriately and effectively. Care is not always financially, geographically or practically accessible for many Australians. Rural and remote communities are often left behind, especially in times of crisis, as we have witnessed during the bushfires, floods and drought. This was evident throughout the Commission's Our Stories—Beyond the Disaster project, released in early 2021.

Although digital technologies offer a promising solution to several access barriers, this area currently lacks the required infrastructure to support its use and the quality of digital supports. We are also yet to fully understand the effectiveness and appropriateness of certain interventions and for certain populations via digital mediums. Reform in this priority area will need to address these issues.

In addition, as more people become willing to seek help, there is a growing awareness of the impacts of stigma and discrimination across the systems. Many people still experience structural stigma via the services they access for support. The Commission will continue to prioritise lived experience participation in the development of Australia's first National Stigma and Discrimination Reduction Strategy, due for completion by December 2022.

Integrated and coordinated care

Continuing reform is needed to deliver better-integrated and coordinated care within and beyond the health system. This includes integration within services and coordinated care within mental health and suicide prevention. We also need all government portfolios beyond health to work towards a common goal and take a whole-of-governments approach to mental health and wellbeing. There have been promising developments to address service fragmentation, and to plan and provide better-targeted and integrated care at a regional level through primary care.

Efforts in this area have included the development of joint regional mental health and suicide prevention plans, efforts to integrate care for people with complex mental health needs, and the introduction of a consistent approach to assessing and referring consumers through the Initial Assessment and Referral decision support tool. Local Health Districts and Primary Health Networks will need to be encouraged and supported to work together to deliver on reforms through the provision of clear government mandates for joint planning, and tools, data and resources to support integrated service systems.

Lived experience participation

The integration of lived experience insights and knowledge in mental health and suicide prevention reform is crucial for a system that best serves the people it is intended for. This requires genuine partnership with people with lived experience, and active support for co-design, co-production and co-delivery of systems and services. Lived experience has played a crucial role in shaping the outcomes of the reform agenda; however, this is yet to translate into the delivery of mental health care that meets the needs of those who access it.

A consistent call through reform to better engage people with lived experience in all aspects of developing, implementing and reviewing mental health programs and services is resulting in changes in the sector. These include workforce changes, such as greater emphasis on the important role of the lived experience workforce and broader engagement. The Commission is leading the development of the *National Lived Experience (Peer) Workforce Development Guidelines* to support these aims.

Workplaces

Workplaces can provide a pathway of support for people who may not have any interaction with the mental healthcare system. It is important to equip these environments with knowledge of early warning signs, appropriate referral pathways and continued supports to enable recovery and to welcome workers who have experienced mental ill health. The spotlight on workplaces intensified in the first half of 2021 as organisations responded to the ongoing challenges posed by the COVID-19 pandemic, such as supporting remote teams or workers providing essential services.

Issues including a lack of knowledge and capacity, a complex legislative environment and diverse needs continue to challenge organisational efforts. With a growing range of initiatives and services being led by jurisdictions and industries, the Commission and the Mentally Healthy Workplace Alliance are working to align these activities into a nationally consistent approach through the National Workplace Initiative.

Mental health workforce

Adequately addressing workforce issues remains key to the success of the mental health reform agenda. We continue to see mental health services at capacity and challenged to respond to increasing demand. Our mental health and suicide prevention workforces are stretched, under-resourced and under-supported. Both short- and long-term measures are required to address issues

such as workforce shortages across professions, maldistribution of the workforce, capacity and capability, limited training and professional development pathways, negative workplace cultures, and the additional demand pressures caused by the pandemic and ongoing natural disaster events.

Change has been slow in this area, despite ongoing development of the National Mental Health Workforce Strategy and announcement of a National Suicide Prevention Workforce Strategy. Implementation of these strategies will help to grow and support the capability and wellbeing of the workforce and collaborative ways of working. Reform in this area will have significant flow-on effects in how services are experienced by consumers and their families, friends and carers, with a shift to truly person-led, recovery-focused systems.

Outcomes-driven systems

To be most effective, services must be underpinned by evidence, and committed to cycles of monitoring and continuous quality improvement, evaluation, and integration of emerging evidence. An increased focus on the collection and use of outcomes data will better inform service and program evaluation, planning and delivery.

Governments have agreed that a national set of outcomes is required. It will be important to accurately define what outcomes are important to all stakeholders, and to build the system's ability to monitor outcomes, drive accountability and identify service gaps. Improved clarity of roles and responsibilities, oversight, and coordination for monitoring and evaluation will also be needed.

The National Suicide and Self-Harm Monitoring System has provided improved coherence, accessibility, quality and timeliness of national data and information on suicide, suicide attempts and self-harm. In a world first, the July 2021 release of new data will include national monitoring of ambulance attendances for suicide attempts, self-harm and suicidal ideation.

Conclusion

Now is the time for meaningful and sustained change to our mental health and suicide prevention systems. We have never been more informed or aware of mental health–related impacts and issues, and the need for change has never been greater. The body of work and comprehensive information provided across the reform agenda has laid out clear and practical recommendations that would both improve the mental health outcomes of Australian communities and benefit the Australian economy. We can now implement meaningful change—beyond commitment from national leadership, we need coordinated, strategic action, and we need it now.

A highlight for this reporting period has been the way in which we have been able to use the collective expertise of the sector to provide informed and rapid advice to the Australian Government. We thank the mental health and suicide prevention sectors for their willingness to collaborate and assist in addressing the immediate and urgent concerns of Australians, particularly during the pandemic. These efforts highlight the importance of real-time data in contributing to rapid decision making to implement much-needed change on the ground.

In 2022, we will embark on our next Connections Tour across Australia. This tour will provide us with the opportunity to hear directly from the community on the impacts of the pandemic, and how the Australian Government's reform activities, specifically the 2021–22 Budget and National Agreement, have been received and implemented. We are also very excited to host the Lived Experience Participation Summit in 2022, which will assist us in further embedding lived experience participation within the mental health and suicide prevention agenda.

In 2022, the Commission celebrates its 10th year, and our anniversary edition of the National Report will give us the opportunity to reflect on the sector's growth and impact over the past 10 years. We know, however, that for many Australians some things have not improved, and it is vital that we reflect and learn from the past 10 years and provide insights into what needs to be done to continue to improve the mental health and wellbeing of all Australians into the future.

Part A The mental health and suicide prevention landscape in Australia

1 Current state of Australia's mental health and wellbeing

Key points

- Poor mental health and suicide are still significant public health issues for Australia, and these have been amplified during the COVID-19 pandemic. This is especially the case for young adults and women—these two groups have experienced worse outcomes for other emotional and wellbeing measures throughout the pandemic.
- Overall, aggregated data is important for understanding the broader mental health trends in Australia; more detailed granular data is needed to identify and monitor populations that may be at greater risk.
- Upcoming publications, including landmark releases from the National Survey of Mental Health and Wellbeing and the National Suicide and Self-Harm Monitoring System, will quantify mental health and suicidality indicators in the context of the COVID-19 pandemic and other ongoing crises.
- The use of mental health services increased during the pandemic. Much more data is needed on mental health service experiences, outcomes and overall effectiveness, to inform ongoing reform and improvement.

Australians faced exceptional challenges in 2021, notably the COVID-19 pandemic and ongoing bushfire, flood and drought recovery, which have directly and indirectly affected emotional and mental wellbeing.

Poor mental health and suicide remain significant public health issues.

The importance of data and research in the mental health and suicide prevention landscape cannot be overstated. Data sharing and access during this difficult period have enabled governments to quickly implement evidence-based responses and identify areas of concern that require further attention. Although there is still ample opportunity to improve data processes in the mental health and suicide prevention sectors (see Ongoing data monitoring and sharing), current evidence continues to highlight poor mental health and suicide as significant public health issues.

As a result of ongoing disruptions, this year's National Report focuses on the first half of 2021, with a reference period encompassing January to June 2021. However, the situation has continued to change rapidly as the global community has grappled with new and emerging COVID-19 variants and their impacts. Notes are included in this report to indicate significant changes in trends that have been observed after the reporting reference period. This data, along with other emerging research, will be further elaborated in the Commission's upcoming 10-year anniversary edition of the National Report.

Mental health and wellbeing

New publications developed specifically to track emotional and mental wellbeing during the COVID-19 pandemic have enabled timely monitoring throughout this unstable period.

During the beginning of the pandemic, psychological distress levels in adults were significantly higher than pre-pandemic levels, with 10.6% of Australian adults experiencing severe psychological distress in April 2020 compared with 8.4% in February 2017.[3] For the rest of 2020, this proportion fluctuated

but remained consistently higher than pre-pandemic levels, peaking at 10.9% in October 2020. In April 2021, average psychological distress levels of all Australians were lower than pre-pandemic levels (although not by a significant margin); however, the proportion of adults experiencing severe psychological distress was still higher at 9.7%.[4,a]

Although the causes have not been established, the increases in rates of high psychological distress during the pandemic have sparked concerns about the impacts of pervasive disruptions and constant uncertainty.

More generally, average levels of life satisfaction among adults have fluctuated significantly throughout the pandemic, with a drop reported in April 2020 and gradual increases in late 2020 that coincided with reduced COVID-19 cases and eased lockdowns.[5] Data on life satisfaction from 2001 to 2019 has shown that, on average, mental health has a greater impact on life satisfaction than physical health. Factors such as social contact and unemployment have also been found to have a significant impact on wellbeing and life satisfaction.[6] These findings emphasise the importance of considering non-health factors such as social connectedness and employment—both of which have been significantly impacted during recent crises—in mental health and wellbeing responses.

Mental health has a greater impact on life satisfaction than physical health.

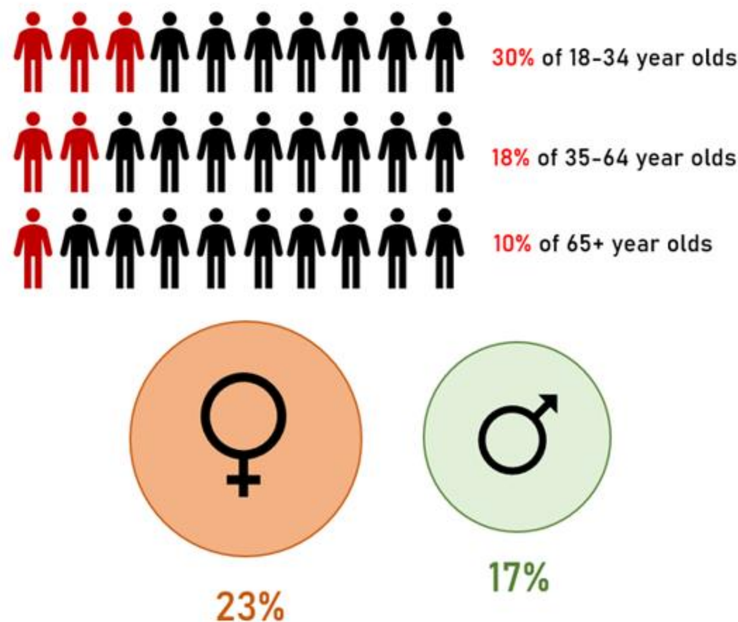
Populations at higher risk

Although aggregated data is important for understanding the broader mental health trends in Australia, it is important that we have more detailed data on populations that may be at greater risk. This involves tracking mental health outcomes for population groups known to be at high risk, and identifying new groups that may be disproportionately affected by crisis events. This information is crucial for the development of targeted strategies that address the specific mental health needs of vulnerable population groups.

In June 2021, there were significant differences among certain age groups and by sex in the proportions of individuals reporting high or very high levels of psychological distress (see **Figure 1**).

Figure 1: Proportion of people with high and very high levels of psychological distress, by age group and sex, June 2021

[a] More recent findings from the same series of surveys are that higher psychological distress and loneliness coincide with regions experiencing COVID-19 outbreaks and lockdown restrictions, and that the reported level of severe psychological distress during the COVID-19 pandemic period was highest in October 2021 (https://csrm.cass.anu.edu.au/sites/default/files/docs/2021/9/Tracking_paper_-_August_2021.pdf; https://csrm.cass.anu.edu.au/sites/default/files/docs/2021/11/Tracking_paper_-_October_2021_0.pdf).



Source: Australian Bureau of Statistics. Household Impacts of COVID-19 Survey: Emotional and mental wellbeing. Canberra: ABS; June 2021. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/jun-2021#emotional-and-mental-wellbeing

In addition to psychological distress, research has highlighted that young adults and women experienced worse outcomes for other emotional and wellbeing measures throughout the pandemic. For example, women and young adults aged 18–24 years were more likely to report anxiety and worry due to COVID-19 in April 2021.[4] There are also growing concerns about increased suicidal behaviours during the pandemic in young females, who have significantly higher ambulance attendance rates for self-injury and suicide attempts than males; females aged 0–24 years particularly showed increased rates from March 2018 to March 2021.[8]

Young adults and women experienced worse outcomes for other emotional and wellbeing measures throughout the COVID-19 pandemic.

The mental health impacts of the pandemic on other at-risk populations, including Aboriginal and Torres Strait Islander Australians, members of the LGBTQI+ community, children and homeless people must be considered a priority. These populations are already more likely to experience poorer mental health outcomes, and these disproportionate impacts may be further amplified during times of crisis. Research should be conducted to understand why certain populations are faring worse than others in crisis situations, to inform targeted prevention and intervention strategies.

"Accountability around responding to the needs of diverse communities… that is often something that is missing" Professional from migrant and refugee services, National Children's Mental Health and Wellbeing Strategy

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Long-term impacts of crises

Many individuals and communities impacted by the 2009 Victorian bushfires are reportedly still in the process of recovery 10 years later. A recent study reported that only 44% of affected individuals felt that their community was mostly or fully recovered.[9] The study found that social connectivity and

community cohesion were associated with better mental health outcomes for individuals, echoing similar findings[6] on the role of social connectedness on wellbeing and life satisfaction. With the devastating 2019–20 bushfires and other natural disasters creating major life stressors, including financial hardship, loss of accommodation and relationship breakdown, significant inequalities faced by affected communities may be further exacerbated by the COVID-19 pandemic.

Long-term mental health impacts of the COVID-19 pandemic and other recent crises are still unknown.

Continued reporting of mental health and suicidality indicators is needed to better understand and respond to these and other potential emerging impacts. Analysis of these findings, in conjunction with broader health and wellbeing measures, will provide insights that enable the development of targeted, cross-sector strategies. While it remains unclear when pandemic disruptions will come to an end, adaptations and adjustments to a 'new normal' can also be informed through regular monitoring (see Ongoing data monitoring and sharing).

Upcoming publications, including landmark releases from the National Study of Mental Health and Wellbeing and the National Suicide and Self-Harm Monitoring System,[10] will help to quantify mental health and suicidality indicators in the context of the COVID-19 pandemic and other ongoing crises.

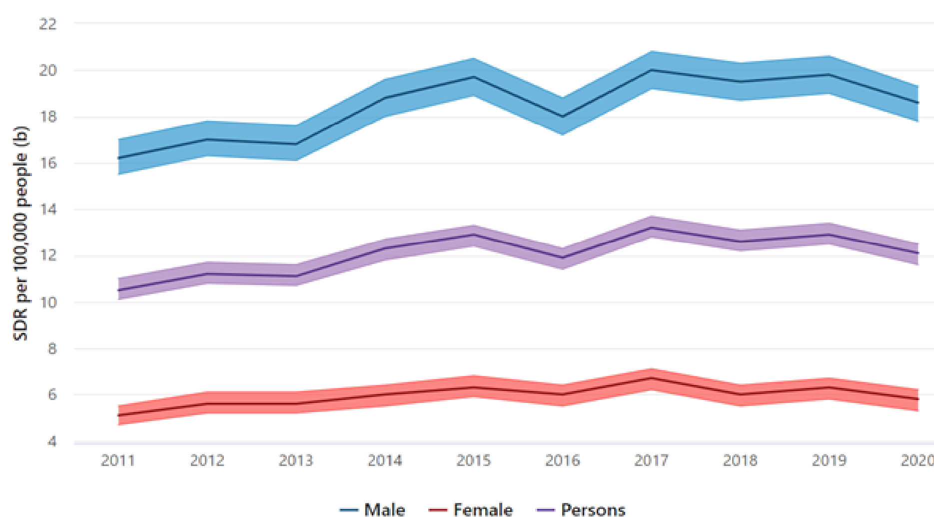
Suicide and self-harm

The potential impact of the pandemic on suicide and self-harm behaviours has been an area of concern in Australia and internationally. However, although certain suicide risk factors have worsened since the beginning of the pandemic, the Australian Bureau of Statistics Causes of Death 2020 release indicates that there has been no significant change in the rate of death by suicide in Australia compared with 2019 (**Figure 2**).[11] Data on suspected deaths by suicide up to mid-2021 that has been made publicly available by New South Wales and Victoria suicide registers also does not indicate any significant change in suicide counts relative to recent pre-pandemic years.[12]

The rates of death by suicide have remained fairly steady since 2019.

However, although there are no immediate changes from pre-pandemic suicide rates, it is not yet possible to draw conclusions about longer-term impacts on suicide—particularly for individuals who developed new mental health conditions and experienced worsening risk factors during the pandemic.

Figure 2: Age-standardised death rates (SDR) for suicide deaths (per 100,000) by sex in Australia, 2011 to 2020



Source: Australian Bureau of Statistics. Causes of death, Australia, 2020. Canberra: ABS; 2021. Available from: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-self-harm-deaths-suicide-in-australia

Each death by suicide represents a unique person lost through immense tragedy, with lasting and profound impacts on families, friends and communities. Suicide figures continue to highlight that more must be done to improve Australia's suicide prevention systems. As recommended in the National Suicide Prevention Final Advice (NSPA Final Advice), the Commission and the broader government must use data, research and lived experience insights to inform effective prevention strategies in pursuit of zero suicides in Australia.

