# The 2016 National Report

## on Mental Health and Suicide Prevention

Australian Government
National Mental Health Commission

## About us

The Commissioners are Mrs Lucinda Brogden, Ms Peggy Brown (ex-officio Commissioner), Ms Jackie Crowe, Professor Pat Dudgeon, Professor Allan Fels AO, Ms Nicole Gibson, Professor Ian Hickie AM, Mr Rob Knowles AO.

## Our vision

**Our goal and reason for existence**

All people in Australia achieve the best possible mental wellbeing to enable them to lead contributing lives in socially and economically thriving communities.

*The World Health Organisation defines mental health as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*

## Our mission

**How we will achieve our vision**

To be a catalyst for change by providing insights, evidence and advice to decision makers, service providers and communities. Connecting people to lead contributing lives.

## Our values

**The principles driving our work**

- Maximised equity and opportunity for all people in Australia, regardless of mental wellbeing.
- Human relationships and social connectedness.
- Mental wealth – a national asset that reflects the resilience and wellbeing of our people.
- Accountability and transparency.

## About this report

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## Acronyms and abbreviations

**Fifth Plan**
Fifth National Mental Health Plan

**LHN**
Local Hospital Network

**NDIS**
National Disability Insurance Scheme

**PHN**
Primary Health Network

**the Commission**
National Mental Health Commission

**the Review**
*Contributing Lives, Thriving Communities – report of the national review of mental health programmes and services*

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# Message from Dr Peggy Brown

I am pleased to present the National Mental Health Commission's (the Commission's) 2016 National Report on Mental Health and Suicide Prevention.

Since joining the Commission in October 2016, I have been overwhelmed by the support of my fellow Commissioners, staff and the sector in these busy, exciting and challenging times. For those of us who have worked in mental health and suicide prevention for many years, the national mental health reforms happening in Australia are significant.

In the Commission's 2014 publication *Contributing Lives, Thriving Communities – The National Review of Mental Health Programmes and Services*, we presented a strong argument for change. We found many people do not get the support they need when they need it. This contributes to substantial system inefficiencies, and financial and human costs for individuals, families, communities, governments and the economy overall.

The Commission maintains that improving mental health is an invest-to-save issue. However, the new focus on prevention and early intervention must not result in an overall decline in funding for mental health and suicide prevention. It is our belief that these mental health reforms can improve the mental wealth of the nation. As the Prime Minister has noted:

> *"Nothing diminishes the mental wealth of our nation, nothing diminishes the human capital of our nation and its capacity, more than mental illness."*
>
> **The Hon. Malcolm Turnbull, MP,**
> **Prime Minister of Australia, 26 November 2015**[1]

The reforms currently underway are shifting the system architecture. They aim to change the way services are planned and delivered to enable better outcomes for people who need mental health support. They are focused on delivering a more person-centred, locally based, stepped care approach to mental health and suicide prevention.

Collaboration will be an important factor in supporting the reforms to succeed. We must engage people with lived experience, their families, support people and communities, and support Primary Health Networks to coordinate and integrate mental health and suicide prevention services at the local level.

Monitoring and reporting on the reforms will be critical. At the Commission, we will continue to provide independent and forthright advice to government and the community to provide insight and evidence on ways to continuously improve Australia's mental health and suicide prevention systems, and to act as a catalyst for change to achieve those improvements.

In this report, we consider the factors that will lay the foundations for the Commission's future monitoring and reporting. As done in our previous reports, we share the experiences of people, families and support people so that we can better understand the things that affect their lives and how we can help shape a mental health system that can respond to people's needs more effectively. We also share examples of the overwhelming good work that is being undertaken in improving mental health outcomes and reducing suicide across Australia.

I would like to pay tribute to the many people, past and present, who have been involved in the Commission's work and thank you all for your commitment, compassion and dedication to improving the lives of people with lived experience, and of all Australians.

Going forward, the Australian Government has committed to strengthening the Commission to realise our vision for all people in Australia to achieve the best possible mental wellbeing to enable them to lead contributing lives in socially and economically thriving communities.

I am extremely honoured to be the Chief Executive Officer of the Commission to lead this vision, and I look forward to sharing the journey ahead with you.

Dr Peggy Brown
Chief Executive Officer
National Mental Health Commission

# Introduction

This report provides a high-level summary of the reform journey in Australia's mental health and suicide prevention systems since the National Mental Health Commission (the Commission) presented *Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services*[2] (the Review) to the Australian Government at the end of 2014.

Since the delivery of that report, Australia has been undergoing significant changes to services, programs and policies in mental health and suicide prevention, as well as in primary health care, disability, housing and social services. These changes have not only been at the national level, but also at the jurisdictional and local levels, through state and territory governments and many local initiatives. Acknowledging the considerable work being undertaken at all levels, this report focuses on the initiatives being announced and progressed at the national level.

**Part 1** outlines the key recommendations of the Review, the Australian Government's response, areas of subsequent progress and where further work is needed.

**Part 2** provides more detail about some of the issues in monitoring and reporting mental health and suicide prevention, and the Commission's ongoing role and plans for further work in this area throughout 2017. This is supported by a snapshot of currently available data for selected indicators of mental health consumer and carer outcomes in **Appendix A**.

**Part 3** sets out where our work will be taking us during the implementation stage of the reforms.

This report is also supported by a compilation of personal stories and case studies from mental health consumers, carers and service providers.

# 1. Catalysing change: a review, a response and subsequent action in mental health and suicide prevention

## 2014 review of mental health programs and services – background

At the end of 2014, the National Mental Health Commission (the Commission) submitted *Contributing Lives, Thriving Communities –The National Review of Mental Health Programmes and Services*[2] (the Review) to the Australian Government.

The Review identified fundamental structural shortcomings in Australia's approach to mental health and suicide prevention. Several factors were contributing to a huge drain on wellbeing and participation in the community – on jobs, on families, and on Australia's productivity and economic growth:

- Mental health resources are not distributed equitably across geographic regions, population groups and levels of need.
- Resources are concentrated in expensive acute care services, and not enough resources are invested in prevention and early intervention.
- Patterns of mental ill-health, suicide and suicide attempts differ across regions of Australia and across different population groups.
- There are gaps in services for people with serious mental illness, and uncertainty about whether this will be improved or exacerbated by the National Disability Insurance Scheme (NDIS).
- Aboriginal and Torres Strait Islander people have a higher risk of suicide and mental ill-health than other Australians.
- Low-intensity services, particularly self-help and e-mental health services, are largely underused.
- Evaluation and research findings are not well translated into practice.
- There are large information gaps about what works. There are no agreed or consistent national measures of whether efforts are leading to effective outcomes and better lives for people with mental illness.

The Review put forward 25 recommendations under nine strategic directions (Box 1). These proposed actions, to be implemented over a 10-year timeframe, are to help the system move towards one that is person-centred, devolves planning and service delivery to the local level, and is based on a stepped care approach that emphasises early intervention.

The recommendations were presented as the structural foundations for future reform, to increase the efficiency and effectiveness of the system, and improve mental health outcomes for individuals and communities in the longer term.

## What is a person-centred approach?

Person-centred approaches to mental health prioritise the needs and preferences of consumers and carers at all stages of service delivery and recovery, and seek to better target services to these needs. This approach also takes a person's physical, mental, social, emotional and overall wellbeing into account, and promotes opportunities for people with mental illness to lead a contributing life.

## What is stepped care?

Stepped care is a planning model that seeks to match individuals to the level and type of care they need, at the right time and in the right place. A successful stepped care health system can reduce reliance on acute care, as well as on medications and other medical interventions. Stepped care also has a strong focus on nonclinical support and early interventions – such as family resilience and strength, support for children, community support, self-help and online services – at the population level.

## Box 1: At a glance: the Review's nine strategic directions

1. **Set clear roles and accountabilities to shape a person-centred mental health system**

   Leadership and regional integration by the Australian Government, a mental health and suicide prevention plan agreed by all governments, and further work into the National Disability Insurance Scheme for people with psychosocial disability.

2. **Agree and implement national targets and local organisational performance measures**

   Eight targets under six domains mapped to the Contributing Life framework, a new Closing the Gap target for the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, and performance requirements for services to encourage use of single mental health care plans and the e-health record.

3. **Shift funding priorities from hospitals and income support to community and primary health care services**

   Resource reallocation from acute to community-based services, defining a central role for Primary Health Networks, regional commissioning of services with pooled funding, implementing place-based care and longer-term contracts, and targeting at-risk groups.

4. **Empower and support self-care and implement a new model of stepped care across Australia**

   Focus on e-mental health services, workplaces, first-responder training, evidence-based practice through general practitioners and other Medicare Benefits Schedule-subsidised services – trial of personal budgets for people with serious mental illness; more equitable distribution of psychological services; and a role for pharmacists in mental health care teams.

5. **Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life**

   Integrated services, and a national framework, for families, infants, children and adolescents; and reducing stigma and discrimination with actions to support older Australians, transgender and intersex people, people with intellectual disability, and people from culturally and linguistically diverse backgrounds.

Box 1: At a glance: the Review's nine strategic directions continued

6. **Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people**

   Working with states and territories and Indigenous primary health care organisations (including Aboriginal community controlled health services).

7. **Reduce suicides and suicide attempts by 50 per cent over the next decade**

   Twelve trials across Australia to test and evaluate locally based suicide prevention strategies.

