A Contributing Life

The 2014 Report Back

On the 2012 and 2013 National Report Cards on Mental Health and Suicide Prevention

Australian Government
National Mental Health Commission

The 2014 National Report Back on Mental Health and Suicide Prevention

In 2012 the Commission set out ten clear recommendations in the first National Report Card on Mental Health and Suicide Prevention (the Report Card) for governments and others to consider. In 2013 we reported back on progress against those ten recommendations, and made an additional eight recommendations.

In 2014 the Commission was directed by Government to undertake the National Review of Mental Health Programmes and Services. Consequently, the Commission has not produced a Report Card for 2014. However, we made a commitment to report back to the community. This document provides a Report Back on the eighteen recommendations made in the first two Report Cards.

In developing this 2014 Report Back, the Commission surveyed both Federal and state and territory governments seeking their input and advice in regard to local progress. We received responses from five Commonwealth Departments: Education, Employment, Health, Social Services and Prime Minister and Cabinet. Responses have been received from all states and territories.

For the first time we also sought advice from the non-government sector for input to the 2014 Report Back. Twenty three non-government organisations (NGOs) have provided data in response.

The Commission acknowledges the efforts of all these agencies, and thanks them for their contributions. All responses have been collated into a separate document. That document can be accessed at http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards.aspx (2014 Report Back Supplementary paper).

The Commission has summarised key information provided by Commonwealth agencies, states and territories, and NGOs for inclusion in this 2014 Report Back. Along with the actions taken by the Commission, this provides a picture of progress against the 18 recommendations. Overall, we see advances in mental health reform, but this continues to vary across Australia. The Commission aims to continue to collaborate with all elements of the sector, and people with lived experience and their families and support people, to enable all to lead contributing lives.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
1: Nothing about us, without us – there must be a regular independent survey of people's experiences of and access to all mental health services to drive real improvement. **Action called for**: The National Mental Health Commission will undertake a regular national survey of people with mental health difficulties and their families and support people. This survey will consider access to services, as well as perceptions and experiences. This will build on and complement existing efforts and ensure that people always have a voice and remain at the centre of decision-making about all the services that impact on them.	Nationally: A National Consumer Experience of Care (CEOC) measure has been developed. The Federal Government currently funds a number of projects to capture perspectives of health care services of people with a lived experience of mental health and carers. Work on the "Living in the Community" survey has been ongoing since 2011, and is designed to capture key aspects of social outcomes and economic productivity of people with a lived experience of mental health including housing, employment, education and community engagement. The Commission looks forward to this measure being publicly available in 2015. Jurisdictions: Governments are actively engaged across a number of fronts to involve people with mental illness and their families/carers. This includes: implementation of paid participation, experience of care surveys and involving people with lived experience in planning and decision-making for mental health services. South Australia has a Statewide Mental Health Lived Experience Register with 163 members who provide information and feedback on mental health policy and strategy work, as well as providing lived experience representation on mental health committees and working groups. NGOs: The sector embeds the voices of clients, families and carers through case coordination, service surveys, and involvement in policy and procedure development. Several NGOs indicated the use of a 'consumer participation framework' within their service, in addition	The Commission has contracted the AIHW to develop an options paper for a national rollout of the Contributing Life Survey. This will be considered in the Commission's future workplan. The Commission established the Mental Health Future Leaders programme to ensure a broad range of people with lived experience and carers have an enhanced voice in providing advice to the Commission and the mental health sector. Eleven Future Leaders completed the programme in October 2014. The Commission's Project Advisory Groups established for all collaborative projects include people with lived experience and carers. During the Review of Mental Health Programmes and Services the Commission undertook a public Call for Submissions. Over the course of the Review we received more than 2,000 submissions which were considered in the development of the Review Report.