Populations at higher risk

Certain population groups, which had been identified before the pandemic, continue to be over-represented in deaths by suicide. This reinforces the NSPA Final Advice about the importance of equity-driven and targeted suicide prevention strategies and systems, to prioritise population groups that are disproportionately affected by suicide (see National Suicide Prevention Adviser Final Advice). In 2020, men were more than 3 times as likely to die by suicide as women—this disparity has been consistently reported for more than a decade.[12,13] Aboriginal and Torres Strait Islander people had a suicide rate that was more than twice as high as that of non-Indigenous Australians, with suicide representing the 5th leading cause of death for Aboriginal and Torres Strait Islander people, and 15th in non-Indigenous Australians. Suicide persisted as a prominent health issue in 2020 for young and middle-aged Australians as the leading cause of death for Australians aged 15–44 years. Suicide also remains as the leading cause of death in Australians aged 5–17 years; this presents particularly difficult challenges for targeted research and preventive measures because of the sensitive nature of suicide in children.[11]

Further research has emerged in an effort to explain the socio-economic associations and psychosocial risk factors for suicide (see National Suicide Prevention Adviser research results), and their relationship with priority populations. From 2017 to 2020, mood disorders, and acute alcohol and drug use (including intoxication) were the first and second most reported psychosocial risk factors for death by suicide, respectively.[11]

The type and prevalence of psychosocial risk factors also depend on age group and sex, further indicating the need for population-specific services, supports and interventions. For example, the most commonly reported risk factor for suicide for Australians aged 5–24 years was acute substance

use, whereas limitation due to illness and disability was the most common risk factor for those aged 85 years and over. Of people who died by suicide, 3.2% were reported to have COVID-19 pandemic–related issues noted as a risk factor. Pandemic-related risk factors were shown to manifest in different ways for individuals, including job loss, relationship pressures and general anxiety about the pandemic. Where the COVID-19 pandemic was reported as a risk factor, this was not determined as an isolated risk.[11] Insights into suicide risk factors support the NSPA Final Advice about the need to shift to a whole-of-governments approach to suicide prevention and develop initiatives through cross-sector collaborations that drive improved outcomes across sectors.

It is important to note that there is currently no standardised process of identifying psychosocial risk factors for reported deaths by suicide—coronial investigations and methods differ by jurisdiction and are translated collectively into categorical codes.[14] Partnerships that enable data sharing and research collaborations, such as those established in support of the National Suicide and Self-Harm Monitoring System, could greatly improve the evidence base that informs the development of suicide prevention policies and strategies. Barriers to these research opportunities, including privacy concerns and subsequent data access restrictions, must be addressed through strategies that reduce stigma and discrimination, and build the public's awareness of the benefits that arise from improved data collection. Recent analysis from the Australian Institute of Health and Welfare, which uses linked data from the Multi-Agency Data Integration Project to identify social factors associated with greater suicide risk, demonstrates the capacity to augment existing data sources while ensuring individual privacy.[15]

Suicidal behaviours

New data from the National Ambulance Surveillance System has provided valuable insights that distinguish deaths by suicide from other suicidal and self-harm behaviours.[b] Although males are much more likely to die by suicide, data from 2020 indicates that ambulance attendances for suicide attempts and self-injury[c] were significantly higher for females than for males. Although ambulance attendances for self-harm behaviours were notably high in both males and females aged 15–24 years, significant increases for suicide attempts and self-injury attendances were observed in females aged up to 24 years from March 2018 to March 2021.[8]

The distinction between deaths by suicide and suicidal behaviours illustrates the complexity of suicidality, and highlights the opportunities to intervene earlier before death by suicide.

This calls attention to the NSPA Final Advice recommendation for data to be routinely collected on all suicidal behaviours and not just focus on suicide deaths. Moreover, as most data is from clinical presentations collected for operational purposes, we may have a skewed view of suicidal behaviour. To understand suicidality better, we must explore potential data sources more broadly to accurately measure the prevalence and impacts of suicidal behaviours.

Mental health services

Most data that measures the prevalence of mental health issues in the context of the COVID-19 pandemic does not include benchmarks or baseline values before the pandemic. However, data on the use of various government-supported mental health services has been consistently monitored before and during the pandemic, and illustrates emerging patterns over time and the effects of government initiatives.

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[b] The National Ambulance Surveillance System uses the umbrella term 'self-harm behaviours' to refer to 4 categories of self-harm-related ambulance attendances: self-injury, suicidal ideation, suicide attempt and suicide.

[c] The National Ambulance Surveillance System defines self-injury as 'non-fatal injury without suicidal intent'.

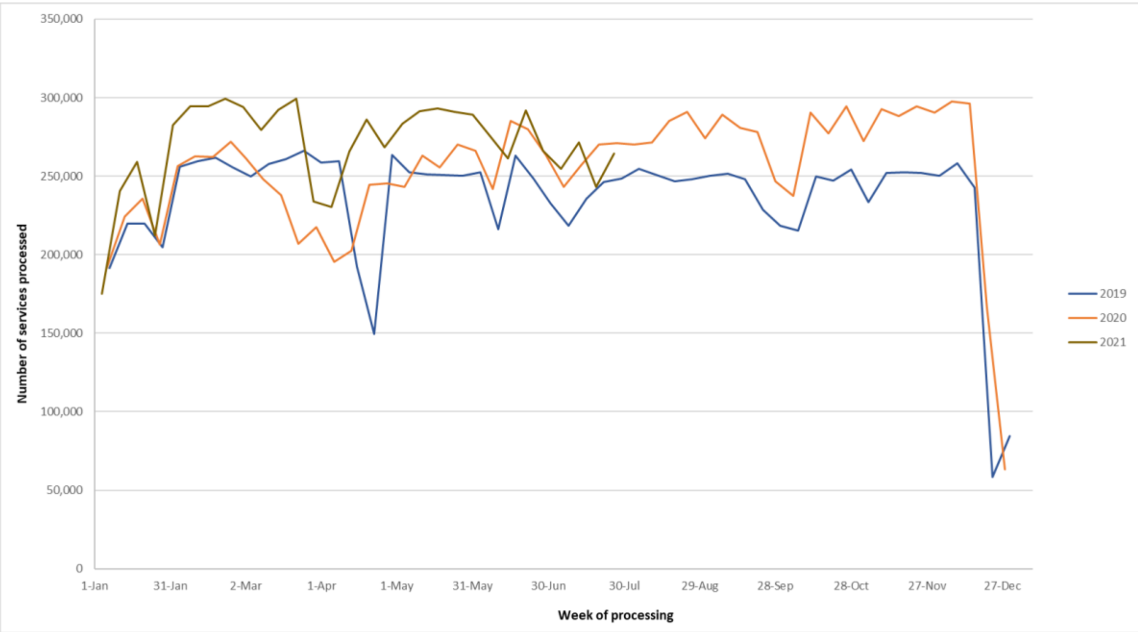
Between 16 March 2020 and 27 June 2021, more than 17 million Medicare Benefits Schedule (MBS)–subsidised mental health–related services were processed. From February 2021 to mid-March 2021, and in May 2021, the number of MBS mental health services delivered had significantly risen compared with the same periods in 2020 and 2019 (**Figure 3**). Following an initial spike observed in March 2020, the weekly volume of mental health-related prescriptions dispensed under the Pharmaceuticals Benefits Scheme was also higher from mid-May 2020 to early August 2021 compared with the same period in the previous year.[16,d]

Other mental health support organisations, including Lifeline and Beyond Blue, have reported substantial increases in demand during the pandemic.[16,e]

Data on service activity before and during the COVID-19 pandemic reveals emerging patterns over time and the effects of government initiatives that support healthcare access.

These increases match the noted increases in psychological distress during the pandemic, but may also reflect growing awareness and acceptance of mental health as a legitimate health concern. Since the onset of the pandemic in March 2020, 27% of people reportedly placed 'more' or 'much more' priority on their mental health.[17]

Figure 3: Number of Medicare Benefits Schedule mental health services, by week of processing, January 2019 to July 2021



Source: Data provided by the Australian Institute of Health and Welfare.

However, despite the increases in mental health service activity during the pandemic, it has been reported that 34.3% of people who needed to see a health professional for their own mental health in 2020–21 had delayed seeing one, or did not see one, on at least one occasion. People aged 15–

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[d] Temporary changes to medicine regulations, originally introduced in response to widespread bushfires, were extended in March 2020 to enable continued access to Pharmaceuticals Benefits Scheme–listed medicines during the pandemic. They include a measure that allowed pharmacists to dispense mental health–related medicines to patients without a prescription, under strict conditions, up to a 1-month supply.

[e] Updated mental health service activity data indicates new record peaks for Lifeline's daily call volumes, compared with the same periods for 2020 and 2019 (https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-impact-of-covid-19; updated 8 December 2021).

34 years were more than 3 times more likely than people aged 65 and over to delay seeing, or not see, a health professional for their mental health because of cost.[18]

It is crucial to further develop a robust evidence base that enables us to measure the experiences of service users and the overall effectiveness of mental health services.

It is vital that we understand how available support services are being used, or why they are not being used, and how they must adapt to meet the changing needs of consumers. The *Your Experience of Service (YES)* survey instrument gathers consumers' perspectives about the care they receive from public mental health services. However, the YES survey instrument has not been implemented in all states and territories and thus does not provide national data coverage.

We also need to recognise the toll of the pandemic on mental healthcare workers, service providers and carers, as flow-on effects have been felt by these workforces, who were facing significant challenges even before the pandemic. Government initiatives that have shaped significant changes in mental health service access and delivery will also benefit from continued activity data, and measurement of service experiences and outcomes.

Evaluation of mental health services will not only show whether demand has successfully been met, but also provide insights into the effectiveness of Australia's systems as a whole.

Telehealth

The risk of COVID-19 infection and imposed restrictions have acted as a catalyst for changes in the Australian healthcare system, including in mental health services. The introduction of national MBS telehealth items in response to the pandemic has been vital for service continuity at a time when mental health support has arguably never been more crucial. In the early stages of the pandemic, there was a sharp increase in the proportion of MBS mental health services delivered via telehealth throughout Australia, which corresponded with the introduction of temporary MBS telehealth items. Nearly half of all MBS mental health services were delivered via telehealth in April 2020, and upward trends in the proportion of telehealth services coincided with localised lockdowns throughout 2021.[19]

However, current data is not yet able to tell us if the use of telehealth mental health services has improved consumer outcomes. It will be important to understand whether telehealth has increased access and improved outcomes, especially for groups considered most likely to benefit (for example, rural and remote communities).

Alternative forms of mental health service delivery should continue to be explored to accommodate different conditions, especially as the sector pays closer attention to specific population needs and lived experience perspectives.

2 Key sector development

Key points

- Australia's mental health and suicide prevention systems are being reformed. Five significant inquiries and reports on mental health and suicide prevention have occurred since 2020, and 2 significant suicide prevention reforms are upcoming.
- Common themes have emerged from the reviews and reports, which the Commission views as priority areas.
- The Australian Government identified 5 key pillars of reform in the National Mental Health and Suicide Prevention Plan it delivered through the 2021–22 Budget, and $2.3 billion will be invested against these pillars over 4 years.
- The Australian Health Ministers' Advisory Council committees that were tasked with implementing the Fifth National Mental Health and Suicide Prevention Plan have been dissolved, and all governments have agreed to establish a new National Mental Health and Suicide Prevention Agreement.
- The National Mental Health and Suicide Prevention Agreement (National Agreement) is a key piece of work intended to provide a mechanism for achieving lasting reform.
- Sector collaboration will be key to reform, and the COVID-19 pandemic has demonstrated that collaboration within and across sectors can be developed rapidly and effectively.
- Collaboration with people with lived experience of mental ill health and their carers and families, including co-design of services, will be essential for effective progress.

Australia has been internationally recognised as a leader in mental health care innovation.[20] Currently, governments across Australia are prioritising mental health and suicide prevention. This is being achieved through collaboration between the Australian Government and state and territory governments, supported by national data collections, national agreements, and national plans and policies.

Building on this, Australia's mental health and suicide prevention systems are in the midst of a huge reform agenda and has undergone numerous reviews over the past 2 years. In 2021, a record $2.3 billion mental health reform package was announced in the 2021–22 Budget, and the Hon David Coleman MP was appointed as Assistant Minister to the Prime Minister for Mental Health and Suicide Prevention.

However, from the perspective of people needing or using services, change has been painfully slow. Despite the high profile given to mental health and suicide prevention reform, many people are yet to see changes in the services or care pathways they access.

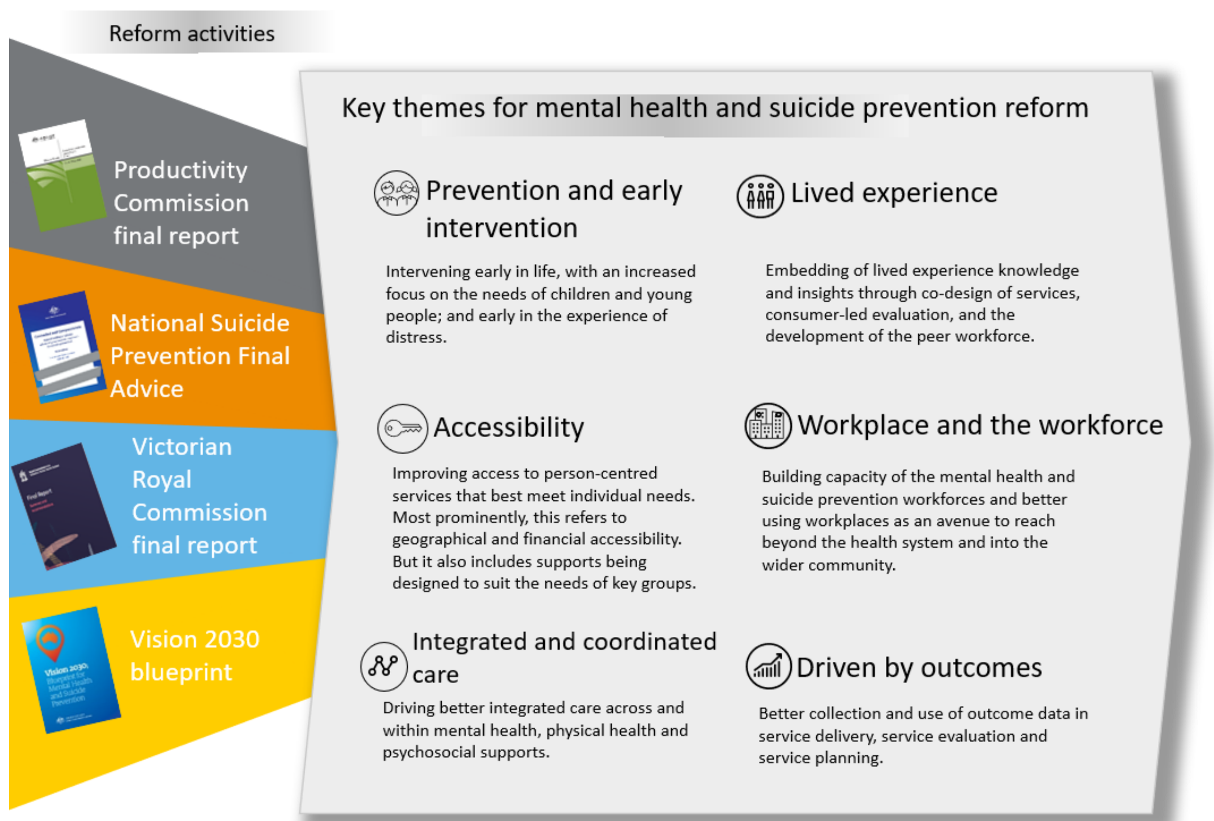
"I was sectioned under the Mental Health Act, but they couldn't find a bed in a psych ward so was released with phone numbers and followed up once or twice, saw my GP a few times, found it really hard to navigate the system and couldn't afford ongoing therapy. So still struggling and still fighting alone." Personal story, Private Voices study[28]

More significant reforms are needed to deliver systems that are integrated, person centred and driven by outcomes.

Key themes have emerged from the recent reports and inquiries (see Recent and upcoming inquiries and reports on sector reform). The Commission has identified 6 priority areas requiring greater and continued focus to work towards an effective, connected and well-functioning mental health and suicide prevention systems, consistent with the goals of the Commission's Vision 2030 (**Figure 4**). These are:

- prevention and early intervention (see Chapter 3)
- accessibility (see Chapter 4)
- integrated and coordinated care (see Chapter 5)
- lived experience participation (see Chapter 6)
- workplace and the workforce (see Chapter 7)
- outcomes-driven systems (see Chapter 8).

Figure 4: Key themes for mental health and suicide prevention reform



Recent and upcoming inquiries and reports on sector reform

Key reports from national and state and territory mental health reviews and inquiries over the past 12 months are aligned in their findings that further significant reforms are required to deliver systems that are integrated, person centred and driven by outcomes.

It is also important that promising early wins from previous reforms are not abandoned as new waves of reform and new ideas come through. For example, the momentum in regional joint mental health and suicide prevention planning, which has resulted from the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), can be harnessed to implement many of the more recent suggestions about integrated care (see Integrated and coordinated care).

Further reform works, including those targeting specific high-risk population groups, are expected in 2022.

Productivity Commission Inquiry into Mental Health

The Productivity Commission Inquiry into Mental Health, released towards the end of 2020, provided a framework to address structural and social issues and gaps within the mental health and suicide prevention systems. The inquiry emphasised the need for person-centred, nationally consistent, comprehensive mental health and suicide prevention systems that reach beyond health to encompass the social determinants that can affect our wellbeing.

House of Representatives Select Committee on Mental Health and Suicide Prevention

The House of Representatives Select Committee on Mental Health and Suicide Prevention (Select Committee) launched its inquiry into mental health and suicide prevention in February 2021. The inquiry will examine the findings of recent strategic reviews of the current mental health systems in light of events such as the 2019–20 bushfires and the COVID-19 pandemic, as well as other matters not addressed by recent reviews.

Released in April 2021, the Select Committee's interim report noted a particular interest in structural stigma, coordination and funding of services, workforce issues, accessibility and affordability, and early intervention for further investigation.

Royal Commission into Aged Care Quality and Safety

The Final Report of the Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) was tabled in the Australian Parliament on 1 March 2021. The Aged Care Royal Commission has recognised that poor mental health is a serious problem in aged care and that social connection, as well as professional health and personal care, is important.