8. **Build workforce and research capacity to support systems change**

   Including increased funding for mental health research that responds to policy directions and community needs, support for mental health nurses and mental health peer workers, and education and training for the broader mental health workforce.

9. **Improve access to services and support through innovative technologies**

   Streamlined platform for telephone and online access, national operating standards, competitive funding for e-mental health services, focusing on at-risk groups, intersectoral cooperation and local integration.

*Source: Contributing Lives, Thriving Communities – The National Review of Mental Health Programmes and Services*[2]

## Australian Government response to the Review

The Australian Government released its response to the Review in November 2015.[3] Although specific endorsements were not made against each of the 25 recommendations, the response indicated broad agreement with the Review's proposed direction for reform. The Australian Government signalled a new approach to mental health and suicide prevention, focusing on person-centred and stepped care approaches, regionalisation, early intervention, digital mental health and national leadership.

Recognising that shifting resources and system improvement would require structural and longer-term reform, the Australian Government committed to some initial actions that would provide a foundation for further improvements. These actions and other progress to date are outlined in the following sections.

## Primary Health Networks and stepped care

Aligning with the Review's recommendations, the Australian Government gave a core role to Primary Health Networks (PHNs) in national mental health and suicide prevention reform. PHNs are now the key vehicle for local-level action in mental health and suicide prevention, including in leadership, embedding stepped care approaches and driving service integration.

PHNs are also responsible for commissioning all regionally delivered Australian Government Department of Health mental health programs, guided by six key priority areas identified by the Australian Government:[4]

- improved targeting of resources through low-intensity mental health services
- cross-sectoral approaches to early intervention for children and young people
- addressing service gaps for people in rural and remote areas, and other underserviced or hard-to-reach populations
- services for people with severe mental illness, including clinical care coordination
- local approaches to suicide prevention
- local integration of Aboriginal and Torres Strait Islander mental health services.

There are 10 PHN mental health lead sites, which will document and evaluate their approaches to stepped care, regional planning and integration, and delivering low-intensity services.[5,6] Of these 10 sites, some will demonstrate innovative approaches in preventing suicide, as well as services for both youth and adults with severe and complex mental health conditions.[7] The 10 lead sites (as well as suicide prevention trial sites – discussed in Section 1.2.2) and their areas of focus are shown in **Table 1**.

**Table 1: Areas of focus for 10 Primary Health Network mental health lead sites (Groups 1–3) and other Australian Government suicide prevention trial sites (Group 4)**

| Group | Stepped care | Regional planning and integration | Suicide prevention | Low intensity | Youth severe | Adult severe complex |
|---|---|---|---|---|---|---|
| Group 1 | ✓ | ✓ | | ✓ | | |
| Group 2 | ✓ | ✓ | | ✓ | ✓ | |
| Group 3 | ✓ | ✓ | ✓ | ✓ | | ✓ |
| Group 4 | | | ✓ | | | |

Group 1: Murrumbidgee, Central and Eastern Sydney, Eastern Melbourne, Perth South

Group 2: Tasmania, Australian Capital Territory, South Eastern Melbourne

Group 3: Brisbane North, North Western Melbourne, North Coast

Group 4: Group 3 Primary Health Networks, plus Country South Australia, Tasmania, the Kimberley region (Western Australia), Townsville, Perth South, Geraldton region (Western Australia), Darwin, Central Queensland, Western New South Wales

## What are Primary Health Networks?

On 1 July 2015, 31 Primary Health Networks (PHNs) were established by the Australian Government to increase the efficiency and effectiveness of medical services, and to improve coordination of care for people accessing those services by working with providers at a regional level.[8] Although PHNs span the entire primary health care system, they have six key priority work areas: mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, e-health and aged care.

The Australian Government's response to Contributing Lives, *Thriving Communities –The National Review of Mental Health Programmes and Services* expanded the roles and responsibilities of the PHNs in mental health. PHNs are now required to develop and embed a stepped care approach in the mental health services they commission, and in their regional mental health and suicide prevention plans developed with Local Hospital Networks.

From 1 July 2016, PHNs will have access to annual funding through the Primary Mental Health Care flexible funding pool – $1.030 billion over 3 years, starting in 2016–17.[9] This includes $385 million in 2018–19, drawn from consolidating seven previous individual programs, for these additional efforts in mental health.[10,11]

PHNs have now completed regional needs assessments and mental health activity work plans for 2016–17. Data collection about PHN activities has started through the Primary Mental Health Care Minimum Data Set managed by the Australian Government Department of Health.[12,13] In 2017, PHNs will seek to develop regional mental health and suicide prevention plans, in conjunction with Local Hospital Networks (LHNs) or the equivalent, and other local stakeholders.

PHNs are still in their establishment phase. Transition arrangements are in place to maintain existing programs and services, while PHNs form and build relationships with local stakeholders and LHNs to help plan for the longer term and refocus local services.

Some key tasks for PHNs in their new role will be to:

- work across health and non-health sectors to undertake needs assessments, develop regional mental health plans, and commission integrated delivery systems and pathways
- establish mental health stakeholder advisory mechanisms and ensure strong engagement and participation of people with lived experience, their families and support people
- embed partnerships with LHNs, Aboriginal and Torres Strait Islander organisations, NDIS service providers and other stakeholders
- establish strong and evidence-based stepped care delivery of services, including promotion, prevention, early intervention and recovery
- identify and respond to the needs of vulnerable populations
- ensure that adequate and suitably skilled workforce and resources are available
- collect information consistently over time, to determine what services have been provided to whom with what effect (considering both health and non-health outcomes for clients), and use this information to inform ongoing improvements

Although many PHNs are ready for their new roles in mental health, others may require additional support and guidance. Robust national and local data about the needs of consumers in their region, and new tools such as the National Mental Health Service Planning Framework will help PHNs to build an evidence base for implementing new local stepped care models with LHNs.[14] This will be an important leadership task for the Australian Government Department of Health, which is providing guidance and data to support PHNs in their new role and will evaluate the activity of the lead sites.[4]

## Suicide prevention

The Australian Government's response to the Review committed to a new suicide prevention strategy comprising four key components:

- national leadership and infrastructure, including evidence-based population-level activity and crisis support
- a systematic and planned local approach to community-based suicide prevention, led by PHNs, which will allow for locally appropriate solutions that leverage community partnerships and investment
- refocus efforts to prevent Aboriginal and Torres Strait Islander suicide
- work to ensure that effective, systematic postdischarge follow-up arrangements are in place after a suicide attempt.

New data released in 2016 (Box 2) show the importance of ongoing efforts to deliver tailored, localised approaches to developing and implementing suicide prevention responses.

### Box 2: Suicide in Australia

In 2015, more than 3000 people died from suicide in Australia, equating to 58 deaths per week.[15] This is the highest number of suicides in the past decade. The number of suicide attempts is even higher.[16]

Suicide rates vary significantly across the population, for different groups and different geographic regions across Australia:

- Suicide rates for Aboriginal and Torres Strait Islander people are twice as high as for Australia's non-Indigenous population, and four times as high for Aboriginal and Torres Strait Islander people aged 15–24 years than for non-Indigenous people aged 15–24 years.[15]
- For males, the suicide rate for former serving members of the Australian Defence Force is 13 per cent higher than for the general population (adjusting for age), and almost twice as high for former serving men aged 18–24 years.[17]

Since the Australian Government's response, actions on the ground include:

- **PHNs being specifically tasked with commissioning regional and culturally appropriate suicide prevention activities and services**. PHNs are expected to work with LHNs and other local organisations, and be guided by the *National Aboriginal and Torres Strait Islander suicide prevention strategy*[18]

- **New suicide prevention trials**. Twelve trial sites will demonstrate local system-based suicide prevention models, in collaboration with people with lived experience of mental illness and suicide, their families, support people, LHNs and other stakeholders. The Australian Government has provided $34 million to support this activity.[19] The sites are shown in **Table 1**. Several state and territory governments have also announced support for additional suicide prevention trials. Victoria is funding six trial sites, Queensland is conducting community trials in two sites, and New South Wales has committed to four trial sites.
- **$12 million provided** by the Australian Government for a coordinated approach to commissioning research, through the suicide prevention research fund.[19]

Many jurisdictions have also released new plans and strategies, including for suicide prevention.

Suicide prevention is also a priority for collaborative efforts by all governments under the draft Fifth National Mental Health Plan (Fifth Plan).[14]

## Aboriginal and Torres Strait Islander social and emotional wellbeing

PHNs have been identified as the primary reform vehicle for improving mental health and suicide outcomes for Aboriginal and Torres Strait Islander people.

The Australian Government's response was silent on the Review's proposed Closing the Gap target for Aboriginal and Torres Strait Islander social and emotional wellbeing. However, several other initiatives are underway to better support outcomes in this area:

- The *Gayaa Dhuwi* (Proud Spirit) Declaration was launched in August 2015, renewing calls by Aboriginal and Torres Strait Islander people to link mental health, social and emotional wellbeing, suicide prevention, and substance misuse services.[20]
- The final report of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project was released in November 2016.[21] The report presents 17 recommendations to the Australian Government about addressing the unacceptable rate of suicide in Aboriginal and Torres Strait Islander communities.
- The Aboriginal and Torres Strait Islander Suicide Prevention and Mental Health Advisory Group is currently developing a renewed national social and emotional wellbeing and mental health framework.
- Aboriginal and Torres Strait Islander social and emotional wellbeing is identified as a national priority under the draft Fifth Plan.