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	to the collection and evaluation of client feedback to improve services. **Work on the roll out of the Contributing Life Survey continues. The Commission looks forward to the National Consumer Experience of Care (CEOC) being made publicly available in 2015.**	
2: Increase access to timely and appropriate mental health services and support from 6-8 per cent to 12 per cent of the Australian population. **Action called for**: All governments must agree and meet the target in the Fourth National Mental Health Plan Measurement Strategy that 12 per cent of the population should be able to access mental health services in a year.[i] There must be an agreement to this indicator with an implementation plan and investment strategy to achieve this.	Nationally: We know that in 2011-12 an estimated 9.2 per cent of the population received clinical mental health services (up from 8.6 per cent in 2010-11). While AIHW reporting identifies that more people are accessing mental health services, there has been no co-ordinated national strategy to increase access to mental health services. Jurisdictions: A number of states have implemented new services, along with planning frameworks and investment plans. These are at an early stage. South Australia has a policy directive which includes procedures for equitable and timely access to mental health services. Western Australia applied the National Mental Health Service Planning Framework to its state mental health plan, *The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* launched in December 2014 for consultation. NGOs: NGOs identified that gaps in services continue to exist, and changing funding criteria can affect access to services for people with a mental illness. There is general agreement that the Better Access programme resulted in improved access to services, and that online alternative models and helplines have a role in improving access to services, although clear online pathways are needed.	The Commission has completed the National Review of Mental Health Programmes and Services, identified where gaps and barriers are, and where money is spent effectively, efficiently and for the best outcome. The Review also included consideration of timely access to mental health supports across the population and lifespan. The Report of the Review was submitted to Government on 1 December 2014.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
	While current data indicate that access to mental health services has increased, there has been no co-ordinated national strategy to increase access to mental health services, nor agreement to the target of 12 per cent of the population per year accessing mental health services.	
3: Reduce the use of involuntary practices and work to eliminate seclusion and restraint. **Action called for**: All jurisdictions must contribute to a national data collection to provide comparison across states and territories, with public reporting on all involuntary treatments, seclusions and restraints each year from 2013. This information should be reported at the service unit level. **Action called for:** The National Mental Health Commission will call for evidence of best practice in reducing and eliminating seclusion and restraint and help identify good practice treatment approaches. We will do this in partnership with the Mental Health Commission of Canada and Australian partners, including the Safety and Quality Partnerships Standing Committee, Disability Discrimination Commissioner, Australian Human Rights Commission and interested state mental health commissions.	Nationally: Involuntary admissions are not currently reported at the jurisdictional level for admitted patient care. The national rate for admitted patient separations with an involuntary mental health legal status was 29.5 per cent. Involuntary admissions for state and territory Community Mental Health Care (CMHC) services and Residential Mental Health Care services (RMHC) are published annually in the AIHW's *Mental health services in Australia* report. The national rate for involuntary service contacts in CMHC services was 13.2 per cent. For RMHC episodes, the involuntary rate was 22.8 per cent. The 2014 Report on Government Services included reporting against a new indicator on seclusion events. All jurisdictions are working towards the development of a national seclusion and restraint data collection which will be reported by AIHW. The NDIS is also developing an approach to restrictive practices which will be consistent with the 2014 National Framework for Reducing Restrictive Practices in Disability Services. Jurisdictions: All jurisdictions contribute to the collection of data on seclusion, and Victoria has also developed and implemented guidelines on seclusion and restraint with the aim of decreasing the use of restrictive practices. The Australian Capital Territory is developing a training package that focuses on engagement and de-escalation to reduce aggression and distress. South Australia has developed a Restraint and	National data on seclusion and restraint was released for a second time in December 2014. The Commission called for evidence and commissioned a literature review and report to identify good practice and facilitate improvements in services. The Report by the University of Melbourne informed the development of a position paper auspiced by a core reference group. This position paper was released on 29 may 2015 at the 10th National Forum on Seclusion and Restraint.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
	Seclusion Minimisation Policy which will be implemented statewide. NGOs: The NGO sector reported to the Commission that access to services is on a voluntary basis with a "no restraint" policy. The sector supports reform in the use of seclusion and restraint practices, with several organisations noting that they are contributing to state and territory policy development on this issue. **The rates of involuntary treatments are reported nationally. Seclusion events were reported in the 2014 Report on Government Services. While most jurisdictions are working to reduce the use of seclusion and restraint, we remain a long way from eliminating the use of these practices. The Commission will continue to work with others on this issue.**	
4: All governments must set targets and work together to reduce early death and improve the physical health of people with mental illness. **Action called for**: Enduring mental illness must be given the status of a chronic disease to give it higher national focus and support. **Action called for**: The physical health needs of people with mental health problems need to be given a higher priority in all areas of health. The initial focus must be on rapidly reducing cardiovascular disease by reducing risk factors such as smoking, poor diet and by increasing physical activity for people living with mental health problems. **Action called for**: All government funded mental health related programmes must also be measured on how they support people to achieve better physical health and longer lives. Priority should be given to the financing of multi-disciplinary primary care	Nationally: While mental health has been identified as a National Health Priority Area, and the Standing Council on Health has released a statement on the rights and responsibilities of people who provide mental health services, there has been little progress on establishing national agreed targets to reduce early death and improve the physical health of people with mental illness. Jurisdictions: A majority of jurisdictions indicated that they have policies to improve the physical health of people with mental illness, or policies and/or standards are in the development stage. Victoria has a new Mental Health Act (2014) with a range of programmes and initiatives. The Australian Capital Territory has co-morbidity clinicians working across mental health and alcohol and drug programmes. South Australian policy promotes that co-morbid physical and mental health	The Commission's previous work for COAG on targets and indicators in 2013 remains to be endorsed by COAG. However, this work informed the 2014 National Review of Mental Health Programmes and Services in which again the priority to develop a set of national mental health targets was identified - R*ecommendation 4: Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.* The Commission is now facilitating the development of a national consensus statement on implementation of reforms to maximise the physical health of people with severe mental ill health problems.