The report's 148 recommendations outline how the Aged Care system can better meet the complex care needs of people living in community and aged care settings who require access to comprehensive health services, including mental health treatment and services. The release of the final report has been welcomed by many within the mental health sector, shining an overdue light on the mental health needs of people within the aged care system.

Royal Commission into Victoria's Mental Health System

The Royal Commission into Victoria's Mental Health System (Victorian Royal Commission) released its final report on 2 March 2021. Although it was a state-focused inquiry, the Victorian Royal Commission explored many issues concerning the need for reform at both national and state levels to address structural problems that act as barriers to patient-centred care.

A key focus of the report is the delivery of an integrated, community-based model of care, where people access treatment, care and support close to their homes and in their communities. The report also identifies the need for better collaboration between primary and secondary care to target the needs of individuals, and the need for innovative ways to make optimal use of the available workforce.

The release of the final report has been welcomed with a sense that it will provide a catalyst for positive change. The Victorian Government's commitment to implement all 65 ambitious and expansive recommendations means that significant change is expected in the way mental health care is considered, delivered, funded and experienced for many Victorians.

National Suicide Prevention Final Advice

The National Suicide Prevention Final Advice (NSPA Final Advice) was released in April 2021. The NSPA Final Advice is the culmination of extensive lived experience input, research and targeted consultations. It provides 8 key recommendations for a more connected and compassionate approach to suicide prevention.

A more detailed analysis of the NSPA Final Advice is in Chapter 3 (see National Suicide Prevention Adviser Final Advice).

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2021–2023

Gayaa Dhuwi (Proud Spirit) Australia has been tasked by the Australian Government with renewing the 2013 National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. Building on work completed in 2020, Gayaa Dhuwi conducted the final round of consultations on the strategy in May 2021.

The renewal of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy is important for the suicide prevention sector. Several system and policy changes have occurred since development of the strategy in 2013, and it is important that communities remain in control as integrated approaches to Aboriginal and Torres Strait Islander suicide prevention continue to be rolled out nationally. Aboriginal and Torres Strait Islander communities have distinct challenges and cultural practices that need to be considered in the implementation of policy to ensure that they are reflected at the local level in suicide prevention responses and services.

Royal Commission into Defence and Veteran Suicide

In April 2021, the Australian Government announced the establishment of a Royal Commission into Defence and Veteran Suicide. An interim report is due by 11 August 2022, and a final report by 17 June 2024. The members of the Royal Commission include former Chief Executive Officer of the Commission, Dr Peggy Brown AO. The National Commissioner for Defence and Veteran Suicide Prevention Bill 2020, currently before the Australian Parliament, will be amended to complement the Royal Commission's work. It is intended that the National Commissioner will have responsibility for implementing the Royal Commission's recommendations.

Planning and governance

Changes in governance in the mental health sector are designed to improve collaboration and coordination, and support the needs identified in recent reviews (see Recent and upcoming inquiries and reports on sector reform).

Building on the achievements of the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), the initiatives funded in the 2021–22 Budget have provided a good foundation in many areas to improve the mental health and suicide prevention systems. The challenge is now to quickly and collaboratively implement the changes for which there is such strong policy alignment. The reform journey will need to maintain momentum and be supported by collaborative partnerships.

Negotiation of the National Mental Health and Suicide Prevention Agreement will be a critical milestone, which should lay the groundwork for a shared commitment to delivering improved outcomes.

Changes to mental health and suicide prevention governance

Australian governments are reshaping and refocusing governance arrangements for the mental health and suicide prevention sectors. On 29 May 2020, the Prime Minister announced the cessation of the Council of Australian Governments, replacing it with the National Federation Reform Council (NFRC) and a more streamlined intergovernmental structure. This saw the dissolution of the Australian Health Ministers' Advisory Council committees that were tasked with implementing the Fifth Plan, and the establishment of the new Health National Cabinet Reform Committee.

In December 2020, the NFRC set out its vision for reform of the mental health and suicide prevention systems. Specifically, it agreed to collaborate on systemic, whole-of-governments reform to be achieved through the National Agreement, due to be delivered in early 2022.[21] The NFRC also established principles to underpin whole-of-governments efforts to transform and improve Australia's mental health care and suicide prevention system.

The new National Mental Health and Suicide Prevention Agreement will facilitate collaboration on systemic, whole-of-governments reform to deliver a comprehensive, coordinated, consumer-focused and compassionate mental health and suicide prevention system.

Fifth National Mental Health and Suicide Prevention Plan

Since 2017, the Commission has been responsible for monitoring and reporting on the implementation of the Fifth Plan and the performance of the mental health and suicide prevention systems against identified indicators. This is drawing to a natural conclusion, with delivery of a final progress report slated for early 2022.

Pleasingly, many of the reforms of the Fifth Plan are complete or now part of business-as-usual activities. Some actions under the Fifth Plan have also been incorporated into the mental health reforms announced in the 2021–22 Budget. These include reforms capturing whole-of-community approaches to suicide prevention (Action 5) and community mental health support needs of people who do not qualify to receive supports under the National Disability Insurance Scheme (Action 6). Development of the National Stigma and Discrimination Reduction Strategy also builds on actions identified under the Fifth Plan (see National Stigma and Discrimination Reduction Strategy).

A small number of Fifth Plan action items will continue to progress through new mental health reforms or business as usual activities. The Commission expects to continue to play a critical role in monitoring and reporting on the national reform agenda in collaboration with the Australian Government Department of Health, to ensure that all Australians receive the benefits of integrated regional planning and service delivery, systems-based suicide prevention, coordinated treatment and supports, reduced stigma and discrimination, and a safe, high-quality, effective mental health system.

Mental health budget reform

The Australian Government's 2021–22 Budget can be considered the first part of its response to the findings of the Productivity Commission Inquiry into Mental Health and the NSPA Final Advice (see National Suicide Prevention Adviser Final Advice).

The Australian Government supported, or supported in principle or in part, 21 of the Productivity Commission's recommendations. Most of these require collaboration with state and territory governments, and some will be pursued through the new National Agreement. The Australian Government also supported, or supported in principle or in part, all 8 recommendations from the

NSPA Final Advice and announced immediate action against each of these recommendations through the 2021–22 Budget.[22]

The Australian Government supported most or all of the recommendations from the Productivity Commission and the National Suicide Prevention Final Advice.

The Australian Government identified 5 key pillars of reform in the National Mental Health and Suicide Prevention Plan it delivered through the 2021–22 Budget:

- Prevention and early intervention—focusing on transforming digital support; supporting parents, carers and children; promoting mental health and wellbeing in education and sport; addressing barriers to employment; supporting businesses and employees; improving engagement with the legal system and the housing sector; and addressing stigma.
- Suicide prevention (through a whole-of-governments approach informed by lived experience)—including the establishment of a National Suicide Prevention Office and focusing on aftercare, postvention and distress intervention; and supporting communities to prevent suicide.
- Treatment—focusing on delivery of critical community-based multidisciplinary, coordinated care, including establishment of additional Head to Health adult mental health centres.
- Supporting the vulnerable—focusing on providing targeted supports for vulnerable Australians, such as LGBTQI+ people, Aboriginal and Torres Strait Islander people, rural and remote communities, and veterans and their families.
- Workforce and governance—committing to growing and upskilling the mental health and suicide prevention workforce; supporting the mental health of our critical workers; improving evidence and evaluation and; stronger governance and accountability.

The Commission welcomed the $2.3 billion investment against these pillars over 4 years and notes the considerable alignment with the Commission's mental health and suicide prevention priorities (see Key sector development).

The Commission was particularly pleased to see funding for expansion of new locally focused models of accessing and receiving integrated and targeted care. Emerging models of centre-based care, such as Head to Health centres, were expanded through the Budget. Furthermore, funding for children's Head to Health Kids Hubs will offer better-targeted and connected mental health and wellbeing services for children (aged 0-12 years) and their families. This is consistent with recommendations of the National Children's Mental Health and Wellbeing Strategy (see Prevention and early intervention).

Investment in some areas of mental health and suicide prevention services builds on existing programs, to address unmet need and further build workforce and service capacity, particularly for vulnerable groups.

The Commission also agrees that promoting a consistent approach to assessment of mental health needs will improve patient-centred care by ensuring that individuals can access the services that best meet their needs. Therefore, the Commission welcomed the provision of funding to support general practitioners in the use of the Initial Assessment and Referral decision support tool (see Integrating services at an individual and system level), and a commitment to requiring a consistent approach to assessment through Commonwealth-funded primary care programs commissioned through Primary Health Networks, including Head to Health centres.

As part of the 2021–22 Budget, the mental health workforce will also see an increase in capacity, including the Aboriginal and Torres Strait Islander mental health workforce, with funding for scholarships and clinical placements. Workforce training will be provided on supporting aged care

resident's mental health for those working in aged care. There will also be mental health support available for healthcare workers.

The 2021–22 Budget committed to making the National Agreement a reality. Development of the National Agreement is considered a key mechanism for achieving lasting reform, including strong collaboration across all governments, the sector and communities, and a commitment to co-designing solutions with people with lived experience.

The high expectations around the release of the National Agreement will need to be followed through to facilitate collaborative, whole-of-governments reforms that the mental health sector has long called for.

Significant funding was also provided for suicide prevention. The Australian Government will work in partnership with states and territories to fund aftercare for every Australian discharged from hospital following a suicide attempt, at a cost of $158.6 million. Aftercare services provide follow-up care in the immediate months after a suicidal crisis or attempt, and support individuals to seek appropriate help when they need it most. Aftercare services will also be trialled for anyone who has attempted suicide or experienced suicidal distress who may not have presented to a hospital.

A key recommendation of the NSPA Final Advice was the establishment of a National Suicide Prevention Office. This was agreed and funded in the 2021–22 Budget. The office will be responsible for building capability to deliver a whole-of-governments approach to suicide prevention, integrating collaborative efforts and reducing the potential for duplication. It will ensure that those aspects of suicide prevention that can be conducted at a national level—because of scalability, the need for consistency, and reach—are implemented in consultation with all jurisdictions.

Additional funding provided for the National Suicide Prevention Trial has allowed the systems-based approach to suicide prevention across 12 sites to continue for another 12 months. Each site is focusing on an at-risk population, such as Aboriginal and Torres Strait Islander people, LGBTQI+ people, youth, men, veterans and older people. In a report on insights and impacts from the National Suicide Prevention Trial sites,[23] released in January 2021, the Black Dog Institute said, "the groundwork laid by the trial sites, such as new support services and pathways to support people in crisis, have been key to responding to the mental health impacts of COVID-19". Similarly, the University of Melbourne's final evaluation of the trials has noted the importance of the knowledge created through the trials in reducing the toll of suicide and providing a foundation for continuing development of initiatives needed across all jurisdictions.[24]

Improving sector collaboration

Collaboration is an essential feature of well-functioning mental health and suicide prevention systems. The mental health and suicide prevention sectors have strongly advocated for reform that will enable a more cohesive experience for both the workforce and consumers. The need for whole-of-governments action is a clear priority.

In addition, governments, service providers and the community are more aware than ever that addressing mental ill health and rates of suicide requires consideration of non-health factors such as education, housing and employment.

For example, several studies have found that those who experienced job loss, reductions in work hours and financial hardship during the COVID-19 pandemic in 2020 were more likely to report mental health problems.[25,26]

However, although the pandemic may have exacerbated the impact of certain socio-economic factors, it is important to recognise the ongoing socio-economic—and subsequent mental health—hardships that have long been faced by many Australians, independent of crisis events.

Further quantifying and understanding these intersections will create different avenues for driving change for both mental health and economic wellbeing across distinct populations in Australia.

The pandemic has reinforced the need for the kinds of reforms the sector and community have long called for—that is, a whole-of-society, whole-of-governments, person-centred approach.

The bi-directional relationship between mental health and socio-economic factors is well defined, presenting rich opportunities for sector collaborations to develop prevention and intervention strategies with impact.[27]

Pandemic Response Plan

The National Mental Health and Wellbeing Pandemic Response Plan (Pandemic Response Plan) is an example of the sector's ability to rapidly respond. It calls for a whole-of-governments approach that is nationally consistent, builds on current momentum and innovation, and responds quickly to address critical gaps. The Pandemic Response Plan introduced 3 immediate actions to meet the needs of Australians during the pandemic: increasing data and modelling, adapting models of care, and improving service linkage and coordination.

To inform the urgent response needed during the pandemic, numerous service providers and governments have shared key mental health and suicide prevention data. Increased data sharing to enable real-time modelling of the mental health impact of COVID-19 was a critical requirement to inform policy actions and allowed models of care to be successfully and rapidly adapted (see Telehealth).

As part of activities under the Pandemic Response Plan, the Commission hosted a roundtable in March 2021 with more than 50 representatives from the mental health and suicide prevention sectors, including service providers, peak organisations, government bodies and research organisations. The roundtable provided an opportunity for representatives to share their experiences of the impact of the past 12 months on mental health services, including key learnings and reflections on ways to increase capacity, learn, and work together in the future.

In June 2021, the Commission provided support for research into the ongoing effects of the pandemic on several priority population groups as part of activity under the Pandemic Response Plan, including:

- LGBTIQ+ populations
- women living with disability
- children and young people
- culturally and linguistically diverse populations
- mental health carers
- men and boys
- people and families experiencing rape and domestic violence
- rural and remote communities
- people experiencing compounding trauma from disasters

- older Australians.[f]

Findings from this research will help to strengthen the Pandemic Response Plan and contribute to future recommendations informed by the unique impact the pandemic has had on these priority groups, and the organisations that represent and support them. The research will also inform updates to the Pandemic Response Plan as the impacts of the pandemic continue to emerge.

Sustaining change

The response to the pandemic has illustrated the value of collaborative partnerships and timely data that can be fed into policy development and government decision making. Positive examples of progress include increased funding to providers such as Beyond Blue, Lifeline, Kids Helpline, the Butterfly Foundation and the Gidget Foundation to respond to increases in demand and service use, and boost services for priority populations affected by the crisis.

Despite these positive examples, the key question is whether this level of collaboration and real-time data collection and sharing can be sustained beyond the current crisis. There are concerns that this rapid action places an administrative burden on service providers that are already at capacity.

Efforts need to translate to real change in communities that is sustained in long-term reform. This will require collaboration to be hardwired into systems.

The sector is looking to the National Agreement, due for release in early 2022, as a key mechanism to drive such reform. Establishment of the National Agreement and associated bilateral schedules provides an opportunity to clarify roles, responsibilities and funding contributions across all jurisdictions and support tailored, local-level initiatives.

Ongoing data monitoring and sharing

Although collaborative efforts and data sharing within the sector have been invaluable for monitoring during the pandemic, regular and detailed data monitoring and sharing outside of exceptional circumstances must occur to inform the future management of crises.

With consistent and rapid data collection, sudden changes in mental health can be better monitored and compared, to establish trends over time. The lack of baseline values for dedicated data on emotional and mental wellbeing gathered during the COVID-19 pandemic is a significant limitation when attempting to quantify and discern the direct impacts of the pandemic on mental health.

Rapid data sources dedicated to pandemic monitoring, including ANU poll, Taking the Pulse of the Nation and the Household Impacts of COVID-19 surveys, have demonstrated dynamic changes in mental health and related social determinants throughout the pandemic, particularly for high-risk populations: peaks in psychological distress were observed at the onset of the pandemic and during periods of lockdowns, while initial sharp declines in employment rates have gradually recovered over time to pre-pandemic levels.[27,g]

Data must continue to be carefully monitored after significant events, such as the COVID-19 pandemic, to inform future management of mental health during crises.

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[f] The Commission also attempted to establish a research grant focused on the impact of the pandemic on Aboriginal and Torres Strait Islander communities. However, stakeholders did not have the capacity to complete such a project at the time.

[g] Australian Labour Force data for December 2021 indicates that seasonally adjusted employment and participation rates were higher than in March 2020. Unemployment rates were also the lowest they had been since August 2008 (https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/dec-2021; https://www.abs.gov.au/media-centre/media-releases/employment-65000-unemployment-rate-falls-42).

Co-design

Co-design is a critical part of effective collaboration. It focuses on involving consumers in the design and delivery of services, not only in the initial establishment of a service but throughout the life of the service. Continuing to involve people with lived experience will ensure that supports are accessible and valuable for those who use them. Maintaining alignment with the principles of co-design is particularly important during times of crisis or increased demand to ensure that responses are informed by the people they are intended for.

It is essential that recommendations are implemented with lived experience at the centre, and with the involvement of the full range of perspectives on mental ill health and suicide, beyond government.

Collaborating with consumers and exploring their experiences of accessing support will ensure that problems are identified early and can be rectified as services are delivered.

Co-designing with people from population groups and communities more likely to be affected by mental ill health (for example, Aboriginal and Torres Strait Islander people, people who identify as LGBTIQ+) is also required.

Case study 1: #ChatStarter—collaborating for youth mental health

Mental ill health has increased for children and young people in Australia during the past 2 decades, with evidence seen across data sources including national surveys, rates of service use and consultation with the sector, such as discussions with service providers. The COVID-19 pandemic and resulting lockdowns and restrictions across the country have further impacted children, young people and their parents, and exacerbated the existing decline in child and youth mental health. Noting this urgent need, the Commission commenced work with key experts in 2021 to support the mental health and wellbeing of young people. Key lessons from this period were to connect with young people in ways that speak to them by using tools such as social media, and that parents require support to meaningfully engage with young people about mental health and wellbeing, particularly when the whole family is facing significant challenges.

On 29 June 2021, the Commission brought the sector together to discuss the high levels of distress among young people, the increased demand for services, and the concerns of parents and families. This discussion included representatives from batyr, the Butterfly Foundation, headspace, Kids Helpline, Orygen, ReachOut, the Australian Institute of Health and Welfare, state mental health commissions, the Australian Capital Territory Wellbeing Office, and the Australian Government.

The roundtable identified the need for immediate action to support both young people and their parents and families. In response, the Commission partnered with parents and young people with experiences of mental ill health, and Australia's national mental health organisations that specialise in supporting children, young people, parents and carers, to develop #ChatStarter, an online mental health communication program, which was listed on the Australian Government's Head to Health website.