It is imperative that these initiatives are planned in conjunction with Aboriginal and Torres Strait Islander people and Aboriginal community controlled health services, and embed leadership by Aboriginal and Torres Strait Islander people.

## Digital mental health

The Australian Government's response highlighted that more could be done to take advantage of Australia's world-leading approaches to online and telephone-based mental health services. The response announced the development of a new digital mental health gateway to provide consumers, carers and service providers with the tools and information they need to successfully navigate the digital mental health system and make informed choices about their care. With funding of $2.5 million, a first-release version of the gateway is expected to go live in 2017.[19]

Some important national initiatives being progressed in the digital mental health space since the Review include:

- the continued rollout of My Health Record,[22] a national electronic medical records system that allows consumers to share information (with consent) to clinicians involved in their health care
- the launch of the Australian Digital Health Agency in June 2016, and its development of the National Digital Health Strategy.[23]

The Commission supports the continued rollout of My Health Record, given the potential benefit it provides in sharing information, and consumer engagement and participation. Although digital mental health is taking off in popularity, some people with mental illness may not have the capacity (including in terms of financial or technological resources) to access digital services, and will continue to need support through other service delivery platforms.

It will also take time, commitment and a well-planned strategy to support a sustainable systems approach to digital mental health. For instance, it will be important that e-health services are:

- developed in response to need
- embedded in the broader system, with step-up and step-down pathways to face-to-face services, and consistency in data specifications (including measurement of outcomes) to inform evaluations
- supported so that practitioners and consumers and carers use them effectively.

These will be important considerations for the ongoing development of the digital gateway and in the work of the Australian Digital Health Agency as it develops its overarching view of the e-health system.

## Severe and complex mental illness

As with other priority areas, the Australian Government's response to the Review provided a role for PHNs to address service gaps for people with severe and complex mental illness. PHNs are now responsible for incorporating services for people with severe and complex mental illness into stepped care models in primary health care settings. To do this, PHNs are exploring a range of methods including clinical care coordination (assisted by digital tools), phased implementation of primary mental health care packages and the use of mental health nurses.

As part of its primary health care reforms, the Australian Government will trial the Health Care Homes[24] program for people with complex and chronic illness, including severe mental illness. These trials will consider the health risks presented by different groups of general practice patients,[25] and whether using pooled funding arrangements to purchase packages of care for clients is more effective and efficient than purchasing on a fee-for-service basis. It is expected that eligible patients will begin to be enrolled by 1 July 2017.[26]

The NDIS, launched as a trial in four locations in July 2013, presents the opportunity of individualised care and choice for eligible people with psychosocial disability. Moving beyond its trial phase, the NDIS started its progressive full-scheme rollout in July 2016.

The Commission considers the NDIS to be an important initiative, but is aware of continuing concerns in the mental health sector about the implementation of the NDIS for people with mental illness,[27] including:

- NDIS eligibility criteria for people with psychosocial disability
- which services should be in and out of scope for rolling into the NDIS
- pricing of psychosocial supports
- emerging gaps in services
- supports for carers of people with psychosocial disability
- ongoing availability of early intervention services
- managing workforce and supplier market transitions
- managing the interface of NDIS implementation with mental health reforms, as well as with mainstream health and disability systems.

These issues – for mental health specifically, and more broadly – are likely to be considered through two inquiries into the NDIS in 2017. These inquiries will address the provision of services under the NDIS for people with psychosocial disabilities related to mental illness by the Joint Standing Committee on the NDIS (final report due in June 2017), and the costs and sustainability of the NDIS by the Productivity Commission (final report due in September 2017).

## Youth and children

The importance of support for children and youth issues was recognised in the Review. It recommended embedding prevention and early intervention initiatives early on in life, through service models that integrate health, mental health, education and other relevant sectors, in the context of a stepped care system.

The report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing,[28] released in 2015, showed an increase in access by children and young people to school- and community-based mental health services. However, it also found that particular groups of children and young people with certain socioeconomic characteristics – such as low family income, employment status of parents and family functioning – are more likely to be affected by mental illness. To better respond to these needs, integrated early intervention efforts that support families and children across a range of sectors are needed.

The need for integrated approaches for children's and young people's services was also highlighted by the Barrett Adolescent Centre Commission of Inquiry report, presented to the Queensland Government in June 2016.[29] This report was a sobering reminder of the vulnerability of young people with mental illness, and the consequences of losing the focus on the individual as they move between services. It also highlighted the importance of aligning services for young people, and of comprehensive stepped care pathways to ensure that there is no service gap as young people transition to adulthood.

The Australian Government's response to the Review pledged joined up support for child mental health, and an integrated and equitable approach to youth mental health. PHNs were identified as central partners in these approaches, including working with local headspace services and establishing new early intervention services for young people. In 2016, the Australian Government also provided funding ($28.9 million) for 10 additional headspace centres by 2019, and restored funding ($115.6 million) for six Youth Early Psychosis Programs for 3 years.[19] It remains unclear what flexibility PHNs will have to commission services that target local needs in relation to youth mental health over the next 3 years when the Australian Government has guaranteed funding to headspace and six Youth Early Psychosis Programs as part of the PHN flexible funding pool. Although guaranteed funding is welcomed, the Commission is concerned that the headspace model of a 'one-size-fits-all' shopfront-type approach does not meet the needs of some communities.

The Australian Government's response also provided for cross-sectoral support for children's mental health, though a network that links PHNs, Family Mental Health Support Services, and a new national workforce initiative for clinical and nonclinical professionals assisting children with, or at risk of, mental illness.[30] This network will also link with the National Support for Child and Youth Mental Health Program,[31] which consolidates school-based mental health programs into a single, integrated, end-to-end school-based mental health program. The program is yet to begin. A grants process started in December 2016, and the level of engagement with PHNs throughout this process is not yet clear.

That the Australian Government's response considered children and youth separately is welcomed, and recognises the unique issues and service responses relevant to these age groups. Further to this, and as recommended in the Review, a similar distinction is also required in the provision of support much earlier in the life cycle, for new mothers and families, for infants and in early childhood. Noting the continued work by states and territories following the cessation of Australian Government funding for the National Perinatal Depression Initiative, the Commission views this as an area that demands further attention.

# Other areas of progress

Of course, progress in mental health and suicide prevention reform during the past 18 months is not limited to actions stemming from the Australian Government's response to the Review.

A great deal of work is being undertaken at the jurisdictional and local levels by state and territory governments and community-based organisations across Australia. For instance, many states and territories have released new plans and strategies for mental health and suicide prevention in the past 18 months, all of which are broadly in line with the national directions that were identified in the Review. Western Australia, South Australia, New South Wales and Queensland now all have mental health commissions. The Australian Capital Territory has committed to develop an Office of Mental Health. There are also dedicated ministers for mental health in Western Australia, South Australia, New South Wales, Victoria and the Australian Capital Territory.

A range of other activities are also underway at a national level that will support efforts and understanding of mental health and suicide prevention in Australia.

## Fifth National Mental Health Plan

A significant development in mental health and suicide prevention is the development of a Fifth Plan.[14] Proposed for agreement by all health ministers, the Fifth Plan proposes national collaborative work in seven priority areas:

- integrated regional planning and service delivery
- coordinated treatment and supports for people with severe and complex mental illness
- suicide prevention
- mental health and suicide prevention for Aboriginal and Torres Strait Islander people
- physical health of people living with mental health issues
- stigma and discrimination reduction
- safety and quality in mental health care.

The Commission commends the release of the consultation draft of the Fifth Plan for public consultation in October 2016, and the extension of the consultation phase in response to feedback. The next version of the draft Fifth Plan is expected to be put to health ministers for consideration in August 2017.

The Fifth Plan, once agreed to, will be an important base for a comprehensive strategy for sustained national monitoring of mental health outcomes and the progress of reforms. This is a task of particular interest to the Commission through its national monitoring and reporting role.

The Commission also encourages all health ministers to show leadership in engaging with colleagues in other jurisdictions and portfolios to bridge and coordinate initiatives, to advance whole-of-life improvements for people with mental illness and carers.

## Mental health information and data development

Progress in mental health data integration and data development will help to build the evidence base for use in local service planning, development, implementation and monitoring. The Commission notes the following activities in this area:

- The Australian Commission on Safety and Quality in Health Care released the *Australian atlas of healthcare variation* in November 2015.[32] The atlas describes variation in health care provision across Australia, in areas such as antibiotic prescribing, and surgical, mental health and diagnostic services.
- In specific regions, an Integrated Atlas of Mental Health has been developed to assist in local service planning.[33]
- In July 2016, the Australian Mental Health Care Classification (AMHCC) was released. Developed by the Independent Hospital Pricing Authority[34] with significant sector input, the AMHCC provides an activity-based funding model for mental health services (largely focused on inpatient services), and will be an important tool to inform future funding, budgeting and cost-setting in public hospitals and, potentially, other community-based settings.
- In 2016, the Australian Government was finalising a new version of the National Mental Health Service Planning Framework, to be released to PHNs and all state and territory governments.