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(through GPs and other primary health care organisations). **Action called for**: All relevant services must give priority to tracking of <u>both</u> the physical and mental health needs of those with enduring mental illness.	problems are addressed holistically, as well as seeking to establish performance indicators for physical health. NGOs: Physical health is included in the holistic approach to care embedded in the NGO sector. This includes encouraging clients to have regular physical health checks, the provision of training and education resources, fact sheets and information services. The Partners in Recovery (PIR) programme was highlighted as a programme which managed both the mental and physical health needs of clients. **Enduring mental illness has not been given higher national focus as a chronic disease. The physical health needs of people with mental illness are well recognised, with all sectors identifying physical health as a priority. However, there is little evidence of measurement of service outcomes in this area, or work on tracking the physical and mental health needs of those with enduring mental illness.**	
5: Include the mental health of Aboriginal and Torres Strait Islander peoples in 'Closing the Gap' targets to reduce early deaths and improve wellbeing. **Action called for**: Mental health must be included as an additional target in the COAG 'Closing the Gap' programme. This must be done through the development and implementation of an Aboriginal and Torres Strait Islander Mental and Social and Emotional Wellbeing Plan to commence in 2013. This must also address the future findings of the Aboriginal and Torres Strait Islander Suicide Prevention Advisory Group. **Action called for**: Training and employment of Aboriginal and Torres Strait Islander peoples in mental health services must	Nationally: An Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group (ATSIMHSPAG) has been established to guide the development of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy. The Federal Government continued funding in 2014-15 for the National Empowerment Project which is working to address social and emotional wellbeing issues and high suicide rates experienced among Indigenous communities. The National Review of Mental Health Programmes and Services included programmes and services for Aboriginal and Torres Strait Islander peoples as a specific term of reference. A range of initiatives are	The Commission supported and signed an MoU with the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) in October 2014 to assist NATSILMH to undertake its role in advocating and providing advice and leadership to help restore, maintain and promote the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander mental health was included as a Term of Reference for the national Review, and a specific paper was commissioned to contribute to the development of the Review Report. This paper was developed with the involvement of Professor Dudgeon and Dr Calma AO.

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increase. There must also be better support for Aboriginal and Torres Strait Islander families. There must be regular reporting on progress.	required to address suicide in Indigenous communities. Mental health has not yet been included in the COAG 'Closing the Gap' programme. Jurisdictions: Aboriginal and Torres Strait Islander mental health and wellbeing is identified as a key priority by states and territories. There are a range of programmes including the employment of Aboriginal Liaison Officers, health, training and employment in Indigenous communities. There is a focus on promotion and prevention of mental ill-health, with initiatives involving Indigenous representation for improved access to services as well as better outcomes. The Statewide Specialist Aboriginal Mental Health Service in Western Australia has been evaluated and allocated funding of $29.1 m over the next three years, providing specialist clinical interventions for people with severe and persistent mental illness, and will have a specific focus on children/youth for these years. NGOs: The NGO sector described efforts to ensure culturally appropriate services by providing staff education and support in Aboriginal and Torres Strait Islander cultural awareness. The holistic approach taken by many NGOs has seen an increased Aboriginal and Torres Strait Islander workforce to support service responsiveness and delivery, in addition to involving Indigenous clients in consultation and service reviews. **All sectors advised significant work with Aboriginal and Torres Strait Islander peoples, however mental health has not been included as an additional target in the COAG "Closing the Gap" targets. The Commission will continue to highlight the needs of this group, and its call for regular reporting on progress on Mental and**	The Commission also signed a MoU between the New South Wales Mental Health Commission, Queensland Mental Health Commission, Western Australia Mental Health Commission and the New Zealand Mental Health Commission in July 2014 recognising common areas of concern and potential collaboration, including Aboriginal, Torres Strait Islander and Maori mental health.

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	Social and Emotional Wellbeing, and training and employment of Aboriginal and Torres Strait Islander people in mental health services.	
6: There must be the same national commitment to safety and quality of care for mental health services as there is for general health services. **Action called for**: All governments must agree that there is the same emphasis on improving the quality of care and reducing adverse events in mental health services as applies to other physical health services. Governments must commit to implement nationally agreed and mandatory service standards in mental health services as they have for other health services. The National Mental Health Commission will work with the Australian Commission on Quality and Safety in Health Care to identify what it takes to get proper uptake of national mental health service standards and make them mandatory.	Nationally: The National Mental Health Commission and the Australian Commission for Safety and Quality in Health Care have conducted a scoping study on the implementation of national standards for mental health services. Further work is progressing to consider these standards in the revision of the National Safety and Quality Health Service standards. Organisations receiving funding from the Department of Social Services must meet national standards. Jurisdictions: All states and territories support the provision of quality mental health services, with Victoria's new service delivery arrangements focussing on outcomes, and Western Australia assessing services against the national standards for accreditation purposes. The Australian Capital Territory reports that mental health services participate in an accreditation process alongside general health services. Quality improvement processes are integrated at the Local Health Network operational level in South Australia, and monitored by the Strategic Mental Health Safety and Quality Committee. The Commission is mindful that any changes to processes as a result of quality and safety standards does not increase accreditation burden without substantial benefit. NGOs: A number of NGOs reported that their organisation has professional practice standards or have implemented evidence based service guidelines. Issues relating to the NDIA were raised, in particular that each state has its own standards and auditing requirements	The project undertaken in partnership with the Australian Commission on Safety and Quality in Health Care (ACSQHC) resulted in improved understanding of the barriers and enablers to current national mental health standards and their relationship to mandatory safety and quality health service standards. This work provided insight into what is needed to achieve proper uptake of *National Standards for Mental Health Services* (NSMHS) and incorporate them into the existing *National Safety and Quality Health Service* (NSQHS*) Standards*. Views of service providers, policy makers and people with lived experience and their families and support people were sought and considered in the final report. The report, *Scoping Study of the Implementation of National Standards in Mental Health Services*, was released in August 2014 and has three recommendations. These will also inform the planned review of the *NSQHS Standards*. The scoping study is available on both Commissions' websites. The recommendations are: 1. The ACSQHC should use information regarding the safety issues identified in this scoping study to inform the planned review of the *NSQHS Standards*. 2. The ACSQHC should revise the *NSQHS Standards* to include items that will address the specific safety issues faced by people with