#ChatStarter provides a single point of access to free, evidence-based resources already developed by the mental health sector. #ChatStarter is designed to complement existing supports, providing parents and carers with the confidence and tools to have conversations with their children and loved ones about how they are coping with the challenging circumstances of the pandemic and whether their mental health has been impacted. It also provides young people with skills to talk to their friends about wellbeing, as well as create content on their preferred social media platforms to start conversations and encourage others to access support when they need it.

#ChatStarter is a unique and collaborative approach to community mental health support, developed by the mental health sector, supported and delivered through the support of social networking platforms, and crowdsourced from contributors through TikTok.

The campaign sparked media attention, with an estimated reach of 99 million people across all forms of media. Across social media platforms, the combined organic and advertising credited posts saw #ChatStarter messaging reach an estimated audience of more than 10,868,000 people, which resulted in over 40,000 people viewing the resources on the Head to Health #ChatStarter page.

#ChatStarter highlights the importance of investing in community, family and peer-based resources and supports, alongside more traditional mental health and suicide prevention services. It provides an example of ways to include carers, family and friends—this is a key priority for reform, which will also be important for sustainability. The campaign also showed that governments can work in partnership with business and the sector to improve Australia's mental health outcomes.

The Commission is now undertaking further work to understand the underlying drivers of increased mental ill health for children and young people. With this trend occurring over many years, it is critical to understand what is contributing to increased distress, and particularly what has changed for young people over the past 2 decades. Initial scoping has indicated that increased distress in younger cohorts should be interpreted as symptomatic of societal problems, many of which require a whole-of-governments response. This is consistent with initial findings from the development of the National Stigma and Discrimination Reduction Strategy, which showed that mental ill health can be a response to a complex mix of biopsychosocial factors.

Part B Priority issues in mental health and suicide prevention

3 Prevention and early intervention

Key points

- Many Australians do not, or are not able to, access support when they first begin to struggle with their mental health.
- The National Children's Mental Health and Wellbeing Strategy outlines the requirements for an effective system of care for children up to 12 years old. It seeks to create a new, shared understanding of the roles of families, communities, services and educators in promoting and supporting child mental health and wellbeing.
- Recommendations of the National Suicide Prevention Final Advice include developing a National Suicide Prevention Strategy and National Suicide Prevention Workforce Strategy, developing an outcomes framework for suicide prevention, and implementing support structures to build the lived experience workforce.
- The National Plan to Reduce Violence Against Women and their Children 2010–2022 provides the main policy framework for reducing violence against women and their children in Australia, but it has not achieved this aim.
- We need a more coordinated approach to prevention and early intervention across the touchpoints that have an impact on mental health.

Effective prevention and early intervention initiatives can reduce the incidence, prevalence and recurrence of mental health conditions and lessen the severity or impact of illness when it does occur.

Preventive initiatives are based on reducing exposure to risks and strengthening the coping mechanisms of individuals. Early intervention promotes coordinated, multidisciplinary care that is provided early in the onset, or early in the episode, of mental health concerns. This means taking a broader approach to how we consider the social, economic and environmental factors that impact on our mental health and wellbeing. An early intervention approach can lessen the impacts of such factors when they do occur, including family and domestic conflict and violence, and adverse childhood experiences. Similarly, the drivers of suicidal distress identified in the National Suicide Prevention Final Advice (NSPA Final Advice) all present opportunities for intervening early in experiences of distress.

Arguably, efforts in this area have the greatest potential to improve population mental health and wellbeing. However, they also require significant and sustained efforts across all levels of society.

Currently, many Australians do not, or are not able to, access supports when they first begin to struggle with their mental health.

Lack of access to early support can result in problems becoming more severe and less responsive to low-intensity treatments.

The Productivity Commission highlighted lack of a prevention and early intervention focus within Australia's mental health system, both early in life and early in the progress of illness. To address this, a focus 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 have been recommended. However, although governments appear to be prioritising early intervention, we are yet to see the investment in prevention that is required. For example, the Australian Government's

2021–22 Budget includes a number of early intervention measures, yet a prevention focus is less evident.

Such reforms will require a whole-of-governments approach across a range of institutions (for example, schools, tertiary education, workplaces), and linking mental health and suicide prevention services with social services.

Priorities in this area include effective implementation of the National Children's Mental Health and Wellbeing Strategy (the Children's Strategy), implementation of all recommendations from the NSPA Final Advice to strengthen existing services and embrace a whole-of-governments and whole-of-community approach informed by lived experience; greater consideration of coordinated approaches across family, domestic and sexual violence, mental health sectors and beyond; and a greater focus specifically on prevention approaches.

A prevention focus is evident in the recommendation from the Royal Commission into Victoria's Mental Health System to establish a Mental Health and Wellbeing Promotion Office. The office will be tasked with developing and coordinating a statewide approach to the promotion of good mental health and wellbeing, and the prevention of mental illness. This will contribute to a shift away from a crisis-focused system towards one that is prevention focused, and that promotes wellbeing at its core.

National Children's Mental Health and Wellbeing Strategy

The Commission has developed the Children's Strategy, which was announced by the Minister for Health in August 2019 as part of the Australian Government's Long Term National Health Plan. The final Children's Strategy was released in 2021.

The Children's Strategy is the first of its kind globally, with a focus on children from birth through to 12 years of age, as well as the families and communities that nurture them. The strategy outlines the requirements for an effective system of care for children, and seeks to create a new, shared understanding of the roles of families, communities, services and educators in promoting and supporting child mental health and wellbeing. The Children's Strategy has presented an opportunity for uniting efforts across portfolios to achieve meaningful change. For example, the need for health and education systems to align to support children is clearly articulated in the strategy, with recommended actions to achieve this goal.

The Children's Strategy is now being implemented and is already driving change across Australia. Funding was provided in the 2020–21 Budget to commence priority initiatives such as the multidisciplinary Head to Health Kids Hubs. However, achieving the full vision of the Children's Strategy will take coordinated, consistent and sustained efforts across portfolios and Governments; the Commission is working to ensure that implementation efforts are planned for the long term.

The Children's Strategy is an opportunity to achieve meaningful change for children and young people.

Children's Strategy focus

Extensive consultation contributed to the development of the Children's Strategy, ultimately shaping the approach of the Commission to the mental health and wellbeing of children and young people. The consultation produced several key learnings:

- Children cannot be effectively supported in isolation, particularly when facing disadvantage. Supporting families and communities holistically ensures that a child receives the best possible care.

- Australia's current service system is fragmented and difficult to navigate. There is a lack of clarity about where to seek help, and no clear pathways for referring families to appropriate care.
- Education settings provide an ideal opportunity for supporting children, but educators need the resources and tools to enact positive change.
- Research into children's mental health is behind research for other cohorts, and evaluation of services and programs is not standard practice. This means that we often do not know if the supports we are offering children are genuinely effective.

"To pull out each different part of our family's needs doesn't help us… we come as a unit, our needs are holistic." Parent/carer of a child with mental illness, National Children's Mental Health and Wellbeing Strategy

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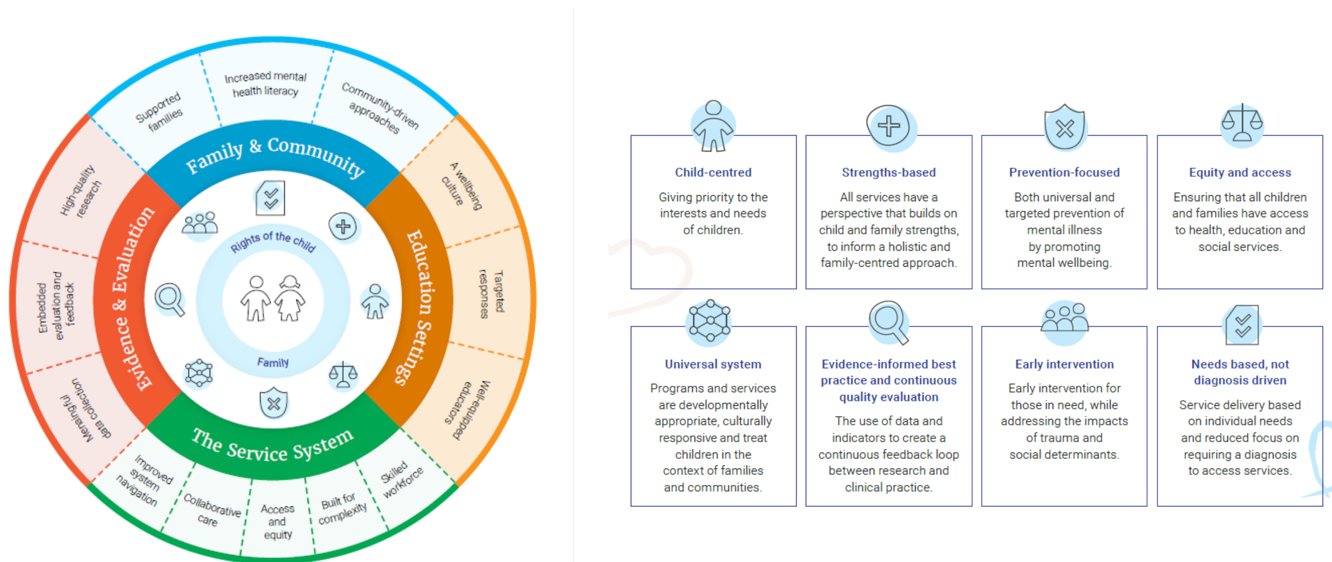
These learnings ultimately informed the 4 focus areas of the Children's Strategy (**Figure 5**). Each focus area has several objectives and actions that will improve the way children receive mental health care.

Figure 5: Focus areas and principles of the National Children's Mental Health and Wellbeing Strategy

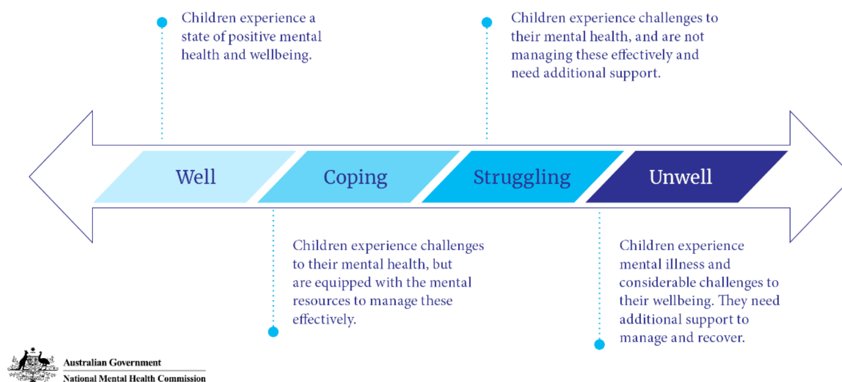


Source: National Mental Health Commission. The National Children's Mental Health and Wellbeing Strategy. Sydney: NMHC; 2021.

Wellbeing continuum for children

Further shifting the focus towards intervening early in life and early in illness, the Children's Strategy also proposes a fundamental, cultural shift in the way we think about the mental health and wellbeing of children through a wellbeing continuum (**Figure 6**).

Figure 6: The wellbeing continuum



Source: National Mental Health Commission. The National Children's Mental Health and Wellbeing Strategy. Sydney: NMHC; 2021.

The wellbeing continuum moves the language of child mental health and wellbeing away from a narrow view of pathology and diagnosis towards a continuum that recognises that everyone's mental health varies over time. Children's emotional experiences cannot always be defined as simply 'well' or 'unwell', nor can their mental health be summed up in a diagnosis of mental illness. The continuum approach promotes early intervention by highlighting that there are opportunities to improve wellbeing before children become 'unwell' and require a diagnosis. It is proposed that services and programs should be built to help children remain in, or move to, the 'well' end of the continuum.

By introducing a wellbeing continuum, we will also have a common language that unifies how we talk about children's mental health across sectors beyond health. Educators, health professionals, parents and carers, and children themselves will be empowered to communicate using common terms that are easy to understand and express a range of emotions. The wellbeing continuum is not intended to replace diagnosis—which is often a necessary component of care that provides useful information for providers and consumers—but to work alongside diagnosis.

The continuum helps to identify children who are struggling but do not meet a diagnostic threshold, and ensures that they still receive support.

The wellbeing continuum concept has gained widespread support, but the terms of the continuum and its interaction with clinical requirements for diagnosis need further exploration. The Commission has funded the Murdoch Children's Research Institute to test and evolve the wellbeing continuum model to ensure that the language used is appropriate and nonstigmatising, and can be translated across languages.

National Suicide Prevention Final Advice

Suicidal and self-harm behaviours are generally not well understood. They are surrounded by shame and social stigma that deter many people from seeking help with suicidal distress; approximately half of Australians lost to suicide did not have contact with mental health services at the time of their deaths.[28] A variety of factors may contribute to suicidal distress, and everyone's journey is different. Current supports focus on crisis services, and do not address the underlying drivers of suicidal distress. A systemic shift of focus to prevention and early intervention that helps people access supports early in life and early in illness could save lives, take pressure off hospitals and emergency services, and benefit the Australian economy.[22]

National Suicide Prevention Final Advice research results

Ten separate studies were commissioned to inform the NSPA Final Advice, including a review of existing research, a large online survey, analysis of public commentary about lived experience of suicide and targeted consultations with identified groups.[29]

The research found that people are often in contact with potential suicide prevention touchpoints before and throughout their journey, but the health system and related systems provide disjointed care, struggle to routinely provide compassionate care, and are hard to navigate or are inaccessible. Some study participants reported being rejected by services for not being deemed in serious enough need. This highlights a vicious cycle whereby individuals in distress can only access support when in crisis, and are often left to navigate recovery support options on their own following discharge. The focus on crisis response, combined with a lack of individualised case management and coordinated care, is undermining trust in the system and leading to disengagement.

A focus on crisis response has left people who need help, but have not yet reached a crisis point, disengaged with the system and not getting the early support they need.

The studies found that a variety of factors contribute to suicidal behaviour, often related to the social determinants of health. Most participants in the research reported that multiple life stressors, key transition points and disconnection from social supports co-occurred in the lead-up to suicidal behaviour:

- Relationship breakdown was the most common adverse event reported, particularly among men. Men also reported that childhood trauma carried into adulthood had a profoundly negative impact on their lives, often contributing to relationship difficulties.
- Onset of mental illness, alcohol and other drug issues, work stresses, relationships, and sexual and cultural identity challenges often occurred in adolescence and early adulthood. Alcohol and other drug issues often increased alongside life stressors in the lead-up to suicidal behaviour. This was especially true of men in the context of relationship breakdowns.
- Unemployment and financial distress were reported as risk factors in adulthood. Some people from culturally and linguistically diverse backgrounds reported the stress of not being able to find employment commensurate with their skills and qualifications.
- Bereavement, social isolation and limitations in daily functioning due to chronic pain or illness were reported as risk factors in older people. Isolation and loneliness were also risk factors for other groups, such as Aboriginal and Torres Strait Islander children removed from their families, culture, language and Country. Loneliness especially affected men.
- Key transition points in life brought unique stressors for study participants, such as the transition from school or university, discharge from hospital following a suicide attempt, discharge from the Australian Defence Force to civilian life, release from correctional facilities, divorce or a change in family structures, impacts of migration and settlement, and change in work status.
- Intergenerational patterns of mental illness, suicide, substance dependence and incarceration were reported. Mental illness was often linked to trauma, disadvantage, negative societal and cultural attitudes, and inequity.

"I have lived with suicide ideation and many attempts. However, the most recent was back in 2013. Just prior to this attempt I was in severe financial stress. I was about to become homeless for the second time in a short period of time. I was isolated and estranged from family and friends."

Personal story, Private Voice study[28]

All of these drivers of suicidal distress present opportunities for early intervention.

Possible touchpoints that could help with early intervention include housing and homelessness services, educational institutions, legal centres and the family law courts, unemployment services, family and community services, and a range of financial and other community services.

The research also found discrimination and stigma presented as barriers to help seeking and accessing health services for some, occurring at both the individual level and a systemic level. This includes racism and discrimination on the basis of cultural and sexual identity, and stigma towards suicidality. Other barriers include lack of mental health support as part of migration services and limited access to services in rural areas (for example, reliance on visiting psychiatrists).

Although limiting the number of subsidised sessions that people can access through a mental healthcare plan makes budgeting more predictable for the Australian Government, it is leaving vulnerable people without support in their time of need. This is exacerbated by a lack of affordable health services, and few services operating outside business hours or with flexible access arrangements. The current increase from 10 to 20 sessions is a welcome improvement, albeit temporary, but there is a need for long-term ongoing care.

Many of the research participants raised concerns about interventions or therapies being ineffective or unhelpful, and a need for more training for general practitioners, hospital staff and medical students so that adequate care is more consistently provided to people in crisis.

Recommendations from the National Suicide Prevention Final Advice

The NSPA Final Advice to the Prime Minister in December 2020 included 8 recommendations to improve suicide prevention in Australia, with a whole-of-governments approach based on lived experience and focused on compassionate responses and early intervention. The NSPA Final Advice calls for governments to work together across jurisdictions and portfolios on several priority areas, identifying four essential enablers and four further priority shifts that are needed.

The key enablers of this new approach include:

- suicide prevention leadership at the highest levels to drive a joined-up response beyond the health portfolio
- integration of lived experience knowledge across all suicide prevention efforts
- increased measurement of outcomes
- evidence-based and compassion-focused workforce development

In addition to the reform needed to enable this new approach further key shifts are needed including:

- outreach and support responses at the point of distress
- service reform to achieve integrated, connected and quality services for people experiencing suicidal distress, their carers and others impacted by suicidal behaviour
- targeted approaches for populations disproportionately impacted by suicide
- a ‘suicide prevention in all policies’ approach.

National Suicide and Self-Harm Monitoring System

The National Suicide and Self-Harm Monitoring System (NSSHMS), developed by the Australian Institute of Health and Welfare (AIHW) in collaboration with the Commission and the Australian

Government Department of Health, provides a timely example of recent data-related innovation, improving the coherence, accessibility, quality and timeliness of national data and information on suicide, suicide attempts and self-harm. The monitoring system plays a key role in better informing public conversations about suicide prevention. It brings together all existing and extensive new data from across states and territories on a website that is regularly updated and improved.