## National Mental Health Commission projects

The Commission has also undertaken key pieces of work, including:

- a position statement on the use of seclusion and restraint in the mental health sector, and a paper published in May 2015[35]
- a review of self-harm and suicide prevention services for former and current members of the Australian Defence Force and their families, at the request of the Prime Minister in August 2016.[36] The final report was provided to the Australian Government at the end of March 2017

- development of a National Consensus Statement on Improving the Physical Health of People Living with Mental Illness. The Commission will monitor progress in this area, and highlight positive changes arising from actions in line with the Consensus Statement
- a project to investigate the economics of mental health in Australia. The Commission hosted Professor Martin Knapp from the London School of Economics to progress the idea of putting mental health on the economic agenda in Australia. The Commission brought together a wide range of stakeholders to discuss mental health resource allocation, mental wealth and return on investment from mental health reforms
- the Mental Health Services – Census Data Integration project, led by the Australian Bureau of Statistics in partnership with the Commission, linked data from the 2011 Census with Medicare Benefits Schedule and Pharmaceutical Benefits Scheme information. Several reports were published on patterns of mental health services and prescription medications, including
  - *Cultural and linguistic characteristics of people using mental health services and prescription medications, 2011*
  - *Housing circumstances of people using mental health services and prescription medications, 2011*
  - *Patterns of use of mental health services and prescription medications, 2011*
  - *Characteristics of people using mental health services and prescription medications, 2011*
- evaluation of the effectiveness of online forums as a peer support mechanism for people with lived experience, their families and support people. The *Thriving Communities project* seeks to build social connection through online peer support for people with severe mental illness. It focuses on people living in rural and regional Australia.

## Cross-sector initiatives

There are several initiatives in portfolios other than health that have immediate impacts for people with mental illness, families and carers. These policy areas include housing, employment, education, drugs and alcohol, and many others.

In 2016, the Australian Government Department of Social Services undertook two initiatives of note:

- The trials of the Individual Placement and Support model[37] will provide young people with mental illness with blended mental health and vocational support services through outposted employment officers in youth mental health services.

- The Australian Government's new investment approach to the welfare system is examining the value of early intervention in social services.[38] Although this reform is not targeted towards people with mental illness, it may have some impact for this group, given the higher rates of mental ill-health in unemployed people. In principle, an investment approach to welfare aligns with the 'invest to save' approach promoted by the Commission. However, some have argued that the implications of the approach are not yet clear, and that there are unintended consequences and other risks that will need to be managed.[39,40]

# Gaps and areas of further work

The discussion so far has outlined the key areas in which recommendations of the Commission's Review have been actioned, and presented a selection of other initiatives relevant to mental health and suicide prevention that are being progressed.

Although a substantial portion of current reforms are laying the foundations for future work, much more remains to be done. For instance, finalising the Fifth Plan will be critical to build on the good work so far in the nominated priority areas.

In addition, there are several of the Review's recommendations that appear to have been supported in principle, but for which there is no clear plan for concrete action. Others still have not been accepted or responded to. As a minimum, further efforts are needed in the following four areas:

- consumer and carer engagement and participation
- the mental health workforce
- leadership and coordination across sectors and jurisdictions
- evaluation, monitoring and reporting.

## Consumer and carer engagement and participation

Systemic and systematic engagement and participation of people with lived experience, their families and support people in all aspects of policy concept, design, delivery and evaluation are critical if reforms are to be truly person-centred and target the needs of consumers and carers. Similarly, the experiences and outcomes of consumers and carers need to be the primary focus of monitoring and reporting in mental health and suicide prevention.

The Commission is also interested in, for example, the extent to which active support is provided to build the capability of consumers and carers from diverse groups to participate in policy, program delivery and review of initiatives, including through PHN governance structures. Partnership with organisations such as Aboriginal community controlled health services is also particularly important when considering services for Aboriginal and Torres Strait Islander people.

Empowering and delivering genuine engagement and participation by mental health consumers and carers require national commitment by all governments, as well as other service funders and providers, and should be a priority area for change.

## Taking the mental health workforce on the reform journey

Reform at a national and local level must engage with the existing mental health workforce, to ensure that workers have the appropriate information, training and skills to manage the practicalities of new arrangements. For instance, implementing stepped care and using new digital technology will require new skills, referral pathways and ways of working together across disciplines in team-based care arrangements.

A more diverse and expanded workforce is likely to be involved in the delivery of mental health services, as new stepped care interventions become available. Additional support may be required to assist this transition, including for emerging workforces such as Aboriginal mental health workers and mental health peer workers.

The National Mental Health Service Planning Framework will be a valuable tool to guide and plan workforce requirements. The framework is of interest to a wide range of stakeholders in the mental health sector, including governments, PHNs, local health districts, regulators, educational institutions, community-sector employers, and professional and peak bodies in public, private and not-for-profit sectors.

## Leadership and coordination across sectors and jurisdictions

Since 1992, coordinated effort in mental health has been under the National Mental Health Strategy, supported by Australian and state and territory government agreements and plans. Within this strategy, the Australian Government has maintained a role in national leadership, particularly by leading population-level promotion and prevention, developing the evidence base, promoting quality services and supporting populations with specific mental health needs (particularly Aboriginal and Torres Strait Islander people).

Although this national leadership role was confirmed in the Australian Government's response, further work is needed to better understand and manage the interface of services and programs beyond health. This includes interactions at the national, state and territory, and community levels, both within and outside the health system, and the experiences and impacts of these intersecting systems for consumers and carers.

Cross-portfolio leadership is also required to embed effective approaches to early intervention – noting that future benefits of investment often happen after the current political or budget cycle, in different portfolios, and sometimes at different levels of government. Collaboration will be critical to successfully negotiate and implement a more sophisticated approach to achieving the Review's recommended shift in resources to a more balanced spread of expenditures across the spectrum of need.

## Evaluation, monitoring and reporting

Despite all the reforms that have been implemented in the past 10 or more years, it is currently difficult to work out whether they are making a difference in mental health and suicide prevention. With multiple and interconnected reforms currently underway, attribution and interpretation of the specific impact of initiatives at a system level are particularly challenging.

As we embark on serious reform efforts at national, state or territory, and local levels, measurement issues must be resolved quickly so we have a clear baseline to assess the impact of reforms over time. Progress of both existing programs and new reforms must be tracked in partnership with consumers and carers.

Meaningful measurement in mental health and suicide prevention requires a coordinated, sustained and consistent strategy that is agreed to by all governments and has the sector's support. With its independent mandate and national remit, this will be a core area of focus for the Commission. In 2017, the Commission will be working on its performance reporting framework to guide its monitoring and reporting of mental health and suicide prevention in the coming years and decades.

With these next steps in mind, **Part 2** of this report outlines priorities and considerations for national monitoring and reporting on mental health and suicide prevention reforms and outcomes for consumers and carers.

# 2. Are we making a difference? Issues in monitoring and reporting on mental health and suicide prevention

> *If we are to encourage contributing lives, we need to develop and apply comprehensive measures of outcomes across the service systems.*
>
> **Rob Knowles, National Mental Health Commissioner**

> *Without definitions there can be no measurement; without measurement there can be no data; without data there can be no monitoring; and without monitoring there can be no evidence-based policy, effective advocacy, or public accountability.*
>
> **UNICEF**[41]

Measurement, monitoring and evaluation of services, systems and outcomes for people are critical to knowing whether, as a nation, we are making a difference to the lives of people with mental illness, their families and carers, and communities and society overall.

Measuring and reporting mental health information informs policies, planning and continuous service improvement, to uphold safety and quality standards, and to empower consumer choice and control when approaching and accessing services.

With new national directions being set, there is an opportunity to refresh and embed a new approach to monitoring of, and reporting on, mental health and suicide prevention in Australia. This is a fundamental role of the National Mental Health Commission (the Commission) – to report publicly on the system, where it is working, where it is not and how it can be improved. A key priority for the Commission in the coming year, therefore, is refining the framework that will guide its monitoring and reporting.

**Part 2** of this report discusses some of the key issues that need to be considered when reviewing reporting frameworks in mental health and suicide prevention, including:

- the Commission's role and purpose in monitoring and reporting
- possible areas of focus for reporting
- gathering the right information.

## What is the Commission's role in monitoring mental health and suicide prevention in Australia?

The Commission's role is to provide insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems, and to act as a catalyst for change to achieve those improvements. This includes the provision of independent reports and advice to the Australian Government and the community. By collating consumer and carer experiences, up-to-date data and the results of recent initiatives and directions in government reforms, the Commission's reporting aims to provide information and analysis of mental health and suicide in Australia that is not available elsewhere.

Since its inception, the Commission has undertaken its reporting role in a variety of formats, including:

- National Report Cards on Mental Health and Suicide Prevention with recommendations in 2012 and 2013, and a report back on those recommendations in 2014
- *Contributing Lives, Thriving Communities – The National Review of Mental Health Programmes and Services* (the Review)
- other occasional reports
- advice directly to government.

The Commission's focus is on the national perspective on the impacts reforms are having for consumers and carers. This national scope might not necessarily be limited to initiatives announced and funded by the Australian Government. Rather, a national perspective could consider, for instance, the intersection and interface between initiatives across portfolios; across government, community-managed and private sectors; and across national, state and territory and local levels.