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	for organisations and services provided within their jurisdiction. A national approach would enable NGOs which operate in more than one jurisdiction to meet common requirements. There was a general view that there are no standards for community mental health services and e-mental health services which was seen as problematic. **The review of the National Safety and Quality Health Service standards includes consideration of incorporating national standards in mental health services; in particular as they relate to seclusion and restraint and participation by people with a lived experience of mental illness and their carers.**	lived experience of mental health issues accessing all health services. 3. Jurisdictions and stakeholders with responsibility for implementing the *NSMHS* should consider the role and function of the National Standards for Mental Health Standards.
7: Invest in healthy families and communities to increase resilience and reduce the longer-term need for crisis services. **Action called for**: Increase enhanced and personalised support for parenting through culturally relevant forms of home based visiting (ante-natal and in the first few years of life). These must be provided at a local or regional level. There must also be active follow up where a family is under stress or experiencing tough financial or social difficulties.	Nationally: Nationally there are a number of funded initiatives providing services for families and communities, including Children of Parents with Mental Illness (COPMI) and KidsMatter, through to Respite: Carer Support and Family Mental Health Support Services (FMHSS). These services provide early intervention support to assist vulnerable families with children and young people who are at risk of, or affected by, mental illness. In April 2013 additional funding for the Mental Health Respite: Carer Support programme was announced by the Australian government; this includes access for approximately 1,100 extra families of people with severe mental illness access to flexible respite and support services. In addition, the Partners in Recovery programme has been funded to support people with severe and persistent mental illness with complex needs and their carers and families. Jurisdictions: States and territories also have a range of mechanisms to support families at different life stages,	The 2014 National Review of Mental Health Programmes and Services reinforced the need to invest early to prevent mental health problems from developing.

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	including help for parents in the antenatal and infant stage, and childhood programmes with early intervention and parenting programmes. These programmes raise awareness about mental illness, and will assist in bringing human service agencies together to provide a person centred approach to meet the needs of clients. Victoria's Services Connect model of service delivery provides one assessment, one client record across agencies and a key worker as a single point of contact for clients. South Australia is implementing Youth Mental Health Services across the state, in addition to recently combining Child and Adolescent Services into a single statewide service. NGOs: NGOs provide services under a range of programmes that seek to increase the capacity of families to manage and respond to mental health issues. Information provision and advocacy around wellbeing, in addition to school programmes and community resilience building all support the mental health of families. **The Commission has seen sector wide commitment to healthy families and communities to increase resilience with a number of programmes providing funding to families.**	
8: Increase the levels of participation of people with mental health difficulties in employment in Australia to match best international levels. **Action called for**: The National Mental Health Commission will pull together a Taskforce including industry, government and community leaders to actively promote effective government and workplace programmes that increase the participation of people with mental health difficulties in employment. The Commission	Nationally: National programmes including the Targeted Community Care (TCC) and Partners in Recovery (PIR) programmes provide person-centred support for employment services for people with mental illness. These programmes received funding of $180.8 million and $65.8 million respectively in 2012 and 2013. An evaluation of the Targeted Community Care programme identified positive outcomes for people, their families and carers. An evaluation of the Partners in Recovery	The Commission initiated the Mentally Healthy Workplace Alliance to encourage and support business in creating mentally healthy workplaces. The Alliance is a coalition of government, business and community working together. The Commission called for evidence in good workplace practices, and the business sector shared their experiences. The spotlight report on good workplace practices was well received, with businesses starting