The monitoring system aims to increase transparency and access to information so that Australians can have a more informed understanding of suicide and self-harm, to improve the ways we respond to suicide and help us work towards zero suicides.

In 2021, the Commission and the AIHW have continued to engage with stakeholders to further develop the suicide data available on the NSSHMS website.

The NSSHMS includes the world's first national monitoring system for ambulance attendances for suicide attempts, self-harm and suicidal ideation.

Women's mental health

Some factors that uniquely or disproportionately affect women can impact their mental wellbeing. These include major life transitions such as pregnancy, motherhood, caring responsibilities and menopause, as well as negative life experiences such as poverty, violence and abuse, infertility, perinatal loss and discrimination. Other gender-specific risk factors include socio-economic disadvantage, low income and income inequality, low or subordinate social status and rank, and unremitting responsibility for the care of others.[30]

Improving women's mental health leads to gender equality and improved women's safety more broadly.

Family, domestic and sexual violence (FDSV) is a significant issue for the safety of women and children in Australia and globally, which can have significant and long-lasting impacts on mental health and wellbeing. Although FDSV can happen to anyone, this kind of violence is experienced primarily by women, in the home and perpetrated by someone they know (likely a current partner or ex-partner). Partner violence is a major health risk factor for women. In 2015, for women aged 15 years and over, mental health conditions were the largest contributor to the disease burden due to domestic violence; these conditions included depressive disorders (43%), followed by anxiety disorders (30%), and suicide and self-inflicted injuries (19%).[31] In 2019, for women aged 15 years and over, intimate partner violence was the second leading contributor to the total burden of suicide, and this has remained consistent over time.[32]

Despite clear evidence of the intersection of mental health and FDSV, there has been limited coordinated effort in addressing the needs of women dealing with both mental ill health and FDSV. Known issues include a lack of coordination across the mental health and FDSV sectors, and a lack of evaluation and data on prevalence of co-occurring FDSV and mental ill health. These gaps reduce opportunities to intervene early across services.

National Plan to Reduce Violence Against Women and their Children 2010–2022

The National Plan to Reduce Violence Against Women and their Children 2010–2022 (National Plan) provides the main policy framework for reducing violence against women and their children in Australia, including a key focus on prevention. Despite this focus, the recent House of Representatives Standing Committee on Social Policy and Legal Affairs inquiry into FDSV found that the National Plan has not achieved its objective of a significant and sustained reduction in violence

against women and their children. The inquiry concluded that governments cannot eliminate FDSV alone and that a whole-of-society response is vital.

The inquiry provided an overview of the successes and shortcomings of the National Plan as noted by FDSV sector experts, who raised various issues:

- Despite development of the foundations for a bipartisan, cross-jurisdictional approach, cross-jurisdictional effort needs to be improved and strengthened to address gaps and harness opportunities for improvement.
- There is much that can be strengthened to provide increased coordination and consistency in working towards a national approach.
- The National Plan only includes 'vague measures of success', restricting the ability of governments to measure their performance against an accountability mechanism.
- Aspects of the implementation of the National Plan have been underfunded, thereby restricting implementation.
- The National Plan takes a broad community approach to violence. More of a targeted approach is required to address the needs of cohorts who are at greater risk of violence, including young women, Aboriginal and Torres Strait Islander women, women living in regional and remote communities, women living with disability, women experiencing financial hardship, pregnant women, women separating from their partners, women on temporary visas and older women.
- The National Plan's definition of violence against women is inherently limiting, problematic and outdated, and does not reflect contemporary understandings.
- The indicator for reducing the proportion of children exposed to domestic violence has focused on women, not children. The needs of children and young people in their own right should be better recognised.

The inquiry's final report made 88 recommendations, the breadth of which reflects the complexity of the issue and requires responses for future direction. Recommendations are grouped into 5 key themes for the next National Plan to focus on:

- a more uniform approach across jurisdictions that is more inclusive of the various manifestations of family violence, as well as the diversity of both victim–survivors and perpetrators
- engendering a culture of accountability and greater workforce support
- education for greater awareness and understanding of the many forms of FDSV, the causes and impacts of this violence, and the ways in which it can be prevented
- the welfare of victim–survivors and their children
- holding perpetrators to account for their use of violence.

Report on Australian women's mental health and wellbeing during the COVID-19 pandemic

In 2021, the Commission engaged the Centre for Women's Health Research at the University of Newcastle to provide a report on women's mental health during the COVID-19 pandemic. The research on which the report is based was conducted as part of the Australian Longitudinal Study on Women's Health at the University of Newcastle and the University of Queensland. The Commission is looking to conduct further analysis in this area and identify opportunities to look more broadly at mental health reform for women.

The research has made several initial findings:

- Existing poor mental health, poor general health, high stress, difficulty with income management, and a history of violence were risk factors for experiencing psychological distress during the pandemic. Optimism, social support and resilience protected against psychological distress.
- The data confirms that the pandemic acted like most other stressors in exacerbating existing or previous mental health issues.
- Those aged 25–31 years were most impacted by COVID-19. There is a concern for this age group regarding perinatal mental health, since this is the age at which women start having families in greater numbers.
- For a proportion of women, the pandemic created situations where they were vulnerable to abuse and violence from family, intimate partners and the general public, in places where they live, work and learn. This was particularly true for women with a history of experiencing violence, and essential workers.
- While the data suggests that telehealth is beneficial for some women, there were barriers to its use and the use of other services by women who lived with abuse. Based on these findings, it appears that the provision of telehealth is helpful for some women, but may also be seen as a barrier or undesirable option by other women, depending on their circumstances and requirements.

Telehealth is beneficial for some women but, for those living with abuse, there were barriers to its use and the use of other services.

Moving forward

For prevention and early intervention to be successful, prevention opportunities and community support capacity need to be strengthened, and barriers to accessing services must be addressed. This includes increasing help seeking and community capacity to assist people before they need community support or appropriate health services.

Efforts to strengthen existing health services are underway. We now need a strengthened whole-of-governments and whole-of-community approach to enable earlier intervention.

This will require:

- leadership and governance to drive a whole-of-governments approach, including
  - all governments continuing to shift to a whole-of-governments approach, with suicide prevention authorised by First Ministers and mechanisms to drive cross-portfolio action
  - implementation of the National Mental Health and Suicide Prevention Agreement, with strengthened and resourced regional arrangements for suicide prevention
- data and evidence-driven outcomes, including
  - development of a national outcomes framework for suicide prevention, using the foundations already built through the National Suicide and Self-Harm Monitoring System
- earlier response to distress, including
  - piloting of early distress interventions for people experiencing intimate relationship distress, employment or workplace distress, financial distress, or isolation and loneliness
  - implementation and evaluation of interventions that support people through transitions such as entering or being released from justice settings, leaving military service, finishing or

disengaging from education or vocational settings, entering retirement, and engaging with aged or supported care services.

Children's mental health and wellbeing must be a reform priority, with the current system described by experts as 'broken'. The optimal mental health system does not wait until a child is experiencing a mental illness before providing support, and the Children's Strategy provides the framework for this system.

Implementation of the Children's Strategy is underway, with a national Steering Committee set to be established in 2022. The Commission will continue to advocate for, advise on and fund activities that support the prioritisation of children's mental health and wellbeing, because we know that investing in our children is investing in our future.

Although there has been a strong focus and investment in women's health across a broad range of strategies, including beyond health- and violence-specific strategies, this has not translated into change on the ground for women. Foundations for a national focus and cross-jurisdictional work have been laid; however, the next National Plan will need to strengthen these efforts through considered coordination across the whole of society. FDSV and mental health are intersecting issues that require a joint response across both sectors. A critical opportunity exists for governments to consider how a strengthened partnership or collaboration across FDSV, mental health sectors and beyond could increase efforts towards reduction of both violence against women and their children and mental health issues. In terms of prevention and early intervention, this means an increased focus on early coordinated supports to prevent both violence and its impacts on mental health.

A coordinated approach will need to prioritise creating pathways to care and integrating services across various sectors, including drugs and alcohol, homelessness, unemployment, disability support, education and family welfare (as highlighted in the Commission's National Mental Health and Wellbeing Pandemic Response Plan). This will address limited capability across mental health and domestic violence services to effectively respond to both issues, which are often addressed in isolation—sometimes across multiple services. It will also promote a much-needed trauma-informed response where issues are addressed within the context of experiences of violence.

4 Accessibility

Key points

- Accessibility remains a key challenge for Australia's mental health and suicide prevention systems. For many Australians, the mental health and suicide prevention systems fail to provide safe, quality and effective care that is accessible to all.
- Barriers to access can be geographical, digital, financial, or fear of stigma and discrimination.
- The Our Stories—Beyond the Disaster project has helped us to understand mental health and wellbeing impacts of natural disasters as experienced by people on the ground.
- The National Disaster Mental Health and Wellbeing Framework is intended to guide improved coordination of mental health and wellbeing, and participative localised responses following disasters.
- The COVID-19 pandemic has accelerated demand for access to digital mental health services when social distancing and isolation measures have prevented access to face-to-face services. However, the evidence is not clear on whether digital service delivery is effective for people with severe mental illness or experiencing an immediate crisis.
- Developing a National e-Mental Health Strategy would help to ensure that appropriate, safe and quality digital and telehealth services are accessible for all. It would also be ideal if the National Safety and Quality Digital Mental Health Standards were made mandatory and legally enforceable.

Accessing and navigating the mental health and suicide prevention systems is a persistent issue for consumers and their carers and families, and was one of the most commonly raised concerns during the Commission's Vision 2030 consultation activities. Many Australians are unable to access mental health care when and where they need it.

"The thing I found most difficult was learning where the resources were and how to access them. I stumbled across the help we found for our daughter." Parent/carer of a child with mental illness, National Children's Mental Health and Wellbeing Strategy

At the service and systems level, accessibility can be a challenge due to workforce factors, the appropriateness of care being offered, a lack of ease when navigating the systems, and fear of experiencing stigma and discrimination when accessing services. When these factors are combined, we are left with systems that fail to provide safe, quality and effective care that is accessible to all.

At the individual level, stigma and discrimination around mental ill health remain a significant barrier to accessing care, and enjoying full economic and social participation. As recommended by the Productivity Commission Inquiry into Mental Health, the Commission is leading the development of the National Stigma and Discrimination Reduction Strategy, which will outline a vision for a society where all Australians can live long and contributing lives, free from stigma and discrimination.

"I have attempted suicide several times when events in my life triggered PTSD which is the result of trauma in my childhood. I experienced some extremely negative responses by health professionals treating me, including a nurse who said I deserved to die and a doctor who said to me 'look at how

much you're upsetting your mother'… I experienced attitudes that I was attention seeking and a general lack of understanding." Personal story, Private Voices study[28]

Geographical and financial factors can also be barriers to services for individuals. The Productivity Commission highlighted the need for structural changes to funding arrangements to drive service planning at a regional level as a strategy to overcome inequity in access to services in regional and remote areas. Recommendations were also made for future commissioning arrangements to strengthen funding across the stepped-care model, with increased investment in early intervention, psychosocial supports and community-based services to address the current imbalance of funding for primary and acute services.

Furthermore, the National Suicide Prevention Final Advice highlighted the need for families, children and young people to be supported to access services early to mitigate adverse childhood experiences. The Final Advice also noted that early access to services is a consideration for priority population groups to enable effective suicide prevention.

National Stigma and Discrimination Reduction Strategy

In 2021, the Commission began work on developing a National Stigma and Discrimination Reduction Strategy.

Eliminating stigma and discrimination on the basis of mental ill health is critical to removing barriers to people living long and contributing lives.

The strategy's focus and objectives are to:

- reduce self-stigma among those who experience mental ill health and those who support them
- reduce public stigma by changing attitudes and behaviours in the general community and among identified target audiences
- take steps towards eliminating structural stigma and discrimination towards those affected by mental ill health in identified settings.

The strategy is being developed alongside people with lived experience of mental ill health and people who have been directly affected by stigma, along with people with other forms of expertise across and beyond the health sector and broader community. A Steering Committee and series of Technical Advisory Groups to guide the development of the strategy have also been established.

In November 2021, a series of workshops were convened to learn from people with lived experience of mental ill health, trauma and distress; their families, friends, unpaid carers and support people; and other stakeholders across a wide range of sectors, and to explore innovative approaches to reduce stigma and discrimination. The insights from these workshops, and the commissioned research, will be used to develop the draft strategy. The strategy will be finalised by December 2022, following further public consultation.

Rural and remote communities

Typically, our regional and remote communities have lower rates of service provision and limited access to specialist psychological care. Often, people in these communities rely on visiting services or have to travel beyond the local area to access mental health support.

"Challenges of living as a young person in a remote/regional area: limited access to mental health support; job opportunities; costs of relocation and issues with living at home; drug use; loneliness; perceived misunderstanding; burdensomeness; lack of resources; parental capacity to support emotional and financial needs; (and) lack of sense of belonging." Personal story, Private Voices study[28]

For this reason, rural and remote communities have been identified as a priority population in Vision 2030. Vision 2030 emphasises that community-based care within rural and remote locations will need to consider ways to provide reliable, regular and local services that have relationships and trust within the community; this includes addressing the low rates of access of services.

Accessibility issues can be exacerbated for rural and remote communities during times of crisis or extreme stress, such as bushfires, floods and drought. This was evident throughout the Commission's Our Stories—Beyond the Disaster project. Used to inform the development of the National Disaster Mental Health and Wellbeing Framework, the project captured examples of lived experience from those who have been impacted by disasters. Struggling to access support services was identified as a significant stressor following disasters.

Accessibility issues can be exacerbated for rural and remote communities during times of crisis or extreme stress, such as bushfires, floods and drought.

People impacted by disasters spoke of multiple barriers to accessing support from services, including:

- not knowing what services are available
- having competing needs to manage
- being overwhelmed by the disaster-related workload
- perceiving services as unsuitable
- waitlists
- physical barriers to accessing services
- being unsure if they are eligible for support
- being worried that other people need the services more than they do.

The lived experience insights highlighted through the project have provided an understanding of the factors most helpful in relation to mental health and wellbeing support for people impacted by disasters. These include practical support; access to appropriate, flexible, supportive and consistent services; and feeling understood.

The way services are delivered (care, communication, flexibility) was noted as being just as important as what is delivered.

Digital mental health care and telehealth

Digital technologies are increasingly providing opportunities for affordable access to mental health and suicide prevention programs, services and treatment. The COVID-19 pandemic has accelerated demand for access to digital mental health services when social distancing and isolation measures have prevented access to face-to-face services.[33]

Australia is an international leader in the development of digital mental health programs, improving access to apps and programs that provide low-intensity treatment options for people experiencing

mental ill health, and increased community awareness of mental health. Many reputable Australian institutions and organisations now provide useful and effective online mental health treatment programs and information. This expansion of online mental health resources has broadened the range of programs available to include different mental health conditions, and specific and general populations.

The Commission views digital mental health care as being more than service delivery. Digital mental health care has a role to play in all aspects of mental health and wellbeing, including prevention (ranging from apps that educate about mindfulness to targeted approaches such as iBobbly, focusing on high-risk populations), research and data, assessment and screening, connection and navigation, as well as methods for planning care, informing policy and modelling. Digital mental health programs and services can educate the general community. They can also 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.[34]

Digital mental health is more than service delivery—it is a way of approaching all aspects of mental health and wellbeing.

The Productivity Commission Inquiry into Mental Health has recommended, as a priority, the development of a national digital mental health platform, to be co-designed with consumers and clinicians, as a way of providing easy access to holistic mental health assessment and digital low-intensity services across Australia. Subsequently, the creation of a single digital platform under the existing Head to Health website was announced under the Australian Government's 2021–22 Budget. Although this is a positive step, the Productivity Commission inquiry has noted the need for further development and improvement of the Head to Health website for it to be suitable as a national digital mental health platform, including expanding the range of services currently listed.

Addressing barriers

Despite the potential of digital services to increase accessibility to mental health services and supports, several barriers to access remain. These include limited access to the internet and telecommunications, especially in regional and remote areas; the need for appropriate matching of services to need; and privacy concerns for some population groups (for example, older people, people from low socio-economic backgrounds).

Although there have been promising results from digital mental health services—enabling equal outcomes for specific populations such as Aboriginal and Torres Strait Islander people,[35] non-English-speaking migrants[36] and older cohorts[37]—there will need to be a continued focus on ensuring that digital services meet the needs of different demographics, and are culturally inclusive and safe. This reinforces the importance of co-design in planning and delivery of digital mental health services.

In addition, the appropriateness of digital mental health services for some population groups and for certain treatments and interventions has yet to be thoroughly explored. For example, the safety of digital service delivery for women and children experiencing family and domestic violence may sometimes be compromised because practitioners are not always able to assess whether the individual is the only person present during a virtual session. Furthermore, whereas digital mental health services are thought to be particularly effective for those experiencing anxiety and depression,[38] the evidence is less clear for severe mental illness or for people experiencing an immediate crisis. The Commission recognises the need for further exploration of these issues, as well as collaboration, coordination and integration in digital mental health to harness the potential of digital mechanisms of service delivery.

There is also a need to better integrate the delivery of digital services with face-to-face contact and to improve workforce capacity to use digital modes of delivery.

Key factors in technology adoption

Research funded by the Commission and conducted by Deloitte examined the key factors that affect the effective adoption and use of disruptive technologies (see the glossary for a definition) to support Vision 2030 project outcomes. Key findings of the project included the following:

- Mental health is a growing priority—this is a significant Australian and global trend, requiring greater funding and focus, including the use of disruptive technologies, in both the public and private sectors.
- No single view has emerged on what constitutes best practice in this field. However, many lessons are being learned, and evidence-based solutions are being defined. The global experience and growing capability can potentially be leveraged in the Australian context. Australia has an opportunity to take a global leadership role in this important field.
- The countries leading globally in their approach to digital mental health care have similar key factors and considerations in their approaches. These include integrated and person-centred models of care, privacy and security, equitable access, prevention and early intervention, and data-driven approaches.
- The market is outpacing government in innovation. This has led to varying degrees of disruption that governments have had to respond to (for example, entry of new technologies or providers into the digital mental health market).
- To enable successful adoption of disruptive digital technology, several priorities need to be addressed. These include interoperability[h] and standards, person-centric models, trust and privacy, co-design, equitable access, and legislative and regulatory reform.