To be influential and effective, it is vital that the Commission's reporting does not duplicate other valuable approaches to mental health reporting developed during the past decades, such as:

- the national mental health reports previously published by the Australian Government Department of Health
- the Reports on Government Services from the Productivity Commission
- performance frameworks stemming from national mental health agreements
- the Mental Health Services in Australia website,[42] published by the Australian Institute of Health and Welfare
- data collections by the Australian Bureau of Statistics
- various reports and program evaluations by Australian, state and territory government agencies, including other mental health commissions.

The Commission's future monitoring and reporting will avoid duplicating this existing information. The Commission aims to add value and insights that are not otherwise publicly available, in a way that is meaningful and accessible to a wide range of audiences.

The Commission's objective in national monitoring and reporting is to uphold the principles of accountability, transparency, consistency and responsiveness. It will pull together parts of the system to offer a unique view of mental health and suicide prevention in Australia from the perspective of consumers, carers and families. Rather than reporting on individual services and programs, it will take a truly national and system-wide view, and seek to influence further improvements to our services and systems overall.

# Policy areas of focus for reporting

Part of the Commission's role is to monitor the broader policy landscape and the impact of reforms for consumers and carers. The complexity of mental health and suicide means there is an extremely diverse range of possible policy areas that could be considered pertinent to the Commission's task in monitoring and reporting. Importantly, effective monitoring and reporting should be able to identify trends in outcomes. However, because many changes in mental health outcomes can take time to realise – for people, communities and Australia as a whole – it is important to measure key indicators of mental health in a routine and consistent way to track progress against plans and identify trends over time.[43] The Commission's reporting framework will also need to balance this consistency with a degree of flexibility to enable it to report and respond to emerging or spotlight issues.

With limitations on time and resources, the selection and frequency of reporting on different topics need careful and pragmatic consideration. Some of the policy areas already flagged for monitoring by the Commission are outlined below.

## Mental health reforms

In the 2016 federal election, the Australian Government committed that the Commission would independently advise the government and monitor the implementation of mental health reforms. This includes monitoring:

- the effectiveness of devolving responsibility for mental health and suicide prevention to the local level
- whether new models of stepped care are better targeting resources to need
- whether there is a shift in resourcing towards prevention and early intervention initiatives
- regional variations in outcomes
- engagement and participation of consumers and carers
- progress in reducing the impact of suicide, both broadly and for particular groups
- the efficacy of new digital interventions and their interface with face-to-face services.

There could also be a role for the Commission in monitoring the implementation and progress of the Fifth National Mental Health Plan (Fifth Plan), cross-sector issues and the suicide prevention trials currently underway across Australia (see Section 1.2.2).

### National Disability Insurance Scheme

Given the unique characteristics of psychosocial disability associated with mental illness and its close connection to both health and disability sectors, there is a case for specific monitoring of the National Disability Insurance Scheme (NDIS) from a mental health perspective. The NDIS is still in early implementation, so transparency and accountability are paramount. Longer-term monitoring and investment in services for people with severe mental illness will be critical to ensure that the respective roles and responsibilities of Primary Health Networks (PHNs) and the NDIS are transparent and maintained. With its national and cross-sector remit for reporting, the Commission would be well placed to have a role in monitoring and reporting on the NDIS and its impacts for people with mental illness both inside and outside the scheme.

### Other areas of a contributing life

Consistent with the Contributing Life framework, there is a wide variety of additional policy areas that could be considered for the Commission's future monitoring and reporting on mental health and suicide prevention in Australia. This broader approach to the Commission's potential monitoring and reporting could, for example, encompass reforms in a range of additional areas, including housing, justice, alcohol and other drugs, social and economic participation, research, welfare reforms, insurance, and health and welfare workforce issues.

## Gathering the right information

To undertake its role in monitoring and reporting across the breadth of issues of relevance to mental health and suicide prevention, the Commission needs access to a wide variety of information. This information needs to canvass the inputs to the system – including regulatory settings, expenditure, workforce and other resources – and the outputs (or activities) that these inputs enable.

The Commission is particularly interested in the substantial investment made each year in mental health and suicide prevention, and whether this is being used efficiently and effectively. Investments need to be tracked carefully, to ensure that resources are not inappropriately diverted from critical services, and so that identified savings (including those achieved in portfolios other than health) are reinvested in initiatives that help to prevent and reduce the impact of mental illness.

To make a true assessment of the effectiveness of the system, information is also needed to track the whole-of-life outcomes for mental health consumers and carers, and any variations over time between population groups and in different regions of Australia. An important consideration for the Commission's future work will be how to collate and report this information, and in which priority areas.

## Indicator frameworks

A number of mental health indicator frameworks are either in place or have been previously proposed as relevant to the task of monitoring activities and outcomes in mental health and suicide prevention:

- The PHN Performance Framework specifies mental health treatment rates as the national headline indicator for PHN performance in mental health. There are also additional mandatory mental health indicators for PHNs, against which their work plans and activities are assessed. However, much of this information is focused on activities and processes rather than on outcomes for consumers and carers.
- In suicide prevention, the Australian Government's Living is for Everyone (LIFE) Framework recommends ways to evaluate suicide prevention projects, activities and programs, including 11 categories of indicator measures.[44] Australian Government funding has been committed for the evaluation of regional suicide prevention models and the 12 new suicide prevention trials,[5] although the details – including the indicators to be used – are not yet clear.
- The National Disability Insurance Agency is regularly reporting on the operations, sustainability and performance of the NDIS, including participants' support needs, outcomes and satisfaction with the scheme.[45] This information is disaggregated by state or territory and, in some places, by disability type, including psychosocial disability.
- Key performance indicators are in place to guide nationally consistent reporting by state and territory public mental health services. These data are published online through the Australian Institute of Health and Welfare's Mental Health Services in Australia collection.[46]
- The National Health Performance Framework[47] and the Performance and Accountability Framework,[48] which guide reporting on the health system more broadly, are also in place and currently under review by the Australian Health Ministers' Advisory Council (AHMAC).[49]

It is notable, however, that these frameworks have been developed for particular and targeted purposes – managing contracts, reporting back to departments and evaluating whether programs are meeting their particular objectives. Although the Commission is interested in the high-level results of such evaluations, its monitoring and reporting role will need to go above and beyond program-specific information, to give a comprehensive system-wide picture of outcomes and experiences of consumers and carers.

## Focusing on outcomes

Perhaps the most important indicators of an effective mental health system are those that shed light on the whole-of-life outcomes that matter to people with mental illness, carers and families.

The draft Fifth Plan acknowledges the important foundation provided by existing collections of mental health information, but notes that 'new information is needed to monitor contemporary mental health reform initiatives and to identify what works and what does not within a complex, multi-layered health and welfare system'.[14]

The draft Fifth Plan sets out 23 indicators for national reform and system performance in mental health and suicide prevention. Of the proposed indicators, 15 would draw on currently available data, with the remainder to be further refined through targeted data development.

The Commission supports the indicators proposed in the draft Fifth Plan as measures of system-wide progress in mental health and suicide prevention. The indicators are based on previous work by the Commission, premised on the central framework of a Contributing Life. The indicators have also been carefully considered throughout the course of their development by the sector, state and territory governments, consumer and carer representatives, and experts in the field of mental health data and information through the Mental Health Information Strategy Standing Committee of AHMAC.

Whether implemented through the Fifth Plan or by other national reporting mechanisms, indicators of population-level outcomes are needed to assess the progress of reforms. Optimally, this would lead all governments (and other stakeholders, such as PHNs) to adopt a process of annual review and adapting their operational plans according to the results.

It is noted, however, that any new indicator framework will require a number of commitments from governments. Actions include formal endorsement; establishment of new systems for collecting, collating and providing data to a centralised reporting source; and a process to formalise and embed these indicators across all sectors. These activities, as well as reporting and further data development where needed, will all require dedicated resources.

**A snapshot of currently available data, based on the domains of a Contributing Life, is in Appendix A.**

## Keeping a focus on consumers, carers and families

The Commission is firmly of the view that experiences and outcomes for consumers and carers need to be the primary focus of monitoring and reporting in mental health and suicide prevention. Measuring the things that matter to people with lived experience provides true measures of quality, and valuable insights that help to interpret other indicators and understand how mental health services and systems are operating in practice.

Customer-centric reforms in other industries illustrate how measuring and publicly reporting on service users' feedback and outcomes can provide incentives for continuous service improvement.[50-53] The application of customer-first principles provides similar opportunities in mental health.

Consumers' and carers' outcomes and experiences can be measured qualitatively through a variety of means, including surveys, interviews, case studies and direct feedback to services. Hearing directly the voices of people with lived experience of mental illness and suicide is important in giving a true representation of the real situations experienced by people.

In parallel, quantitative information enables measurement and comparison of experiences and outcomes over time and between settings. Significant opportunity to do this better in Australia is offered by the development of two new surveys: the Your Experience of Service (YES) survey for consumers and the Mental Health Carer Experience Survey.[a]

a Further information about these surveys is available in Personal Stories and Case Studies 2016.

These surveys will enable consumer and carer feedback to be directly and systematically collected, collated and analysed, so services can better understand their clients and make informed improvements to service quality and person-centred care. The YES survey is being adapted for use by nongovernment organisations that deliver mental health services. Similarly, these surveys could be adapted for use by PHNs to help inform quality improvement, service evaluation and benchmarking for the services they fund.