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
will partner with key industry and community groups to Call for Evidence and work together to advance the adoption of good practice in Australia. **Action called for**: Employment support programmes, initiatives and benefits must be more flexible. They must recognise that mental illness comes and goes and what that means for people and their families. Programmes must provide long term support for the employee, families and support people and the employer, with appropriate incentives and milestones.	programme is underway. In addition, there are 30 Disability Employment Services providers contracted nationally to provide assistance to job seekers, to gain employment and provide support to stay in the workplace. A range of smaller programmes also provide assistance for employment. Jurisdictions: States and territories report a growing number of peer workers within the mental health service sector. Several states, such as Queensland and Victoria include employment services within planning frameworks, while Western Australia is establishing an independent placement support programme for people with mental illness. NGOs: NGOs identified the key role that education and employment have in a person's recovery journey. NGOs provide a range of roles, including individualised approaches for clients and placement support, corporate education programmes and support, and social enterprises. **Significant Commonwealth funding has been provided in support programmes to assist people with mental illness to gain and maintain employment. The Commission has partnered with government and business to produce a literature review on good workplace practices for mental health.**	to actively pursue mental health and wellbeing in their workplaces. A Literature Review on evidence for developing a mentally healthy workplace was undertaken for the Commission by the Black Dog Institute/University of NSW Institute of Psychiatry. The Alliance partnered with beyondblue in its *Heads Up* campaign, promoting the development of mentally healthy workplaces. The campaign includes Alliance developed resources and those developed by beyondblue. Businesses can register to receive tailored information and develop their own mental healthy workplace plan. The Commission will provide seed funding to establish an industry liaison position with the aim of extending Alliance reach, and support business and industry. The position will be based in one of the business member organisations. The Commission provided a submission to the McClure welfare review, highlighting the need for greater consideration of the episodic nature of mental illness in reform proposals.
9: No-one should be discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services into homelessness. Access to stable and safe places to live must increase. **Action called for**: All governments implement and report regularly on the existing COAG commitment of 'no exits into homelessness'	Nationally: There has been national funding for 17 projects under the National Partnership Agreement Supporting National Mental Health Reform. The programme aims to support states and territories to improve health, social, economic, and housing outcomes for people with severe and persistent mental illness. The National Partnership Agreement on	The intrinsic role of safe, stable housing was addressed in the development of the 2014 National Review of Mental Health Programmes and Services report to Government.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
from statutory, custodial care and hospital, mental health and drug and alcohol services for those at risk of homelessness. **Action called for**: Discharge planning must consider whether someone has a safe and stable place to live. Data must also be collected on housing status at point of discharge and reported on three months later, linked to the discharge plan. **Action called for**: Governments must commit to removing any structural discrimination barriers to accessing housing. Just as important is providing support to help vulnerable residents to settle in, adjust and remain in their homes.	Homelessness (NPAH) and the National Affordable Housing Agreement (NAHA) are joint funded programmes by Commonwealth and states/territories providing homelessness services in all jurisdictions. On 30 June 2014 the Commonwealth committed up to $115 million to renew the NPAH. This funding has allowed continuation of homelessness service delivery for another year. There is no indicator of discharge or exits to homelessness, nor data collected on exits to homelessness. Jurisdictions: States and territories have identified the need for greater service provision in this area, and have provided additional supported accommodation and secure tenancies to people with mental illness. The Pathways to Care policy directives implemented in South Australia include that Mental Health Services exit no person to homelessness and ensure that at the point of exit the person has an offer of available and suitable accommodation. An evaluation of the Housing and Support Programme (HASP) in South Australia demonstrated improvements in people's quality of life and reduced hospital admissions and crisis service usage. NGOs: NGOs identified that safe, stable and secure housing is essential for people with mental illness to support their recovery journey. There are a range of programmes that provide personalised support to gain and retain safe and affordable accommodation. The sector suggests that there is a need to expand funding levers to encourage investment along with engagement of the corporate sector to fill the gaps that continue to exist.	

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
	While funding has been provided to improve health, social, economic, and housing outcomes for people with severe and persistent mental illness, no progress has been made on development of a data collection or reporting of exits to homelessness. The impact of inadequate, short term, unaffordable housing on people with a lived experience and carers continues to be of concern to the Commission.	
10: Prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting. **Action called for**: Develop local, integrated and more timely suicide and at-risk reporting and responses. Developing and rolling out well coordinated community based, culturally appropriate, early response systems and suicide prevention programmes which promote community safety, reach the most vulnerable, and using up to date information from the 'first responders' such police officers, occupational health workers, ambulance officers and mental health workers. **Action called for**: Programmes with a proven track record (which are evidence based) must be supported and implemented as a priority in regions and communities with the highest suicide or attempted suicide rates – action needs commitment and a humane approach.	Nationally: The Commonwealth government invested $23.0 million in 2012-13 on the National Suicide Prevention Programme (NSPP), and $19.2 million on the Taking Action to Tackle Suicide (TaTS) programme in the same year, which targeted groups at high risk of suicide. Funding is also provided to a number of helplines. An evaluation of the NSPP found that the initiatives funded reached a broad range of target groups in a range of settings, and achieved improvements in knowledge about risk and protective factors for suicide, social connectedness and mental health literacy. Funding was also provided for Mental Health First Aid training for frontline community workers. Jurisdictions: All states and territories reported action on suicide prevention, at a range of stages. Some jurisdictions have a draft plan, while others have completed planning and have implemented a range of services funded within a defined suicide strategy. The Australian Capital Territory has created a Crisis Response Clinician position within Child and Adolescent Mental Health. South Australia Health has developed a resource "Engaging with the Suicidal Person" for all clinicians working with suicidal people. NGOs: Many NGOs outlined the suicide specific training undertaken by staff, as well as research projects and	We commissioned the Centre for Research Excellence in Suicide Prevention to undertake a 12-month project on people's experiences of suicide attempts. This work provides better insight into people's experiences in the lead-up to and after a suicide attempt. The project also researched what helped people after a suicide attempt, and what did not. A separate report was prepared on Care After a Suicide Attempt: Aboriginal and Torres Strait Islander people – thematic analysis. This work was used to inform the work of the 2014 Review. Suicide Prevention Australia and the Commission entered into an MoU in March 2014 to work together to reduce suicides nationally.