Moving forward

A range of efforts are needed to improve accessibility of services, especially for at-risk populations and during times of crisis. This does not just mean increasing the number of services, but ensuring that services are appropriate and connected, and that innovative methods are used to reduce barriers to services.

The National Stigma and Discrimination Reduction Strategy will be finalised by December 2022, and will identify ways to reduce barriers to service and participation for people with lived experience of mental ill health.

Our Stories—Beyond the Disaster has provided insights into the range of complex and intersecting challenges people may face after a disaster, including accessibility. The project has demonstrated the need for highly connected, flexible, proactive, context-appropriate service systems to reduce adverse impacts on mental health and wellbeing after disasters.

We need connected, flexible, proactive, context-appropriate service systems to reduce adverse impacts on mental health and wellbeing after disasters.

In line with these findings, the National Disaster Mental Health and Wellbeing Framework, is intended to guide improved coordination arrangements for mental health and wellbeing, and participative localised responses following disasters. Importantly, work in this area needs to be

[h] A National Healthcare Interoperability Plan is currently in development, led by the Australian Digital Health Agency in partnership with the states and territories.

progressed between the occurrence of disasters so that arrangements are in place when most needed; this means that implementation of the framework needs to be immediate. The increasing frequency of disasters provides an opportunity to monitor the use of the framework.

As digital and telehealth programs and service delivery continue to rapidly expand, it is increasingly important that key opportunities are harnessed to increase the reach of support, and raise awareness about mental health and suicide prevention. Equally, emerging issues will need to be addressed to ensure that appropriate, safe and high-quality digital and telehealth services are accessible for all. Initial priorities in this area should include:

- actions to bridge inequity gaps in access to the internet and telecommunications, including digital literacy (for example, free provision of iPads for all school students and aged care residents); people in remote and very remote locations, and people without access to adequate platforms or data are more likely to experience digital inequity
- additional guidance on how to best integrate digital service delivery with face-to-face service delivery
- ensuring that the workforce is equipped to work with digital mediums
- continued research and evaluation to maximise the effectiveness and appropriateness of digital mental health apps, programs and services, including specific services and modes of delivery, for the general population and different cohorts; this includes consideration of user experience and impact on mental health outcomes
- further examination of issues around privacy and trust.

The Commission's National Report 2020 recommended the development of a National e-Mental Health Strategy following the release of the National Digital Mental Health Framework, which would address many of these priorities. In addition, the Commission would like to see the National Safety and Quality Digital Mental Health Standards that were developed in 2020 made mandatory and legally enforceable.

The National Safety and Quality Digital Mental Health Standards aim to improve the quality of digital mental health services and protect service users from harm.

5 Integrated and coordinated care

Key points

- Disconnected and fragmented care means that some people are falling between the cracks of the mental health and suicide prevention systems, unable to access services to meet their needs before a crisis occurs.
- To deliver better-integrated and coordinated care, reform is needed at the regional and local levels. Primary Health Networks and Local Hospital Networks provide core regional architecture and leadership to make this happen.
- Hub-and-spoke models of integrated care could be used to support a broader statewide or territory-wide network connecting mental health and wellbeing services.
- The Initial Assessment and Referral decision support tool helps to ensure that people accessing care are directed to the service that meets their needs.
- Mental and physical ill health are often linked, and the years of life lost as a result of physical conditions for people with mental illness may be increasing. Better links between mental and physical health services are needed to provide people with complete support.

In line with the Productivity Commission Inquiry into Mental Health, integration refers to individuals and organisations in different areas and sectors working together, and aligning their practices and policies to deliver high-quality mental health care and achieve good outcomes. From the point of view of the consumer, integrated care means person-centred care that accommodates individual needs, access to the services people need when they need them, and continuity of care, based on effective information flows between clinicians and other services. Coordination refers to different entities or providers working together to ensure that a consumer receives all the different types of care they need in an organised and efficient manner.[22]

Some problems continue in the delivery of integrated and coordinated care, including the need to more clearly define their meaning and scope in order to successfully measure impact at individual and system levels. In addition, people are required to self-navigate complicated systems at a time when they are often already struggling. Planning is not always person led, and services may be poorly connected. The lack of coordination means that people are falling between the cracks of the mental health and suicide prevention systems, unable to access services to meet their needs before a crisis occurs.

"Being suicidal is exhausting and all-consuming. Most of the time, those who are suicidal are also trying to keep their and their family's day-to-day life afloat. Expectations on us to reach out, follow up, navigate siloed services and systems, chase referrals, do extra or self-advocate are completely unrealistic." Statement from lived experience contributors at the Black Dog Institute[28]

The Productivity Commission noted the need for better coordination of care as a cornerstone of the person-centred mental health and suicide prevention systems. This requires improved information sharing and coordination between service providers, leading to improved outcomes for a person's recovery, particularly for people accessing multiple services. The Productivity Commission recommended an overhaul of institutional arrangements and funding mechanisms to address the current fragmented approaches to planning and funding of service delivery.

To deliver better-integrated and coordinated care, reform is needed at the regional and local levels. Primary care continues to play a key role as the first point of contact for most people seeking assistance for mental or physical health concerns. General practitioners (GPs) are the gatekeepers to services for many people with mental healthcare needs, including physical health services, addiction supports and referral to multidisciplinary care.

Coordination between primary care and state-funded secondary and tertiary services is vital to deliver better pathways to care and support a system that delivers better outcomes.

The National Suicide Prevention Final Advice (NSPA Final Advice) also reinforced the need for improved coordination to achieve effective suicide prevention. Its recommendations include the need to coordinate care across service providers and sectors to effectively intervene earlier when people are in distress, and to connect and deliver support for people across settings and in a way that meets diverse individual needs.

Integration and coordination at individual and system levels

Integration and coordination are important at both the individual and system levels to address the problem of fragmentation that has been identified so often in consultations with people with lived experience.

At an individual level, this means experiencing a care pathway that coordinates the links between services across mental and physical health and other sector services, and offers a multidisciplinary team approach.

"Optimal child health includes all elements of physical health, mental health and family mental health and support." Parent/carer of a child with mental illness, National Children's Mental Health and Wellbeing Strategy

At a systems level, integration of care across services is vital to develop care pathways that support person-centred care, and enable ease of referral, information sharing and connection to other needed services. This requires that all aspects of the systems are working together seamlessly, within and across sectors in and beyond health. Vision 2030 notes that integrated approaches emphasise the intersection of mental health with other co-occurring health and social issues.

The Royal Commission into Victoria's Mental Health System (Victorian Royal Commission) and the Productivity Commission Inquiry into Mental Health identified that reforms are required to make the mental health system easier to navigate and to improve consumers' access to services.

There is a shared responsibility across the service system to provide coordinated care regardless of the entry point.

The Productivity Commission has recommended that people with moderate or severe mental illness and multiple service providers should have a single care plan, and that people with severe and persistent mental illness and other complex needs require a care coordinator in addition to a single care plan to achieve coordinated care.

Initial Assessment and Referral decision support tool

An important area of reform in primary care has been further development of a consistent evidence-based approach to assessing consumer needs to help people to access the most appropriate services.

The Initial Assessment and Referral decision support tool aims to ensure that the person asking for help is directed to the most appropriate level of care from their first entry into the systems, reducing the number of times that a consumer has to tell their story.

Primary Health Networks (PHNs) are increasingly adopting the Initial Assessment and Referral decision support tool as part of a more targeted and tailored approach to identifying appropriate regional supports (see case study 2).

Case study 2: Examples of collaboration and care coordination using the Initial Assessment and Referral support tool

Tasmania Primary Health Network

Primary Health Tasmania is working closely with the Tasmanian Health Service and other key stakeholders to implement the Initial Assessment and Referral decision support tool (IAR-DST). The implementation approach includes a commitment by the Tasmanian Department of Health to use the IAR-DST when a person referred to specialist and acute services is triaged as not requiring that level of intervention—answering the question: "if not us, then who?" This is part of the regional commitment to ensuring facilitated and proactive referrals to other service options for people seeking mental health supports.

Country South Australia Primary Health Network

In partnership with three headspace centres and Orygen, Country South Australia Primary Health Network (PHN) piloted the use of the IAR-DST within headspace settings. Team members reported increased time-based efficiency with practice and experience. They found that the IAR-DST would require about 15 minutes additional work for young people with significant complexity in their needs, and less if the young person's experiences were more straightforward. The centres decided to continue to use the IAR-DST beyond the trial period.

Adelaide Primary Health Network—efforts in the northern region

In the northern region of the Adelaide PHN, the North Adelaide Local Hospital Network has worked closely with the Adelaide PHN–commissioned mental health services to implement an integrated practice unit, where all referrals for mental health services for young people are reviewed using the same standard criteria and the IAR-DST. Partners work together with the young person to determine the most appropriate level of care.

Integration of physical and mental health services

Although there have been advances in research and health care, physical health outcomes have not changed for those with mental illness; 80% of people living with mental illness also have a serious physical condition,[67] and the years of life lost as a result of physical conditions for people with mental illness may be increasing.[68] This makes the provision of integrated physical health and mental health services a high priority, requiring continued cross-jurisdictional commitment.

Equally Well

Equally Well was developed by the Commission to promote and advocate for the integration of physical and mental health care, and initiatives are continuing to grow across Australia and internationally. Australia is working in partnership with New Zealand and the United Kingdom, with webinars used in 2021 to gather experts to discuss key issues and share learnings (see case study 3).

The Equally Well Consensus Statement has now been adopted by more than 90 organisations, peak bodies and professional colleges. It has facilitated a

national, cross-sector collective to focus on improving the physical health of people living with mental illness.

The Productivity Commission Inquiry into Mental Health recommended that clear pathways towards achieving Equally Well initiatives should be implemented.[39] Targeted initiatives are underway: the Commission co-funded the Equally Well Healthtalk Project alongside the New South Wales Mental Health Commission and the Victorian Department of Health and Human Services in 2020. This project is managed by RMIT University to develop online resources that will share the stories of people with lived experience of mental and physical health issues. Equally Well is also collaborating with the Mitchell Institute for Education and Health Policy at Victoria University to develop evidence-based policy proposals and actions. To further facilitate collaboration, communities of practice have been established nationally, covering 3 areas of expertise: PHNs, older people, and policy advisers and analysts. The Australian Government provided funding in the 2021-22 Budget of $1.9 million over three years from 2021-22 to 2023-24 for Equally Well.

Multiple factors may contribute to the poorer physical health experienced by people with mental illness. The Commission is currently exploring the social determinants of mental health to inform future priorities. This work is critical, as some research indicates that social determinants play a greater role in influencing health than either health care or individual health behaviours.[40] This emphasises the importance of integration, as everyone's health and wellbeing is affected by their environment, and degree of access to supports and services.

Case study 3: Equally Well webinar—Getting the most out of your GP visit

A webinar held in April 2021 focused on how general practitioners (GPs) can play a role in the integration of care and discussed issues with the current care approach. This included GPs being asked to give referrals but not being included in results, and how a reliance on specialists can encourage a siloed approach. The webinar noted that, because GPs see people on a more regular basis than specialists, they can build a relationship that facilitates assessment of health and wellbeing issues by considering a person's whole history. The webinar highlighted principles for integrating physical and mental health care, such as the need for adequate training that is accessible for providers when they need it.

Head to Health centres and other hub-and-spoke models of integrated care

Vision 2030 highlights the importance of easy-to-access, multidisciplinary models of care in providing integrated services. Centre-based hub-and-spoke models of care are one such model of supporting joined-up approaches to meeting mental health needs.

The Head to Health centres and satellites expanded through the 2020–21 Budget commitment seek to deliver an integrated, person-centred model of care, delivered through a service hub that offers individualised assessment, multidisciplinary care, and 'warm referrals'—that is, where the referrer speaks directly to the service and introduces the person they are referring. The first 8 pilot Head to Health centres were developed in each state and territory, and commenced operation in early 2022.

These centres are similar in intent to the Victorian HeadtoHelp COVID clinics implemented in 2020, which demonstrated how a community-based service hub could complement and support existing services to better meet the needs of people with higher-intensity needs who could potentially fall through the gap between primary and secondary mental health care. The Victorian Royal Commission proposed implementation of new hub-based models of care to provide support to a broader statewide network of local mental health and wellbeing services. The new system divides services across aged-based systems, separating the needs of infants, children and youth from adults and older adults. It proposes integrated approaches to engaging primary care and tertiary services in

meeting the needs of groups for whom there is joint responsibility, including the 'missing middle', and children and youth.

These centre-based integrated models of care also offer potential for offering outreach support to a network of linked services, including specialised services targeting particular needs.

A one-size-fits-all model is unlikely to be practical or allow for regional variation. Hubs will need to be designed and implemented in a way that navigates system and service delivery risks. This includes avoiding duplication of existing services, roles or target groups; considering innovative ways to deliver services in areas where there are limited services or 'spokes' to refer to (for example, in rural and remote areas); and ensuring that governance arrangements support integrated primary and secondary services, or multi-agency planning and pathways.

These risks can be mitigated at the national level through agreements and policy; development of key resources and tools to support appropriate referral, integration and pathways at a regional level; and funding for establishment or redevelopment of existing services. These measures will be key in ensuring that such hub-and-spoke models of care achieve truly integrated and coordinated care.

Mental health reform at the regional level

Stakeholders within the mental health system need to work together to ensure that people do not fall through gaps across the service continuum, or across sectors within and beyond health. Service integration and reform happens at a local level, and this requires:

- better local navigation and care pathways
- improvements in information sharing
- improved regional service planning and coordination.

Key regional commissioning agencies—PHNs and Local Hospital Networks (LHNs)—provide the core regional architecture and leadership to support planning, implementation and delivery of better-integrated services.

The Productivity Commission Inquiry into Mental Health noted a need for an increased level of cooperation between PHNs and LHNs. The Productivity Commission also highlighted the importance of engagement of people with lived experience, Aboriginal and Torres Strait Islander health services, community-managed organisations, GPs, private sector providers, and broader cross-sectoral services in regional planning and service delivery to deliver improved mental health outcomes. The Victorian Royal Commission noted opportunities for better alignment between the primary care and secondary care systems to enable integrated local services offering person-centred care, and proposed new coordination arrangements at a local level, including Regional Mental Health and Wellbeing Boards.

The Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan), released in 2017, signalled a shift in the role for national reform towards setting an enabling environment for regional action, instead of dictating change from the top down. The first action within the first priority in the Fifth Plan required development and public release of joint regional mental health and suicide prevention plans progressively from December 2017.

A number of joint regional plans have been built on extensive community and stakeholder consultation and an analysis of population need. They have offered new models of coordinating care and making optimal use of the workforce and resources appropriate to local needs.

Through regional planning, some PHNs have sought to develop new models of integrated care to address complex needs with their LHN partners, linking primary care to secondary and tertiary care. These models include jointly providing services in areas of limited workforce, and targeting the needs of individuals with comorbid substance use or disabilities (for example, Brisbane North PHN's integrated service for people with severe and complex mental illness).

Moving forward

Continuing reform is needed to ensure that individuals have access to joined-up service pathways, and that services work together to provide integrated and coordinated care. Although services play a role in achieving this, they need to be supported by systems and structures that encourage integrated and coordinated care as the standard—not just an ideal—for delivering services. Further work is required to consider what this looks like for different services and contexts, as well as the funding models required to support integrated and coordinated care.

There have been promising developments to address service fragmentation, and to plan and provide better-targeted and integrated care at a regional level through primary care. This includes continuing efforts to develop joint regional mental health and suicide prevention plans, to integrate care of people with severe mental illness, and to introduce a consistent approach to assessing and referring consumer needs through the Initial Assessment and Referral decision support tool. LHNs and PHNs will need to be strongly encouraged and supported to work together to deliver on reforms through the provision of clear government mandates for joint planning, and tools, data and resources to support integrated service systems. Documentation of learning and progress on new initiatives will be vital to build the evidence base and inform an expansion of integrated and coordinated care.

To contribute to improving integrated and coordinated care, the Commission will continue to:

- work on Vision 2030, with a focus on finalising the Blueprint for Mental Health and Suicide Prevention and accompanying opportunities for implementation
- participate in the Equally Well Alliance and on the Project Reference Group for implementation of Equally Well
- contribute to reforms noted in the 2021-22 National Mental Health and Suicide Prevention Plan, such as
  - establishment of the National Suicide Prevention Office, which will implement changes recommended in the NSPA Final Advice (including the need for improved coordination of care across service providers and sectors)
  - collaboration on setting targets and indicators for integrated care as crucial to any outcomes framework
  - other key national work, including responses to the COVID-19 pandemic and natural disasters.

6 Lived experience participation

Key points

- Partnership with people with lived experience in mental health and suicide prevention to support co-design, co-production and co-delivery of systems and services is vital.
- The input of people with lived experience input can be used to ensure that a service is meaningful, safe, respectful and accessible.
- The input of people with lived experience has helped shape the advice and recommendations of several national and state inquiries and reports.
- A thriving mental health lived experience (peer) workforce is vital for quality, recovery-focused mental health services. The *National Lived Experience (Peer) Workforce Development Guidelines* have been developed to encourage and support the growth of this workforce.
- The Commission will be overseeing the co-design process for a National Lived Experience (Peer) Workforce Professional Network to boost professional collaboration.
- Peak body arrangements are currently being scoped, which will address a key ongoing gap in reform: the availability of a resourced and coordinated national voice for consumers and carers to inform reform efforts.

Partnership with people with lived experience in mental health and suicide prevention—through co-design, co-production and co-delivery of systems and services—lead to better health and wellbeing outcomes, aid recovery, and achieve better experiences for service users and service providers.[41] An optimal mental health system is one that focuses on listening to people with lived experience and acting on their insights; services designed in conjunction with lived experience add significant value to design and implementation of services and systems.[22]

Partnership with lived experience is one of the overarching principles of Vision 2030. This means the integration of qualitative experiential insights from people with lived experience, their families and other support people at all levels of development and delivery of policy and services. It also includes the integration of lived experience in the mental health workforce.