In considering national monitoring and reporting, however, it will be important to manage the impact of survey fatigue, which can happen when participants are exposed to multiple survey tools and reporting measures, and interpretation of results where there are inconsistent methodologies in the way in which surveys are administered. These surveys are also limited to service-specific feedback, so other mechanisms are needed to gather insights into the experiences of the system, such as the ease of referral pathways and the extent of coordination and integration between services and sectors.

## Harnessing other sources of information

Australia has a vast collection of mental health and suicide prevention data, held in multiple locations across government agencies and services in the community.

Many opportunities exist to use technological innovation and data analytics to harness this information and deliver insights into mental health and suicide that have not been previously possible, such as:

- sophisticated technology and real-time analysis of social media to help identify population trends as they emerge
- analysis of administrative datasets (such as our health and welfare systems) and e-health service metadata, to improve the responsiveness of services, including real-time service responses
- more thorough analysis of data collected through key national initiatives, including data from PHNs, suicide prevention trial sites, headspace, the NDIS and services subsidised through the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme, together with outcomes data collected by practitioners

- integration of state- and territory-level information with national data to identify and improve pathways for consumers between services that are funded through different sources and between different service systems, such as housing, employment, social services, drug and alcohol, education and justice systems
- linking state, territory and national administrative datasets to identify and analyse the effectiveness of service pathways used by people before and after suicide attempts.

Programs such as the Australian Bureau of Statistics' Multi-Agency Data Integration Project[54] are helping to lay the foundations for building this style of analytics capacity, and are establishing appropriate standards for data management and security.

Challenges in harnessing new data sources include that information is often not readily accessible, not available to third parties for analysis or not fit for purposes other than that for which it was originally collected. To fully realise the opportunities these datasets can offer, significant technical work and collaboration from governments and the sector will be required to enable datasets to be compared and combined. This work also requires quality metrics to be embedded in programs from the outset, and privacy to be considered to protect the anonymity of individuals and organisations.

## Refining and developing new data

In some cases, the required information simply does not exist, leaving gaps in our understanding of the effectiveness of services and the system to support consumers and carers to lead contributing lives. For example, data are relatively thin for:

- whole-of-life outcomes, because current mental health data collections overwhelmingly measure process and activity
- outcomes for mental health carers, because many collections do not identify this group separately, or do not use a consistent definition that is well understood by consumers, clinicians or carers
- rates of self-harm, suicide and suicide attempts at local, jurisdictional and national levels, and when and where clusters may be emerging
- mental health outcomes for Aboriginal and Torres Strait Islander people, and their use of general population mental health and suicide prevention services[55]
- the use of restraint in public mental health services.

The collection and reporting of these data can lead to significant service improvement. For instance, work by all jurisdictions to better measure and report on seclusion in public sector acute mental health hospital services has led to steady reduction of this practice nationally during the past 5 years.[56]

In Australia, work is needed to improve the accessibility of data from hospital-based systems and surveys.[57] Timely, accurate and comprehensive local and national data are required to inform prevention efforts and ensure well-timed responses to need.

Some data collections and frameworks already in place may need to be modified to capture priority issues, particularly consumer and carer outcomes.

The development of new data items and improvements to existing data quality and standards is needed to help improve the evidence base on which policy and program decisions are made. The need for this work was noted in the Australian Government's response to the Review, which committed to supporting and coordinating data collections, and measurement and evaluations required to inform system monitoring, accountability and service quality improvement. However, the processes in place to progress this activity are unclear.

At a minimum, and as flagged in the draft Fifth Plan, national priorities for mental health information development need to be re-scoped and agreed to by all governments. The Commission agrees that a third edition of the *National mental health information priorities*[58] (most recently updated in 2005) should be developed and identify priorities for national mental health information for the next decade. This could consider, for example, the benefits of a single patient dataset for primary health care services, changes to improve the comparability of data in community services, and options for further developing and implementing consumer and carer outcomes data.

The Commission will continue to evolve a national monitoring and reporting framework that is contemporary, adds value, and captures and presents meaningful data focused on longer-term outcomes. The final section of this report sets out where our work will be taking us during the implementation stage of the reforms.

# 3. Where our work is taking us

## A note from the National Mental Health Commission team

It's been a busy time for the National Mental Health Commission (the Commission) since delivering *Contributing Lives, Thriving Communities –The National Review of Mental Health Programmes and Services* (the Review) in 2014.[2] We are encouraged by the strong commitment to mental health reform in Australia and the dedicated people we work with.

This report leads us to the next stage: implementing change. During the coming years, the Commission expects that transformational change will occur. We have a clear destination, but like an individual's recovery journey we recognise it will take time to develop and evolve. Although challenges exist, so will many opportunities as we move from where we are now to where we want to be.

### The Commission would like to see a coordinated mental health system where:

- there is widespread public knowledge and understanding of mental illness and suicide
- people with lived experience, families and support people encounter a system that involves them in decisions, is easy to navigate and provides continuity of care
- the focus is on outcomes
- access to support is available at the right time and in the right place
- support services wrap around the person and respond to whole-of-life needs
- the system is proactive and strategically aligned.

The cornerstone of why we exist and what we do is people – people with lived experience, their families and support people, carers, population groups with specific needs and the Australian population more broadly. At the Commission, we are keenly interested and invested in how people are being engaged in reform. As we move forward, we will be listening carefully and openly as reforms roll out. We will provide advice to government that presents the voice of those affected by these changes, to provide a 'big picture' view.

Part of both the challenge and opportunity will be monitoring and reporting on the changes that we outlined in **Part 1** of this report. As addressed in **Part 2**, we need to learn answers to questions such as: Are we making a difference? What is working? If it's not working, what needs to be done to improve it? As the national Commission, we are committed to our monitoring and reporting role to bring transparency and accountability to the system with a person-centred lens.

The next stage of our work program has a strong emphasis on monitoring and reporting and will focus on several activities:

- **Holding the system accountable for improved outcomes in mental health and suicide prevention**. The Commission will provide independent reporting on whole-of-life outcomes and experiences of the mental health of consumers and carers, best-practice examples of cross-sectoral systems and services to support contributing lives, and progress in implementing national mental health reforms.
- **Driving improved approaches to suicide prevention**. The Commission's Australian Advisory Group on Suicide Prevention, together with a wider group of stakeholders, will shape advice for government to assess current action, identify gaps and recommend evidence-based approaches to support improved outcomes in suicide prevention, especially care after a suicide attempt.
- **Supporting the role of Primary Health Networks (PHNs) in relation to mental health**. Working with PHNs and the Australian Government Department of Health, the Commission will seek opportunities to work with PHNs as they transition to commissioning mental health services according to identified needs within their region.
- **Building on the Review and this report to create intersectoral momentum**. Capacity building across a range of sectors, to promote positive mental health, prevention and early intervention, and support for people to lead contributing lives will be pursued through all Commission projects.

In evolving our approach to reporting, you can expect us to consult widely and partner with people and organisations to report back on what matters. We will present information that monitors progress across the mental health and suicide prevention system over the medium to longer term that is both sustained and consistent. In doing so, we aim to develop a report that is meaningful and accessible, and adds value and insights.

In these exciting times of change, many challenges and opportunities will come in 2017 and beyond. As a team, we look forward to working collaboratively and creatively to bring about the changes we all want to see in our systems so that, as a community, we can all achieve the best possible mental health and wellbeing.

# Appendix A Indicator figures

**Table A1: Proportion of children developmentally vulnerable[a] in the Australian Early Development Census (AEDC), 2015**

| Category | Subcategory | Developmentally vulnerable (%) |
|---|---|---|
| **Jurisdiction** | New South Wales | 20.2 |
| | Victoria | 19.9 |
| | Queensland | 26.1 |
| | Western Australia | 21.3 |
| | South Australia | 23.5 |
| | Tasmania | 21.0 |
| | Australian Capital Territory | 22.5 |
| | Northern Territory | 37.2 |
| | **Australia** | **22.0** |
| **Sex** | Male | 28.5 |
| | Female | 15.5 |
| **Indigenous status** | Indigenous | 42.1 |
| | Non-Indigenous | 20.8 |
| **Socioeconomic status[b]** | Quintile 1 (most disadvantaged) | 32.6 |
| | Quintile 2 | 24.8 |
| | Quintile 3 | 20.9 |
| | Quintile 4 | 17.9 |
| | Quintile 5 (least disadvantaged) | 15.5 |
| **Geographical remoteness** | Major cities | 21.0 |
| | Inner regional | 22.4 |
| | Outer regional | 25.2 |
| | Remote | 27.5 |
| | Very remote | 47.0 |

a. Refers to children identified as vulnerable in one or more of the five domains of the AEDC.

b. Reported using the Index for Relative Socio-Economic Disadvantage.