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	services specifically to prevent and reduce suicide. Adequate discharge planning from services is a key area needing attention, and many identified the value of peer workers within their service to support those at risk of suicide, and those surviving suicide. The success of the ATAPS Suicide Support Line was highlighted as providing active case management to ensure continuity of care for clients within the mental health system. **The Commission acknowledges the significant efforts by all sectors to address suicide in our community. However, suicide rates are no longer falling. Additional efforts are required to prevent and reduce suicide, and to provide greater assistance to those who attempt suicide. Local responses and reporting have been introduced in some communities. Evaluations of programmes suggest that gaps in services exist, and further actions are required to overcome these gaps.**	
11: People with co-existing mental health difficulties and substance use problems must be offered appropriate and closely coordinated assessment, response and follow-up for their problems. **Action called for**: We must have a mechanism to test compliance with "No Wrong Door" practices and ensure they do not exclude or discriminate against people with co-existing mental health and substance misuse problems. The benchmark for this must come from the experience of people affected by these difficulties, their families and supporters, then we can start to measure uptake of policies and impacts on peoples' experiences. **Action called for**: the Commission calls for innovative responses in this area that do not discriminate against people with co-existing difficulties - particularly around integrated services, funding and policy. These must embed appropriate assessment, treatment and	Nationally: The Commonwealth-funded headspace model provides a service platform and "no wrong door" policy. Commonwealth funding is also provided to the Centre for Research Excellence in Mental Health and Substance Use for a 'comorbidity project' which will revise and update guidelines on managing clients, and undertake a scoping exercise to assess training and support needs of mental health workers. Jurisdictions: All states and territories which responded to this recommendation are in some way integrating mental health care and comorbid substance abuse to better service people with coexisting difficulties. Initiatives include staff training, improved assessment and service models, and the introduction of comorbidity clinicians who work across mental health and alcohol and drug programmes. These improvements are making	Issues relating to the impacts of co-existing illness were addressed within the development of the report of the 2014 National Review of Mental Health Programmes and Services.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
professional supervision and be systematically evaluated. This will expand our understanding about what works, and help develop more effective models of practice appropriate to different groups. **Action called for**: Funding must facilitate these actions, not create barriers to them.	a difference for both clinicians and clients, however the Commission is aware that "wrong door" practices still exist. NGOs: The NGO sector has similarly used staff training and professional development to improve service outcomes for people with co-existing difficulties, and ensure that people are not turned away from a service. The service model approaches used by a number of NGOs, which involve the development of individual support plans and the use of warm referrals through established referral pathways improve the capacity of the sector to integrate mental health care and co-morbid substance abuse services. **There is agreement across the sector that people with co-existing mental health and substance use problems need to be provided integrated services including appropriate assessment, treatment and professional supervision. There are many examples where services have been integrated to ensure that people receive appropriate care. However, while these improvements are making a difference, the Commission is aware that "wrong door" practices still exist, and further work is needed to ensure that people with co-existing difficulties are not discriminated against.**	
12: National, systematic and adequately funded early intervention approaches must remain. This must be accompanied by robust evaluation to support investment decisions, with a focus on implementation, outcomes and accountability. **Action called for**: People using services, their families and supporters must be engaged with co-design, evaluation and monitoring of early intervention initiatives.	Nationally: A review of the headspace model began in January 2013 and is expected to be completed in 2015. The review has involved clients, families and carers, and affiliated service providers. The Department of Social Services funds the Family Mental Health Support Services (FMHSS) community mental health initiative which provides early intervention support to assist vulnerable families with children and young people who are at risk of, or affected by, mental illness. These	The Commission emphasised its commitment to an increased focus on early intervention in its 2014 Report to Government.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
Action called for: Continuous practice improvement must be driven by the findings of ongoing independent rigorous evaluation and appropriate accountability.	service models were designed and developed in collaboration with service providers and other key stakeholders. Jurisdictions: While states and territories informed the Commission about a range of improved promotion, prevention and early intervention initiatives and priorities, a national systematic approach is not apparent in terms of implementation and evaluation. NGOs: The NGO sector has participation in service design at the core of their work, with many reporting co-design principles and comprehensive participation by people with a lived experience of mental health. Some parts of the sector have advised the Commission that new service streams for the severely ill are required, as conditions left untreated are associated with poor outcomes. **Early intervention services such as headspace have been introduced and evaluation is underway. Further models of early intervention are needed that include robust evaluation so that funding decisions and continuous practice improvement are based on evidence of what works.**	
13: A National Mental Health Peer Workforce Development Framework must be created and implemented in all treatment and support settings. Progress must be measured against a national target for the employment and development of the peer workforce. **Action called for**: All governments and agencies must work together and with suitably experienced people with lived experience and their families to agree and implement a National Mental Health Peer Workforce Development Framework.	Nationally: Funding was provided to develop resources for a Certificate IV in Mental Health Peer Work. Jurisdictions: A National Framework remains outstanding, however most states and territories employ peer workers in mental health services, and the numbers of peer workers are growing. The Australian Capital Territory has implemented a Consumer and Carer Consultants Roles and Responsibilities Document. South Australia has a Statewide Mental Health Lived	The National Mental Health Commission has funded Community Mental Health Australia to develop learning and assessment resources for a Certificate IV in Mental Health Peer Work. These training materials have been completed, and are being piloted in Sydney by the Mental Health Coordinating Council, with the Commission scoping suitable websites for future hosting of materials.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
Action called for: This framework must identify a target and implementation strategy for the employment of peer workers in all support and treatment settings. **Action called for**: The Certificate IV Peer Work training materials developed by Community Mental Health Australia must be rolled out nationally when available.	Experience Workforce Development Project which commenced in 2013. This project involves the NGO and government sectors working collaboratively to develop a Mental Health Lived Experience Workforce Policy, Standards and Implementation Plan. This will utilise the Certificate IV Peer Work training materials funded by the Commission. NGOs: The use of peer workers by the NGO sector is increasing, with most NGOs advising that professional development and supervision of peer workers is a key focus, and many identifying a commitment to implementing the Certificate IV across their organisation. The increasing recognition by clinical teams of the benefits provided by the peer workforce was noted by the sector. One NGO reported that it has identified a need to develop a Peer Workforce Development Framework that will assist in matching peer workers to service users in recognition that life courses and lived experience of mental illness can differ between individuals. **The mental health peer workforce is expanding and their value in the care of people with mental illness is being recognised by clinical teams. The nongovernment sector has expressed commitment to implementing the Certificate IV course within organisations.**	One of the requirements of the National Training Package is that trainers of the Certificate IV have the qualification themselves. The Commission has provided funding to support 30 future trainers (the Champions Project) of the Certificate IV. There will be two cohorts in 2015, the first in Sydney in March, followed by Melbourne in June. The Champions have been selected from across Australia.
14: A practical guide for the inclusion of families and support people in services must be developed and implemented, and this must include consideration of the services and supports that they need to be sustained in their role. **Action called for**: Effective approaches to the meaningful inclusion of families and informal support people exist, and these must be	Nationally: The Commonwealth Government has funded three national projects to develop new survey measures to capture consumer and carer perspectives of health care services. These include the Consumer Experience of Care (CEOC) measure which developed the "Your Experience of Service" survey. Parallel work to develop a survey to capture carers' experiences of services has	Family and carer inclusive approaches were supported in our work on the 2014 National Review of Mental Health Programmes and Services. Work on the Contributing Life Survey is continuing, and when implemented data will be available to inform upon trends in family experience of services.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
harnessed and incorporated into a national practical guide. **Action called for**: The Commission will use the Contributing Life survey to assess compliance with these principles. This will complement the work being developed on the Consumer and Carer Experience of Care tool.	also been funded. Work on the "Living in the Community" survey has been ongoing since 2011, and is designed to capture key aspects of social outcomes for people with a lived experience of mental health including housing, employment, education and community engagement. The Commission looks forward to these measures being publicly available in 2015. Jurisdictions: All responding states and territories acknowledged the vital role of family and carers within mental health and the need to support them in this role through a range of initiatives and programmes. As examples, Queensland funds 14 organisations to provide family and carer support. The Victorian Mental Health Act (2014) recognises and supports the important role of carers in the assessment, treatment and recovery of people with mental illness. The Australian Capital Territory has established a Carer Consultant position in Adult Mental Health Services to better meet the needs of carers and undertake system advocacy, following the evaluation of the Consumer and Carer Participation Framework. South Australia has developed a Mental Health Consumer Rights and Responsibilities brochure, in addition to Pathways to Care Policy Directives and Guidelines which include procedures to ensure participation of the person, their family and support person/s in mental health services. NGOs: Families and carers are valued within services in the NGO sector. NGOs report providing support groups, information sessions and specific resources to assist families and carers. Several NGOs indicated that they are focussed on building organisational capacity to more effectively respond to families and carers, and to	