People with lived experience, and their families and carers, have contributed significantly to the mental health and suicide prevention service reform process.

Lived experience engagement and partnership

The importance of lived experience was embedded in the National Suicide Prevention Final Advice (NSPA Final Advice), the Productivity Commission Inquiry into Mental Health and the Royal Commission into Victoria's Mental Health System (Victorian Royal Commission). Lived experience feedback, participation and coordination also helped shape the NSPA Final Advice, which found that success will only come when governments, communities and stakeholders work closely with people who have lived experience—all levels of suicide policy and service development should be co-designed with those who have lived experience.[28]

The Victorian Royal Commission noted that some of its most powerful contributions were from people with lived experience and led to recommendations that are a first for Victoria, such as setting up initiatives led by people with lived experience of mental illness or psychological distress and establishing lived experience leaders throughout the system.[42]

The Victorian Royal Commission also noted that the perspectives and experiences of people with lived experience of mental illness or psychological distress, as well as their families, carers and supporters are often overlooked and left out of decision making and engagement. Recommendations from the Victorian Royal Commission included that supporting consumers to exercise their rights should be a priority.

The Productivity Commission highlighted the need to increase consumer, family and carer participation and advocacy in all aspects of the mental health system, including strengthening systemic advocacy. It made recommendations about how people with lived experience in mental health and suicide prevention can be involved in reform, including through involvement in planning and delivery of services, mental health and wellbeing programs, and information campaigns, and reinforced the importance of co-design. Recommendations to facilitate this centred on instilling incentives and accountability for improved outcomes in the system; the recommendations included strengthening evaluation culture, focusing on outcomes that matter to people and reporting at service provider level.

In February 2021, the Commission launched the *Mental Health Safety and Quality Engagement Guide* under the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) to strengthen the role of consumers and carers in safety and quality initiatives. The guide was developed in consultation with the National Mental Health Consumer and Carer Forum, and the Safety and Quality Partnership Standing Committee. Following the launch, an interactive webinar was held for consumers and carers to discuss the guide.

The Commission, in collaboration with the Australian Institute of Health and Welfare, has ensured that the development of the National Suicide and Self-Harm Monitoring System (NSSHMS) has been informed by people with lived experience of suicide (see National Suicide and Self-Harm Monitoring System). This includes lived experience representation on the Expert Advisory Group, which has provided advice on the development of the system since its conception. The Commission also established a lived experience working group to ensure that people with lived experience of suicide were connected with the monitoring system and able to participate in project activities.

Input and advice from people with lived experience have aided the development of the NSSHMS website. The monitoring system will continue to seek lived experience input to inform ongoing development and continuous improvement—for example, for all new data releases, and development of the Analyst Portal of the NSSHMS.

The Commission has created a senior designated lived experience role to ensure that lived experience can better inform and shape the agenda of the Commission's work. The role will be responsible for ensuring that the Commission's work benefits from a diverse range of lived experience perspectives, including the full breadth of mental illnesses, stages of recovery and population groups.

People with lived experience of suicide are also included in media and sector briefings for data updates and releases, and the Commission encourages media to report the stories of people with lived experience to enhance the use of the statistics.

Lived experience (peer) workforce

Lived experience workers play an important role in building recovery-oriented approaches to care through systemic advocacy, providing meaningful, non-clinical support to people with similar lived experience and modelling hope for recovery. The Fifth Plan, Productivity Commission Inquiry into Mental Health and Victorian Royal Commission emphasise that peer work is an essential part of

quality mental health systems and supports, and particularly important in supporting a recovery approach.

> *"Lived expertise means that I have expertise that comes from lived experience, but I am also drawing on theory and literature that is developed and written in this field – many people have lived experience that they don't use in their work."* Lived Experience contributor to the development of the National Lived Experience (Peer) Workforce Development Guidelines

The Fifth Plan is clear that the mental health workforce is in need of growth and development, including options to collaborate and network nationally (case study 4 provides an overview of the progression of lived experience roles). The Productivity Commission noted the need to support the growth and development of this workforce.

The *National Lived Experience (Peer) Workforce Development Guidelines*, led by the Commission, are the result of extensive consultation and a co-production process to ensure that national standards for development of the lived experience workforce are grounded in lived expertise. The guidelines were published in December 2021 as a suite of documents that will be updated as the lived experience workforce grows, and our shared knowledge and understanding of this essential work deepens. The first documents released were the guidelines, a roadmap for ongoing collaboration, and a summary of the feedback that informed the guidelines.

The guidelines aim to support the delivery of a larger lived experience workforce, by providing employers and sector leaders with a guide to understanding the principles of lived experience (peer) work and the value it can add to quality, recovery-focused mental health services across diverse settings.

Success of the guidelines depends on their being adopted by workplaces, and a continued cultural shift towards genuine recognition of lived experience as valuable and essential.

An increased lived experience workforce will benefit both service providers, consumers and carers and communities, because products and services will be more effective and better designed to meet the needs of service users. Additionally, peer-based supports will be more available for consumers who have needs that are not met through traditional clinical approaches.

In line with the Australian Government's National Mental Health and Suicide Prevention Plan, the Commission has responsibility for developing a model for a national lived experience worker network.

Case study 4: The progression of lived experience roles

In 2016, Brisbane North Primary Health Network (PHN) advertised a 6-month Peer Participation Project Officer position. This was the first time that a position in Australia required a lived experience of mental health issues and recovery. In 2017, a National PHN Stepped Care Workshop identified 2 key priorities: consumer and carer engagement, and lived experience workforce development. This resulted in the Australian Government Department of Health funding the national PHN Mental Health Lived Experience Engagement Network (MHLEEN) for 1 year. In 2019, the Australian Government Department of Health released guidelines for PHNs for peer workforce development.

As a result of this interest in growing the lived experience and peer workforce, there has been an increase in peer-run organisations (for example, Peach Tree Perinatal Wellness, the Lived Experience Telephone Support Service). The number of peer workers at the front line has also increased, and

people with lived experience are being employed on tender assessment panels and interview panels. People with lived experience are increasingly involved in facilitating focus groups and leading training in academic settings.

Over the past few years, there has been a noticeable improvement in, and alignment of, lived experience position descriptions, mostly due to lived experience workforce frameworks. In 2020, MHLEEN undertook a stocktake to assess progress by PHNs and commissioned services since 2018. It found that there was an increase in the number of PHNs that used lived experience workers in areas such as suicide prevention, alcohol and other drugs, and psychological therapies. There was also an increase in the number of PHNs that had people with lived experience involved in research and peer work, and on tender assessment panels. Increases were also evident in PHNs that had key performance indicators around lived experience in their reporting requirements.

Despite a general growth in peer workers in public mental health services, the number of peer workers varies from region to region. Many state and territory health departments do not have identified lived experience positions; however, Victoria is beginning to address this. Furthermore, not all states and territories have active lived experience peak bodies, and there is no clearly mandated national peak body. This has resulted in system fragmentation, a lack of agreed standards and varied levels of capacity building.

Source: Input provided by the National PHN Mental Health Lived Experience Engagement Network

A national peak body

A key ongoing gap in reform has been the availability of a resourced and coordinated national voice for consumers and carers to inform reform efforts. This was highlighted by the Productivity Commission Inquiry into Mental Health, which recommended establishment of a national peak organisation. An important step towards this was the 2021–22 Budget announcement of a $300,000 commitment to work with mental health stakeholders to investigate and co-design future national peak body arrangements, to provide consumers and carers with a greater say in the future of the mental health systems.[43]

The Commission has been tasked with scoping these peak body arrangements. It will be vital for the scoping process to draw on information gleaned from previous efforts and momentum gained over the years to establish a national body representing the views of people with lived experience of mental illness. It will also be vital to draw on the views and expertise of state peak bodies and existing consultative forums representing lived experience of mental illness, together with input from other stakeholders in the mental health sector.

Moving forward

The voices of lived experience have laid the groundwork for fostering genuine engagement and participation, offering invaluable insights, time and effort.

However, greater efforts are now required across the mental health and suicide prevention system to bolster these efforts and act on the recommendations for system reform from lived experience advocates.

The Commission will continue to engage and partner with people with lived experience—for example, in the NSSHMS and to inform the National Stigma and Discrimination Reduction Strategy (see National Stigma and Discrimination Reduction Strategy).

Future Commission work in this area will include encouraging uptake of the *National Lived Experience (Peer) Workforce Development Guidelines*, and progressing work to create a model for a national lived experience worker network to boost professional collaboration, and to investigate and

co-design future national peak body arrangements. This will be crucial in strengthening lived experience participation in the design and delivery of mental health services and ultimately outcomes for consumers and carers.

7 Workplaces and the workforce

Key points

- Workplaces can promote mental health and intervene earlier in suicidal distress, but more clarity, information and support are required to enable employers to meet this duty of care.
- Several jurisdictional, organisational and industry-led initiatives have been developed to support mentally healthy workplaces. Some legislative and regulatory requirements have also been clarified; however, organisations are grappling with a complex and evolving legislative and regulatory environment.
- The Commission and the Mentally Healthy Workplace Alliance are leading the development of a nationally consistent approach to align initiatives, so that organisations have a comprehensive and holistic suite of supports.
- The current mental health workforce does not have the capacity to deliver quality mental health services to diverse communities. Adequately addressing workforce issues underpins the success of the mental health reform agenda.
- The National Mental Health Workforce Strategy will be a critical mechanism for mental health reform in this area.

Workplaces have been identified as prime avenues to support and promote mental health and intervene earlier in suicidal distress, including by the Productivity Commission Inquiry into Mental Health, the Royal Commission into Victoria's Mental Health System (Victorian Royal Commission) and the National Suicide Prevention Final Advice (NSPA Final Advice).[22,42,44] This spotlight on workplaces intensified in the first half of 2021 as organisations responded to the challenges posed by the COVID-19 pandemic, such as supporting remote teams or workers providing essential services.

Issues including a lack of capacity, training quality and availability, a complex legislative environment and diverse needs continue to challenge organisational efforts.

Reforms in relation to the mental health workforce have been slow to progress, despite being an essential foundation for achieving an effective, connected and well-functioning mental health and suicide prevention systems. It will be vital to ensure that the National Mental Health Workforce Strategy and the National Suicide Prevention Workforce Strategy adequately address ongoing issues. Furthermore, the development of an implementation plan following the completion of the National Mental Health Workforce Strategy will be essential to ensure that the strategy is operationalised as intended.

Mentally healthy workplaces

Although awareness of mentally healthy workplaces has increased, a lack of clarity around what actions to take or where to find support continues to challenge many organisations. Even where organisations have legislated responsibilities, such as addressing work-based risks to psychological health, there is confusion about how organisations can achieve this.[22] Organisations often struggle to find information about evidence-informed practices for creating mentally healthy workplaces. The Productivity Commission and Victorian Royal Commission both noted the limited evidence in this area, echoing earlier reviews.[45]

The diversity of workplaces across industries, business sizes and locations means that organisations often struggle to find support that meets their specific needs.

For example, a third of small business owners have reported a diagnosis of either stress, anxiety or depression in the previous 12 months,[46] and often report difficulty prioritising mental health or finding suitable support.

There are diverse needs across different industries, arising from their distinct types and locations of work, and workforce demographics. The Productivity Commission noted construction, transport and emergency services as industries with a higher risk profile for mental ill health.[22] Often, mental health risks inherent to an industry, such as isolated work or frequent customer aggression, are challenging for an individual organisation to address. The Victorian Royal Commission recommended engaging industry stakeholders to address barriers to mentally healthy workplaces in industry contexts.[42]

Some business models or organisational structures have emerged as additional challenges for mentally healthy workplaces. For example, billable hours targets or pressures to generate returns for shareholders can create pressure to work unreasonable hours. Similarly, insecure work arrangements such as casual contracts or gig work can negatively impact mental health.[47] There has been increasing discussion about the 'right to disconnect' from work, with concerns that technology can create pressure for some workers to be constantly available.

Organisations are also grappling with a complex and evolving legislative and regulatory environment, which varies across jurisdictions. Numerous pieces of Commonwealth and state and territory legislation relate to mentally healthy workplaces, including legislation relating to work health and safety (WHS), workers compensation, antidiscrimination, privacy and workplace relations.

There are also challenges in identifying optimum approaches to legislating and regulating complex constructs such as psychological risk. The Centre for Future Work observed that workers' representatives, regulators and inspectors did not have sufficient tools to ensure that organisations were meeting their legislated responsibilities.[48]

Key mentally healthy workplace reforms and activities

A growing range of initiatives and services are being led by jurisdictions and industries. The Commission and the Mentally Healthy Workplace Alliance are working to align these activities into a nationally consistent approach through the National Workplace Initiative. A digital platform and the Blueprint for Mentally Healthy Workplaces are among the key initial activities of the National Workplace Initiative (see National Workplace Initiative).

The Commission expects that this coordinated national approach will be paramount to helping realise the policy aspirations for workplaces as avenues of mental health promotion. The Commission anticipates an increasing focus on the complex legislative environment and its impacts on organisations' efforts to create mentally healthy workplaces. Further, there will likely be greater focus on how to effectively create and manage flexible and hybrid work environments that support team cohesion and equitable opportunity, and the potential for optimal work design that benefits the individual and organisation.

Many jurisdictions are investing in building awareness and capability to create mentally healthy work environments. For example, the New South Wales Government is undertaking a range of activities through the New South Wales Mentally Healthy Workplaces Strategy, including awareness raising, training and employer coaching.[49]

Similarly, the WorkWell program by WorkSafe Victoria and the Victorian Department of Health and Human Services enables organisations to gather materials such as resources, templates and case studies.[50]

There have also been some efforts to create clarity around legislative and regulatory requirements. In May 2021, a majority of Australian Government and state and territory WHS ministers agreed to amend the model WHS regulations to deal with psychological injury.[51] An earlier review[52] had recommended this change to provide clarity about regulatory obligations around psychological health.

In addition, several jurisdictions are developing codes of practice to provide guidance to organisations. In May 2021, New South Wales released its *Code of Practice: Managing Psychosocial Hazards at Work*,[53] and Safe Work Australia is also developing a model code of practice on psychological health.

The Australian Government recommended changes to the *Fair Work Act 2009* and WHS regulations among measures to prevent and respond to sexual harassment in the workplace under its *Roadmap for Respect: Preventing and Addressing Sexual Harassment in Australian Workplaces*, released in April 2021.[54]

New services and programs to help organisations with specific needs have been released.

In March 2021, Beyond Blue launched its NewAccess for Small Business Owners coaching service (see case study 5).[55] Deakin University is delivering its Counting on U program for small business advisers with national accountancy and mental health bodies. Additionally, Everymind's Ahead for Business digital hub released further resources for small businesses in 2021 following additional Australian Government funding.

Case study 5: NewAccess for Small Business Owners

NewAccess for Small Business Owners is a free mental health program to support small business owners, developed by Beyond Blue and delivered by coaches from a small business background.

The coaches, trained in low-intensity cognitive behavioural therapy, guide small business owners through a tailored 6-week program. The program for small businesses is based on Beyond Blue's general NewAccess program, which has a recovery rate of 70% and has been operating since a pilot commenced in 2013.

There has been a significant increase in industry-led initiatives to support mentally healthy workplaces. For instance, the Healthy Heads in Trucks and Sheds industry-led initiative released its National Mental Health and Wellbeing Roadmap for the transport, warehousing and logistics industries,[56] and the Australian Resources and Energy Group (AMMA) released its Resources and Energy Industry Workforce Mental Health Framework.[57]

Other initiatives have been released to help workplaces measure elements of mentally healthy workplaces. National and state and territory WHS regulators co-funded the development of People at Work, Australia's first validated psychosocial risk assessment tool.[58] The free digital platform helps organisations to identify, assess and control risks to psychological health and safety. Meanwhile, the University of South Australia is developing a world-first Psychosocial Safety Climate Observatory to gather and analyse national and international data on the workplace psychosocial safety climate. These initiatives add to existing tools such as the New South Wales Government's Mentally Healthy Workplaces Benchmarking Tool and SuperFriend's annual Indicators of a Thriving Workplace survey.

The NSPA Final Advice highlighted the role of workplaces in suicide prevention, advocating an approach to supporting people where they "live, work, learn and interact".[28] Suicide Prevention Australia released the first framework for suicide prevention in the workplace in June 2021 (see case study 6).[59]

Case study 6: Suicide Prevention: A Competency Framework

Suicide Prevention Australia produced Suicide Prevention: A Competency Framework to build the capacity and capability of Australian workers to respond to and support people experiencing suicidal thoughts and behaviours in the workplace.

Suicide Prevention Australia describes the framework as a starting point for organisations and workers to explore what they need to know to respond effectively and reduce suicidal behaviour in their workplace. Given the diversity of workplaces in Australia, the framework is accompanied by suggestions for how it can be adapted to different environments.

National Workplace Initiative

Greater knowledge and capacity facilitated through the various initiatives will help organisations to address workplace-based risks to mental health, ensure that workplaces are a venue for reaching people experiencing mental ill health, and realise the potential of workplaces to enhance mental health.

However, it is clear that a nationally consistent approach is required to align the growing array of initiatives so that organisations have a comprehensive and holistic suite of supports. The Commission and the Mentally Healthy Workplace Alliance secured Australian Government funding for the National Workplace Initiative in the 2019–20 Budget[60] to lead this nationally consistent approach.

In 2021, the National Workplace Initiative led the development of Australia's first Blueprint for Mentally Healthy Workplaces[61] to define a vision of mentally healthy workplaces that can be shared by all organisations across Australia. The blueprint defines the core principles and focus areas for creating workplaces that protect, respond to and promote mental health.

The National Workplace Initiative is producing a digital platform to connect organisations with information and resources based on their specific needs and size. It is also creating resources to address identified gaps in resources and supports.

Alignment of stakeholders' initiatives through a nationally consistent approach can reduce duplication of effort and resources. Further, alignment will enable gaps in service or research to be identified and acted upon. The National Workplace Initiative's approach will also support industry-led initiatives, thereby facilitating coordinated and system-level action on issues experienced across multiple workplaces.