*Source: Australian Government Department of Education and Training*[59]

## Table A2: Rate of long-term health conditions in people with mental illness, 2014–15

| Category | Subcategory | Mental illness and any long-term health condition (%) |
|---|---|---|
| **Jurisdiction** | New South Wales | 16.1 |
| | Victoria | 15.9 |
| | Queensland | 15.8 |
| | Western Australia | 16.6 |
| | South Australia | 13.2 |
| | Tasmania | 19.0 |
| | Australian Capital Territory | 12.6 |
| | Northern Territory | 16.6 |
| | **Australia** | **15.8** |
| **Sex** | Male | 13.9 |
| | Female | 17.7 |
| **Age group** | 0–24 years | 10.0 |
| | 25–34 years | 16.7 |
| | 35–44 years | 18.2 |
| | 45–54 years | 20.0 |
| | 55–64 years | 21.2 |
| | 65–74 years | 18.6 |
| | ≥75 years | 16.2 |
| **Socioeconomic status**[a] | Quintile 1 (most disadvantaged) | 20.1 |
| | Quintile 2 | 16.8 |
| | Quintile 3 | 15.7 |
| | Quintile 4 | 13.1 |
| | Quintile 5 (least disadvantaged) | 13.7 |
| **Geographical remoteness** | Major cities | 15.2 |
| | Inner regional | 17.4 |
| | Outer regional and remote | 17.2 |

Table A2: Rate of long-term health conditions in people with mental illness, 2014-15 (continued)

| Category | Subcategory | Mental illness and any long-term health condition (%) |
|---|---|---|
| **Labour force status**[b] | Employed | 14.9 |
| | Unemployed | 34.2 |
| | Not in labour force | 27.8 |
| **Highest educational attainment** | Bachelor degree or above | 14.4 |
| | Advanced diploma/diploma | 17.6 |
| | Certificate | 21.0 |
| | Year 12 or equivalent | 16.0 |
| | Year 11 or equivalent | 19.0 |
| | Year 10 or equivalent, or below | 21.0 |
| **Disability status** | Profound or severe core activity limitation[c] | 49.0 |
| | Other disability or restrictive long-term health condition | 37.2 |
| | No disability or restrictive long-term health condition | 10.2 |

a. Reported using the Index for Relative Socio-Economic Disadvantage.

b. For population aged 15–64 years.

c. Individuals who require help or supervision for one or more core activities, such as self-care, mobility or communication.

*Source: Australian Bureau of Statistics*[60]

## Table A3: Prevalence of mental illness

| Category | Subcategory | NSMHW 2007 (%) | NHS 2014–15 (%) | CASMHWB 2013–14 (%) |
|---|---|---|---|---|
| **Jurisdiction** | New South Wales | NR | 17.8 | NR |
| | Victoria | NR | 17.5 | NR |
| | Queensland | NR | 18.1 | NR |
| | Western Australia | NR | 14.6 | NR |
| | South Australia | NR | 18.3 | NR |
| | Tasmania | NR | 20.8 | NR |
| | Australian Capital Territory | NR | 18.4 | NR |
| | Northern Territory | NR | 14.8 | NR |
| | **Australia** | **20** | **17.5** | **13.9** |
| **Sex** | Male | 17.6 | 15.8 | 16.3 |
| | Female | 22.3 | 19.2 | 11.5 |
| **Age group** | 0–14 years | NR | 8.9 | 13.9 (4–17) |
| | 15–24 years | 26.4 | 19.4 | NA |
| | 25–34 years | 24.8 | 19.0 | NA |
| | 35–44 years | 23.3 | 19.7 | NA |
| | 45–54 years | 21.5 | 20.4 | NA |
| | 55–64 years | 13.6 | 21.3 | NA |
| | 65–74 years | 8.6 | 18.7 | NA |
| | ≥75 years | NR | 16.2 | NA |
| | 75–85 years | 5.9 | 16.7 | NA |
| **Socioeconomic status**[a] | Quintile 1 (most disadvantaged) | 21.5 | 21.5 | 20.7 |
| | Quintile 2 | NR | 18.7 | 14.4 |
| | Quintile 3 | NR | 17.4 | 13.3 |
| | Quintile 4 | NR | 15.0 | 11.7 |
| | Quintile 5 (least disadvantaged) | 15.9 | 15.0 | 10.9 |

Table A3: Prevalence of mental illness (continued)

| Category | Subcategory | NSMHW 2007 (%) | NHS 2014–15 (%) | CASMHWB 2013–14 (%) |
|---|---|---|---|---|
| **Geographical remoteness** | Major cities | 20.4 (major urban) | 16.9 | 12.9 |
| | Inner regional | 19.2 (other urban) | 19.0 | 14.8 |
| | Outer regional and remote | 19.2 (rest of state) | 19.1 | NR |
| | Outer regional | NR | NR | 19.0 |
| | Remote or very remote | NR | NR | 14.0 |
| **Labour force status**[b] | Employed | 20.3 | 16.0 | NA |
| | Unemployed | 29.4 | 36.5 | NA |
| | Not in labour force | 18.6 | 24.7 | NA |
| **Highest educational attainment** | Bachelor degree or above | 16.9 | 15.2 | NA |
| | Advanced diploma/ diploma | 21.9 | 18.4 | NA |
| | Certificate | 20.2 | 22.5 | NA |
| | Year 12 or equivalent | NR | 17.6 | NA |
| | Year 11 or equivalent | NR | 20.9 | NA |
| | Year 10 or equivalent or below | NR | 22.2 | NA |
| **Disability status** | Profound or severe core activity limitation[c] | 42.9 | 52.3 | NR |
| | Other disability or restrictive long-term health condition | NR | 38.5 | NR |
| | No disability or restrictive long-term health condition | 16.6 | 11.9 | NR |
| **Sexual orientation** | Heterosexual | 19.6 | NR | NA |
| | Homosexual/ bisexual | 41.4 | NR | NA |

Table A3: Prevalence of mental illness (continued)

| Category | Subcategory | NSMHW 2007 (%) | NHS 2014–15 (%) | CASMHWB 2013–14 (%) |
|---|---|---|---|---|
| **Homelessness** | Ever been homeless | 53.6 | NR | NR |
| | Never been homeless | 18.9 | NR | NR |
| **Suicidal behaviour** | Ideation | 71.7 | NR | 7.5 |
| | Plans | 77.5 | NR | 5.2 |
| | Attempts | 94.2 | NR | 3.2 |
| | No suicidal behaviour | 18.7 | NR | NR |

CASMHWB – Child and Adolescent Survey of Mental Health and Wellbeing

NA – not applicable

NHS – National Health Survey

NR – not reported

NSMHW – National Survey of Mental Health and Wellbeing

a. Reported using the Index for Relative Socio-Economic Disadvantage.

b. For the population aged 15–64 years.

c. Individuals who required help or supervision for one or more core activities, such as self-care, mobility or communication.

*Sources: Australian Bureau of Statistics,*[61,62] *Lawrence et al.*[28]

## Table A4: Proportion of adults with very high levels of psychological distress, 2014–15

| Category | Subcategory | NHS[a] (%) | CASMHWB[b] (%) |
|---|---|---|---|
| **Sex** | Male | 3.1 | 4.0 |
| | Female | 4.3 | 9.5 |
| | Persons | 3.7 | 6.6 |
| **Age group** | 18–24 years | 4.0 | NA |
| | 25–34 years | 3.1 | NA |
| | 35–44 years | 4.1 | NA |
| | 45–54 years | 4.7 | NA |
| | 55–64 years | 4.3 | NA |
| | 65–74 years | 3.3 | NA |
| | ≥75 years | 1.7 | NA |

CASMHWB – Child and Adolescent Survey of Mental Health and Wellbeing

NA – not applicable

NHS – National Health Survey

a. Psychological distress scores using the Kessler Psychological Distress Scale (K10).

b. Psychological distress scores using an enhanced version of the Kessler Psychological Distress Scale (K10+).

*Sources: Australian Bureau of Statistics,*[62] *Lawrence et al*[28]

**Table A5: Proportion of Aboriginal and Torres Strait Islander adults with high/very high levels of psychological distress, compared with non-Indigenous Australians, 2011–13**

| Category | Subcategory | Indigenous[a] (%) | Non-Indigenous[b] (%) |
|---|---|---|---|
| **Sex** | Male | 23.5 | 8.9 |
| | Female | 34.8 | 12.6 |
| | Persons | 29.4 | 10.8 |
| **Age group** | 18–24 years | 30.2 | 13.2 |
| | 25–34 years | 29.9 | 11.0 |
| | 35–44 years | 30.5 | 11.1 |
| | 45–54 years | 34.7 | 11.1 |
| | 55–64 years | 24.5 | 9.2 |
| | 65–74 years | NA | NA |
| | ≥75 years | NA | NA |
| **Remoteness** | Non-remote | 31.2 | 10.8 |
| | Remote | 22.8 | 11.3 |

NA – not available

a. Psychological distress scores using the modified Kessler Psychological Distress Scale (K5).

b. Non-Indigenous results are derived from the Australian Health Survey 2011–13.