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
	identify their specific needs and roles. The need to fund this activity was raised, as the sector indicated that supporting families and carers is not included in their funded role. A one stop shop for families was also suggested as a service model which could provide improved assistance to families and carers. **The Commission continues to learn of more examples of approaches to including families and support people in services, their development, implementation and evaluation. However, work remains outstanding on a national practical guide to the meaningful inclusion of families and support people in mental health services.**	
15: The Commission calls for the implementation and ongoing evaluation of a sustained, multi-faceted national strategy for reducing discrimination. **Action called for**: We will continue to work with others to consider ways to end the vilification of people with mental illness. **Action called for**: We need more targeted anti-discrimination initiatives, beginning with those who come into frequent contact with people with mental health problems and their families and support people, as well as those among whom discrimination is the greatest.	Nationally: The Department of Health provides funding to a range of organisations and programmes to raise awareness and reduce stigma associated with mental illness. Organisations include beyondblue (national depression and anxiety initiative), and SANE StigmaWatch and SANE Media Centre (National Suicide Prevention Programme). The Mindframe Initiative is building a collaborative relationship between the media and other sectors to promote the responsible, accurate and sensitive media representation of mental illness and suicide. In terms of employment programmes, the Fair Work Act 2009 provides a range of measures that may assist employees with mental illness, including leave entitlements, flexible work arrangements and general protections from discrimination. Job Services Australia has developed an online mental health capacity building training package for staff engaged in employment services. Jurisdictions: States and territories have taken a number of actions to reduce discrimination against people with mental illness. These include providing funding to the	The Commission partnered with beyondblue on the *Heads Up* campaign during 2014 which included addressing discrimination in the workplace. The Mentally Healthy Workplace Alliance works to create more mentally healthy workplaces, including reducing stigma and discrimination of employees.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
	NGO sector to deliver community awareness, education and stigma reduction activities, legislation regarding employment adjustments for people with a disability, and participating in Mental Health Week. The Victorian Charter of Human Rights and Responsibilities outlines considerations for people with a disability, their families and carers. In 2014, Victoria established a Mental Health Complaints Commissioner. NGOs: The NGO sector plays a number of important roles, including the delivery of advocacy programmes, strategies in community awareness (such as the use of high profile ambassadors), and providing education about discrimination and its effects. There was general support for an increase in the number of funded agencies to advocate for people on an individual and systemic level to stop discriminatory practice across a range of sectors. **A considerable amount of effort has been made in reducing discrimination against people with mental illness, however the Commission is aware that it still occurs in our society. We call for an increased effort in assisting people on an individual and systemic level to challenge and report discriminatory practices.**	
16: All Australians need access to alternative (and innovative) pathways through school, tertiary and vocational education and training. **Action called for**: Australian governments must collect data, and report nationally on the educational participation of people experiencing mental health difficulties. A target must be set to reduce the numbers of those with mental health problems falling into the "not in education, employment or training" (NEET) group, thus tracking our progress against that of other countries.	Nationally: The Measurement Strategy of the Fourth National Mental Health Plan included the following indicators: • 1a Participation rates by people with mental illness of working age in employment: general population • 1b Participation rates by people with mental illness of working age in employment: public mental health service consumers • 2a Participation rates by young people aged 16–30 with mental illness in education and employment:	Engaging people in school, tertiary study and training was considered within the Review of Mental Health Programmes and Services.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
	general population • 2b Participation rates by young people aged 16–30 with mental illness in education and employment: public mental health service consumers Indicators 1a and 2a are reported in the National Mental Health Report 2013.[ii] Data shows that rates of participation by people with a mental illness of working age in employment have decreased over the past five years, and are currently (2011-12) 62 per cent employed compared to 80 per cent of those without a mental illness. Employment and education participation for young people (16-30) with a mental illness have remained stable over the same period at 79 per cent of Australians aged 16-30 years with a mental illness employed and/or enrolled in study. This compares to 90 per cent of their same aged peers in employment or study. The rates for public mental health service consumers (1b and 2b) are not reported as no current data source exists. The Youth Connections Programme (2010-2014) provided alternative pathways for young people who were disengaged, or at risk of disengaging, from school, through flexible and individualised case management. For the four years 2010-2013, just over 74,000 young people participated in the programme, with mental health identified as a barrier by 21,200 participants. Of these young people, approximately 10,000 achieved sustained engagement in education or training. The Commission notes that this programme ceased in December 2014. A new Youth Employment Pathways programme was announced in September 2014 to assist disengaged young people in regional areas to get back into school, training or the workforce. The programme	