Mental health workforce

The Commission reported in its 2020 National Report that the current mental health 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. Unfortunately, the workforce issues contributing to these outcomes persist, including:

- workforce shortages across most occupations
- inadequate training and professional development pathways
- maldistribution of the workforce
- low retention rates
- additional demand pressures caused by the COVID-19 pandemic and ongoing natural disaster events
- negative workplace cultures

- a lack of data driven system planning
- sustainability of the current workforce model.

"The chance of getting a good mental health professional who is able to work with children is like finding hen's teeth… we don't have a group of professionals who've got the specialised practice that we can bring to a cohort of really traumatised young people." Parent/carer of a child with mental illness, National Children's Mental Health and Wellbeing Strategy

The National Mental Health Workforce Strategy is considered a critical component of mental health reform. The strategy is currently being developed, but reform in this area is not moving quickly enough.

Across inquiries, consultation efforts have repeatedly heard that, too often, people are not involved in their own care or empowered to make decisions about their own treatment and supports. In efforts to address these issues, the Productivity Commission Inquiry into Mental Health proposed 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.

To achieve these measures, and therefore a system that is truly person led and recovery focused, a well-supported, well-trained and well-resourced mental health workforce is required. This has been recognised in the recommendations of the Victorian Royal Commission that focus on increased support for the mental health workforce.

The COVID-19 pandemic and other natural disasters have highlighted the need to plan for future crises and their impact on workforces, factoring in sustainability and links to non-traditional forms of care and support (see Accessibility).

Moving forward

Governments have increasingly sought to support mentally healthy workplaces through awareness raising, strategies, and legislative and regulatory activities, such as developing codes of practice. However, a national approach is required to align this rapidly increasing activity, reduce duplication of effort, and address gaps in service and resources. Additionally, there is a need to address the complex legislative landscape governing mentally healthy workplaces.

The Commission will continue to contribute to the development of the National Mental Health Workforce Strategy. As recommended in its National Report 2020, the Commission would like to see the development of an implementation plan (or series of plans) to be released with the strategy that highlights priority actions, and identifies measurable milestones and realistic time frames. Many of the required implementation activities will not be undertaken concurrently or immediately. Therefore, the strategy needs to articulate the intended progress across the short, medium and long terms. Given the significant demands experienced across the mental health system, the strategy needs to clearly articulate how we get there as quickly as possible. The Commission would also like to see the strategy articulate an approach to its evaluation, including implementation and associated time frames, and who is responsible for evaluation.

In addition, the National Suicide Prevention Office has been tasked with leading the development of the National Suicide Prevention Workforce Strategy in collaboration with all jurisdictions and stakeholders. The Commission considers this a critical piece of work to support the delivery of the National Suicide Prevention Strategy, consider all relevant workforces across government and

community settings, and ensure a whole-of-community approach to building suicide prevention capability.[28]

Adequately addressing workforce issues underpins the success of the mental health reform agenda. As part of activities to inform the development of Vision 2030, the Commission commissioned research into the mental health workforce that identified 9 focus areas for improvement:

- supporting the multidisciplinary workforce, including development of the lived experience (peer) workforce
- enabling a multidisciplinary workforce to work to top of scope[i] to increase efficiency, capacity and job satisfaction
- improvements to mental health education and training, including the broader health and social service workforces, as well as the mental health sector
- expanding the role of social services (including education, policing, justice and importantly drug and alcohol services) to better address the social determinants of health (safe and secure housing, financial security, improving living standards, participation in education, and employment)
- taking an integrated and inclusive approach in all sectors and governments; primary health services, mental health services, disability services, aged care services and various social services all need to work collaboratively
- improving staff safety and wellbeing to reduce stress and burnout
- addressing culture, values and attitudes, which are areas constantly reported as requiring attention
- focusing on growing and sustaining the rural and remote workforce
- considering opportunities to improve access to services, and a broader range of allied health providers using technology and e-health.

Achieving these will require a combination of long- and short-term measures, as well as building on work that is already underway.

[i] This concept has been defined by Te Pou (a national workforce centre for mental health, addiction and disability in New Zealand) as follows: “At a systems-level, working to top of scope means optimising workforce capacity and effectiveness through validating and maintaining current best practice; developing new roles and new ways of practising; and ensuring that policy, provider, and service environments support these new roles and practices to succeed … At an individual and practice level, working to top of scope means enhanced opportunities and capacity to utilise specialised knowledge and expertise in a way that is efficient, adaptive, collaborative, holistic and ethical, and fundamentally supports the service user and their wider family.”

8 Outcomes-driven systems

Key points

- The National Federation Reform Council and the Productivity Commission Inquiry into Mental Health have highlighted the need for a health system with a nationally agreed set of outcomes, where continuous improvement is informed by research, monitoring and evaluation of outcomes, underpinned by robust data.
- Collecting data on outcomes and feeding it back into systems can drive continuous improvement matched to stakeholder needs. Several processes are needed to make this possible.
- Outcomes need to be identified and defined according to stakeholder needs, to ensure that any change is valuable and effective. Clear definitions and common terminology must be used to ensure that measurements are consistent across systems. Outcomes must be linked to accountability to ensure appropriate commitment and responsibility.
- The Australian Government has committed to establishing a comprehensive evidence base to support real-time monitoring and data collection.
- Investment in new data collection, storage and sharing technologies will need to be considered at a national level and supported by all system stakeholders.

Data-driven continuous improvement is essential to delivering well-functioning mental health and suicide prevention systems. It is also essential that data provides information on key outcomes, rather than just outputs. This ensures that system improvements meet consumer and stakeholder needs. Although there are rich sources of data that report on mental health outcomes in Australia, we must better use these to draw meaningful evaluations about our systems.

An outcomes framework needs to be developed to drive change.

An outcomes framework needs to include the governance and processes to take learnings and translate them into changes in policy and practices, within a continuous improvement approach that evaluates whether the changes are achieving what they are meant to. This will need national leadership to prioritise and drive the direction of improvements, and ensure that they feed back into the systems and work towards achieving sustained impact.

"What is the feedback and how are services flexible and responsive to adapt to what a particular community or subgroups within a community need in terms of mental health… it changes overtime as communities develop or new communities come." Professional working with migrant and refugee services, National Children's Mental Health and Wellbeing Strategy

There is growing acknowledgment that our current approach to, and use of, data is limited in its ability to provide an understanding of system effectiveness. Although the forthcoming National Mental Health and Suicide Prevention Agreement (National Agreement) will include a focus on system-wide data practices, it is not clear that this will provide the level of vision or direction needed to fundamentally shift our data systems to the extent required to effectively measure systems change. The Commission would like to see the development of an outcomes framework alongside the National Agreement as a crucial step towards driving this fundamental shift.

Development of an outcomes-driven framework

Key principles for development of a national outcomes framework should include the following considerations.

Stakeholder priorities

The framework and outcome targets must be driven by stakeholder priorities. For the mental health and suicide prevention systems, these include consumers and carers, service providers, funders, policy makers and governments.

System outcomes that are likely to be valued across all the groups may include health status and quality of life, consumer satisfaction, effectiveness, and economic performance measured at individual, community and population levels. But different stakeholders may have differing priorities and definitions for such things as the quality, efficiency and effectiveness of services. In addition, there are likely to be specific outcomes required by stakeholders to complete their own monitoring and evaluation activities, as well as program-specific outcomes.

It will be important to identify and agree on a reasonable suite of both broad and specific outcomes to reduce the risk of the framework becoming too complex to monitor and therefore failing to demonstrate change.

Defined and achievable outcomes

Outcomes should be derived from a theory of change and a program logic that will demonstrate how they can be achieved. They include short-term outcomes that could be expected immediately, medium-term outcomes that may occur later, and longer-term outcomes and impacts that may only be realised many years after a policy, program or service intervention is provided.

Outcomes should be attributable to a source, where possible, so that change can be identified over time between an intervention and the outcome being measured.

Forms of evaluation relevant to the context and level of inquiry need to be incorporated into an outcomes framework. For more complex evaluations of systems change, where attributional conclusions are more difficult to make, a range of models may need to be considered—for example, dynamic systems theory, realist and developmental evaluation models.

Using a theory of change and program logic to guide the development of outcomes will also deliver a better understanding of what services are being delivered by whom, to whom and why. There is currently no shared national model or service taxonomy. As a result, there are inconsistencies in describing and defining services across the systems, which makes measuring the effectiveness of services difficult. Categorising services is important because each will have different inputs, outputs and outcomes (such as improving awareness or recovery), while contributing to high-level outcomes such as improved mental health and wellbeing for everyone.

Having a theory of change for each service category will provide a common understanding and agreement on target populations, workforce requirements, resourcing and the key outcomes for that service type. This shared understanding will promote joined-up service systems (see Integrated and coordinated care) and appropriate distribution of resources. For example, based on the overall effectiveness of awareness training programs, are we over- or under-invested in providing this service type? Joining across the systems allows us to map the services being delivered and identify any gaps in populations being serviced, in the workforce or in services.

Accountability

Accountability is a vital aspect of an outcomes framework to drive commitment to change and identify who is responsible for implementation. This includes responsibility for both inputs (what is needed to complete the activity, including funding, workforce and policy) and outputs (the direct results of an activity—for example, the people completing a training activity—that are necessary to achieve an outcome).

Currently, there is little shared understanding and agreement about the inputs and outputs of activities, programs or the service systems more broadly. This dilutes the lines of accountability through a lack of clarity and consistency at a system level.

Outcomes data

Fundamental to a well-functioning health system is the appropriate collection and use of data, and consistent national monitoring and reporting for improved outcomes. Particularly in the long term, measuring the effects or impact of an activity, service or program intervention is important for policy and service improvements—measurement can capture both positive and negative effects, direct and indirect effects, and intended and unintended consequences.

Existing data and evaluation approaches in the mental health sector do not effectively support the measurement of outcomes or impact. Current data systems do not effectively support the routine and timely monitoring of outcomes or service delivery.

Monitoring the implementation of activities is important so that issues can be resolved well before they affect the achievement of outcomes and longer-term impacts.

The importance of systems driven by outcomes is increasingly recognised at the national level, notably in the National Federation Reform Council's agreed vision for Australia's future mental health and suicide prevention systems (intended to be achieved through the National Mental Health and Suicide Prevention Agreement). The vision is for a health system with a nationally agreed set of outcomes, where technology and innovation are harnessed to improve outcomes, and continuous improvement is informed by research, monitoring and evaluation of outcomes, underpinned by robust data.[62]

The Productivity Commission Inquiry into Mental Health was clear in its recommendations on the need for governments, through co-design processes, to establish targets and time frames that specify key mental health and suicide prevention outcomes. It also recommended that the Commission monitor progress against outcomes as part of its national monitoring and reporting role. The Commission is conscious of ensuring that its monitoring and reporting activities are aligned with the needs of the sector and, most importantly, that activities contribute to improved mental health and wellbeing for all Australians. The Commission supports the focus on developing targets and time frames that specify key mental health and suicide prevention outcomes in the National Mental Health and Suicide Prevention Agreement, as well as clarity around roles and responsibilities for driving such reforms.

The 2021–22 Budget committed $117.2 million over the next 4 years to establishing a comprehensive evidence base to support real-time monitoring and data collection for our mental health and suicide prevention systems. This investment is essential to assess whether mental health outcomes, programs and service effectiveness are improving.

A shift to monitoring and evaluation using an outcomes framework will require a fundamental change to the current data system. Changes are required not only in the approaches to data but also in the use of new technologies, such as metadata and artificial intelligence (AI). The increasing use of digital services, apps and wearables will provide new ways to collect data, and the development of these services and tools will need to consider how they will support an outcomes framework.

Privacy, security and bias risks need to be appropriately managed to ensure the integrity of personal and identifiable information, and to ensure that data is accurate and does not create or reinforce biases in AI algorithms that could disadvantage certain groups. Use of AI in Australia's mental health and suicide prevention systems should align with Australia's Artificial Intelligence Ethics Framework.

It will also be important to consider the way we store, manage and share data; interoperability between systems and services is increasingly critical. Technological advances in this area are demonstrating the benefits of metadata approaches, where large volumes of data from multiple sources can be used to support timely reporting and dashboarding.

Moving forward

The Commission views the establishment of co-designed outcomes within a national framework as a vital step towards ensuring consumer-centred, effective and sustainable mental health and suicide prevention services. However, establishing an effective outcomes framework requires more than the identification of the outcomes themselves.

For outcomes to demonstrate system effectiveness, a long-term commitment to sustain a framework is necessary.

The framework will need all stakeholders to:

- agree on the outcomes to be measured
- contribute consistently to data collection and sharing
- collaborate on monitoring and evaluation
- share translation and improvement actions and priorities.

These functions need to be implemented and linked from a program to a system level. National leadership is needed to provide consistent direction over the life of the framework and establish the required levels of collaboration for success. Changes in data collection, storage and sharing will also be vital to support change.

Acronyms and abbreviations

Commission	National Mental Health Commission
FDSV	Family, domestic and sexual violence
Fifth Plan	Fifth National Mental Health and Suicide Prevention Plan
GP	General Practitioner
LHN	Local Health Network
MBS	Medicare Benefits Schedule
NSPA	National Suicide Prevention Adviser
NSSHMS	National Suicide and Self-Harm Monitoring System
PHN	Primary Health Network
WHS	Work health and safety

Glossary

Analyst Portal

The National Suicide and Self-Harm Monitoring System includes an Analyst Portal for sharing content from national and state and territory data custodians, and other approved users, such as Primary Health Networks, nongovernment organisations (NGOs) and researchers. The portal is currently under development, and the Australian Institute of Health and Welfare and the Commission are working collaboratively with jurisdictions, Primary Health Networks, NGOs and researchers to determine what data can be made available in the portal and who needs to access it. See the Commission's website for further detail.

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

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

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'.

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 (OIE), and the Food and Agriculture Organization of the United Nations. COVID-19 is also known as '2019 novel coronavirus', '2019-nCoV' or 'coronavirus'.

Digital mental health
Digital mental health comprises services, programs or apps delivered via online, mobile or phone based platforms. They may be self-driven or practitioner guided and can be used alone or in combination with face-to-face therapy.[63]

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

Disruptive technology
Innovative technology solutions that significantly change the way we identify, diagnose, treat and support mental health and wellness. Examples are cognitive artificial intelligence, telemedicine, big data and digital reality.

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 ill health and its associated social disadvantage.

e-mental health

The use of the internet and related technologies to deliver mental health information, services and care.[64]

Head to Health centres
Multidisciplinary adult mental health treatment centres. The centres include teams of mental health support workers, including psychologists, mental health nurses, mental health occupational therapists, social workers and peer workers, and offer mental health and assessment services.

Head to Health website
The Australian Government's digital mental health gateway website. The website lists digital mental health services and resources, including a range of free or low-cost apps, online support communities, online courses and phone services.

HeadtoHelp centres
In August 2020, the Australian Government announced the creation of 15 mental health clinics, called HeadtoHelp, across Victoria to enhance essential support during the COVID-19 pandemic. The clinics opened on 14 September 2020, primarily targeting moderate mental health issues. They are located at various general practice clinics and community centres, where health care is often accessed.

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. (There are multiple variations of this term—for example, LGBTQIA.)

Lived experience
In this report, refers to people who have either current or past experience of mental ill health, trauma or distress.

Lived experience (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.

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.

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 issue 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, mental health condition
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' or 'mental health condition' is used in place of 'mental health disorder' and 'mental health disease'.

National Ambulance Surveillance System (NASS)
A world-first public health monitoring system providing timely and comprehensive data on ambulance attendances in Australia. The NASS is a partnership between Turning Point, Monash University, and state and territory ambulance services across Australia. The NASS is funded by the Australian Institute of Health and Welfare as a component of the National Suicide and Self-Harm Monitoring System to collate and code monthly ambulance attendance data for participating states and territories for self-harm behaviours. See the Australian Institute of Health and Welfare website for further detail.

National Disability Insurance Scheme
A scheme that provides individualised support packages for eligible people with permanent and significant disability, and their families and carers.

National Suicide and Self-Harm Monitoring System
Established by the Australian Institute of Health and Welfare and the Commission, the National Suicide and Self-Harm Monitoring System brings together all existing and extensive new data from across states and territories on a website that is regularly updated and improved. It improves the coherence, accessibility, quality and timeliness of national data and information on suicide, suicide attempts and self-harm. The suicide monitoring system plays a key role in better informed public conversations about suicide prevention.

Nongovernment organisations
Private, not-for-profit community-managed organisations that typically function independently of government 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.

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'.

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, refers to 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 7 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.

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

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.

Self-harm
The act of intentionally causing pain or damage to a person's own body.

Self-harm behaviours
The National Ambulance Surveillance System uses the umbrella term 'self-harm behaviours' to refer to 4 categories of self-harm-related ambulance attendances. These are self-injury, suicidal ideation, suicide attempt and suicide.

Self-injury
The National Ambulance Surveillance System defines self-injury as 'non-fatal injury without suicidal intent'.

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

Socio-economic disadvantage
Reduced access to material and social resources, and subsequent capacity to participate in society, relative to others in the community.

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

Stigma
The disapproval of, or poor treatment of, an individual or group based on characteristics that serve to distinguish them from other members of a society. Stigma results from complex social, political and psychological processes. It can include negatively stereotyped characteristics, attitudes and responses that are personally internalised, community socialised and/or structural, which harm a person's day-to-day health and wellbeing by excluding, devaluing or shaming them.[65]

Substance use problems
A range of harms associated with use of alcohol or other drugs. These can include dependence (sometimes referred to as addiction), which is a health condition that occurs when someone finds it difficult to stop consuming a drug or engaging in an activity or pattern of behaviour, even if it is causing physical or psychological harm, or adversely affecting their life.

Suicide attempt
The National Ambulance Surveillance System defines suicide attempt as 'non-fatal intentional injury with suicidal intent, regardless of likelihood of lethality'.

Suicidal ideation
The National Ambulance Surveillance System defines suicidal ideation as 'thinking about killing oneself without acting on the thoughts'.

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

Suicide
The act of ending one's own life.

Theory of change
A theory of change explains how activities are understood to produce a series of results that contribute to achieving the final intended impacts.[66]

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