*Source: Australian Bureau of Statistics*[63]

## Table A6: Rate of social, community or family participation in people with mental illness, 2014

| Category | Subcategory | Has mental health condition (%) | Does not have mental health condition (%) |
|---|---|---|---|
| **Frequency of face-to-face contact with family or friends living outside the household** | Everyday | 15.1 | 19.4 |
| | At least once a week | 61.5 | 57.7 |
| | At least once a month | 15.7 | 15.8 |
| | At least once in 3 months | 3.5 | 3.8 |
| | No recent contact | 4.1 | 3.4 |
| **Has actively participated in groups in the past 12 months** | Social groups | 48.9 | 51.9 |
| | Community support groups | 34.5 | 32.6 |
| | Civic and political groups | 15.4 | 13.0 |
| **Feels able to have a say within community on important issues** | All/most of the time | 20.0 | 25.3 |
| | Some of the time | 26.7 | 29.4 |
| | Little/none of the time | 53.2 | 45.2 |

*Source: Australian Bureau of Statistics*[64]

## Table A7: Proportion of people with mental illness in employment, 2014–15

| Labour force status | Has mental health condition (%) | All persons (%) |
|---|---|---|
| **Employed** | 52.4 | 64.2 |
| **Unemployed** | 7.1 | 3.8 |
| **Not in labour force** | 40.5 | 32.0 |

*Source: Australian Bureau of Statistics*[62]

## Table A8: Change in mental health consumers' clinical outcomes, 2014–15

| Age group | Subcategory | Outcome | | |
|---|---|---|---|---|
| | | Significant improvement (%) | No significant change (%) | Significant deterioration (%) |
| **≤17 years** | Completed inpatient | 56.0 | 34.3 | 9.7 |
| | Completed ambulatory | 47.9 | 45.3 | 6.7 |
| | Ongoing ambulatory | 36.5 | 49.2 | 14.4 |
| **18–64 years** | Completed inpatient | 75.4 | 20.4 | 4.2 |
| | Completed ambulatory | 48.4 | 45.1 | 6.5 |
| | Ongoing ambulatory | 25.9 | 58.5 | 15.6 |
| **≥65 years** | Completed inpatient | 69.4 | 24.4 | 6.1 |
| | Completed ambulatory | 44.5 | 49.6 | 5.8 |
| | Ongoing ambulatory | 24.3 | 62.1 | 13.6 |
| **All ages** | Completed inpatient | 73.2 | 21.9 | 4.9 |
| | Completed ambulatory | 47.6 | 46.0 | 6.4 |
| | Ongoing ambulatory | 27.6 | 57.2 | 15.2 |

*Source: Australian Institute of Health and Welfare*[42]

## Table A9: Population access to mental health care, 2016

| Category | Subcategory | Rate per 100 population[a] |
|---|---|---|
| **Source** | State and territory services | 1.8 |
| | Private psychiatric services | 0.2 |
| | MBS/DVA | 9.0 |
| **Indigenous/ non-Indigenous** | State and territory services | 4.8 |
| | Private psychiatric services | NR |
| | MBS/DVA | 8.7 |
| **Non-Indigenous** | State and territory services | 1.6 |
| | Private psychiatric services | NR |
| | MBS/DVA | 8.3 |

DVA – Australian Government Department of Veterans' Affairs
MBS – Medicare Benefits Schedule
NR – not reported
a. Rates are age-standardised to the Australian population as at 30 June 2001.

*Source: Australian Institute of Health and Welfare*[65]

## Table A10: Population access to mental health care, by geographical remoteness, 2014–15

| Remoteness | Source | Rate per 100 population[a] |
|---|---|---|
| **Major cities** | State and territory services | 1.5 |
| | Private psychiatric services | 0.2 |
| | MBS/DVA | 9.2 |
| **Inner regional** | State and territory services | 2.1 |
| | Private psychiatric services | 0.1 |
| | MBS/DVA | 9.9 |
| **Outer regional** | State and territory services | 2.6 |
| | Private psychiatric services | 0.1 |
| | MBS/DVA | 7.5 |
| **Remote** | State and territory services | 3.3 |
| | Private psychiatric services | NR |
| | MBS/DVA | 4.0 |
| **Very remote** | State and territory services | 3.1 |
| | Private psychiatric services | NR |
| | MBS/DVA | 2.2 |

DVA – Australian Government Department of Veterans' Affairs
MBS – Medicare Benefits Schedule
NR – not reported
a. Rates are age-standardised to the Australian population as at 30 June 2001.

*Source: Australian Institute of Health and Welfare*[65]

## Table A11: Population access to mental health care, by age group and gender, 2014–15

| Category | Subcategory | Rate per 100 population[a] |
|---|---|---|
| **Age group** | <15 years | 1.0 |
| | 15–24 years | 2.7 |
| | 25–34 years | 2.2 |
| | 35–44 years | 2.2 |
| | 45–54 years | 1.7 |
| | 55–64 years | 1.2 |
| | ≥65 years | 1.3 |
| **Sex** | Male | 1.8 |
| | Female | 1.8 |

NR – not reported

a. Rates are age-standardised to the Australian population as at 30 June 2001.

*Source: Australian Institute of Health and Welfare*[65]

## Table A12: Rate of post-discharge community care follow-up, 2014–15

| Category | Subcategory | Post-discharge community care (%) |
|---|---|---|
| **Jurisdiction** | New South Wales | 63.3 |
| | Victoria | 73.1 |
| | Queensland | 74.8 |
| | Western Australia | 58.0 |
| | South Australia | 59.9 |
| | Tasmania | 67.9 |
| | Australian Capital Territory | 70.3 |
| | Northern Territory | 53.2 |
| | **Australia** | **67.0** |
| **Age group** | <15 years | 67.4 |
| | 15–24 years | 66.6 |
| | 25–34 years | 65.9 |
| | 35–44 years | 67.1 |
| | 45–54 years | 69.2 |
| | 55–64 years | 68.5 |
| | ≥65 years | 64.3 |
| **Sex** | Male | 65.6 |
| | Female | 68.4 |
| **Indigenous status** | Indigenous | 62.4 |
| | Non-Indigenous | 67.5 |
| **Geographical remoteness** | Major cities | 66.9 |
| | Inner regional | 69.5 |
| | Outer regional | 70.8 |
| | Remote and very remote | 60.6 |

*Source: Australian Institute of Health and Welfare*[65]

## Table A13: Proportion of total mental health workforce accounted for by the mental health peer workforce, 2014–15

| Jurisdiction | Consumer worker (FTE per 10,000 health care provider FTE) | Carer worker (FTE per 10,000 health care provider FTE) |
|---|---|---|
| New South Wales | 40.0 | 7.7 |
| Victoria | 28.9 | 29.1 |
| Queensland | 51.8 | 3.9 |
| Western Australia | 13.7 | 1.9 |
| South Australia | 66.7 | 32.1 |
| Tasmania | 7.7 | 8.0 |
| Australian Capital Territory | 0.0 | 0.0 |
| Northern Territory | 4.2 | 9.3 |
| **Australia** | **36.8** | **13.5** |

FTE – full-time equivalent

*Source: Australian Institute of Health and Welfare*[66]

## Table A14: Rates of suicide, Australia, 2015

| Category | Subcategory | Suicide rate per 100,000 population[a] |
|---|---|---|
| **Age group** | 0–14 years | 0.3 |
| | 15–24 years | 12.5 |
| | 25–34 years | 15.4 |
| | 35–44 years | 18.7 |
| | 45–54 years | 20.3 |
| | 55–64 years | 13.5 |
| | 65–74 years | 11.9 |
| | 75–84 years | 13.6 |
| | ≥85 years | 18.0 |
| **Sex** | Male | 19.3 |
| | Female | 6.1 |
| **Jurisdiction** | New South Wales | 10.6 |
| | Victoria | 10.8 |
| | Queensland | 15.7 |
| | Western Australia | 15.0 |
| | South Australia | 13.4 |
| | Tasmania | 16.3 |
| | Australian Capital Territory | 11.6 |
| | Northern Territory | 21.0 |
| | **Australia** | **12.6** |
| **Indigenous status[b]** | Indigenous | 25.5 |
| | Non-Indigenous | 12.5 |

a. Age-specific rate per 100,000 of estimated mid-year population.

b. Results by Indigenous status only include data for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory.

*Source: Australian Bureau of Statistics*[15]

## Table A15: Rate[a] of seclusion in acute mental health units, 2015–16

| Category | Subcategory | Seclusion events per 1000 bed days |
|---|---|---|
| **Jurisdiction** | New South Wales | 8.7 |
| | Victoria[b] | 8.6 |
| | Queensland[c] | 9.4 |
| | Western Australia | 4.8 |
| | South Australia | 5.0 |
| | Tasmania | 13.1 |
| | Australian Capital Territory | 1.6 |
| | Northern Territory[c,d] | 23.9 |
| | **Australia** | **8.1** |
| **Target population** | General | 9.2 |
| | Child and adolescent | 10.3 |
| | Older person | 0.5 |
| | Forensic[c] | 9.2 |
| **Geographical remoteness** | Major city | 7.9 |
| | Inner regional | 7.7 |
| | Outer regional and remote | 11.2 |

a. Rate of seclusion events per 1000 bed days for public sector acute specialised mental health hospital services.

b. Victoria has fewer beds per capita than other jurisdictions and, as a result, it may be useful to view the rate of seclusion events in a broader population context.

c. Queensland and the Northern Territory do not report any acute forensic services; however, forensic patients can and do access acute care through general units.

d. Due to the low ratio of beds per person in the Northern Territory compared with other jurisdictions, the apparent rate of seclusion is inflated when reporting seclusion per patient day compared with reporting on a population basis. Due to the low number of beds in the Northern Territory, high rates of seclusion for a few individuals have a disproportionate effect on the rate of seclusion reported.

*Source: Australian Institute of Health and Welfare*[56]

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