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
	commenced in March 2015 and is managed by the Department of Industry and Science. Jurisdictions: Some states and territories expressed support for this recommendation, however few activities were identified. Queensland highlighted its Ed-Linq initiative which operates statewide to improve linkages between education, primary care and mental health services. The initiative aims to support collaboration across these sectors to enhance the early detection and treatment of mental illness affecting school aged children. The Commission looks forward to the results of an external evaluation of this programme which is currently underway. NGOs: The NGO sector has developed a number of programmes to improve the mental health and wellbeing of children and young people, and to support those experiencing mental health difficulties to continue to participate in school, university and TAFE. The need to provide awareness training to students in a range of settings was highlighted, to assist students to understand and help people experiencing mental ill-health. **The participation rates in employment of working age people with a mental illness have fallen by two per cent in the past five years. Participation rates of young people with mental illness in education and employment are stable, although lower than their same age peers. An agreed target to reduce the numbers of those with mental health problems falling into the "not in education, employment or training" group remains outstanding.**	

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
17: Where people with mental health difficulties, their families and supporters come into contact with the criminal justice system and forensic services, practices which promote a rights and recovery focus and which will reduce recidivism must be supported and expanded. **Action called for**: State and territory governments must scale up diversion schemes, justice re-investment, and transition support. **Action called for**: State and territory governments must provide better mental health programmes to those who come into contact with the justice system, so that people have their mental health improved rather than diminished.	Jurisdictions: All states and territories which responded to this recommendation provided advice on programmes and initiatives to assist people with mental health difficulties who come into contact with the criminal justice system and forensic services. These programmes target justice reinvestment and diversion, and offer assistance following exit from a custodial setting. Northern Territory has implemented a "sentenced to a job" scheme to encourage employment following incarceration. Several programmes provide tailored intensive support, including the Australian Capital Territory Detention Exit Community Outreach programme and similar programmes in Western Australia. South Australia has implemented a Court Liaison Service. NGOs: A number of NGOs gave information on programmes that provide intensive support through individualised recovery planning, including for people leaving a custodial stay. Specialised training for staff is also provided by some organisations to better support people with mental illness who have been in contact with the criminal justice system. **States and territories have scaled up diversion schemes, justice reinvestment and transition support for people in contact with the criminal justice system. However, little advice was provided on mental health programmes to improve the mental health for people who come into contact with the justice system.**	
18: Governments must sign up to national targets to reduce suicide and suicide attempts and make a plan to reach them. These targets must be based on detailed modelling. **Action called for**: Suicide prevention programmes with a proven	Nationally: The Commonwealth provides funding to a number of suicide prevention programmes, in addition to completing an evaluation of suicide prevention activities in April 2014. The evaluation assessed activities funded through the National Suicide	The Commission funded a research project by the NHMRC Centre for Excellence in Suicide Prevention (CRESP) into the experiences of people who have attempted suicide and their experiences of the types of services and support they received, and what made

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
track record (which are evidence-based) must be supported and implemented as a priority in regions and communities with the highest suicide or attempted suicide rates – action needs commitment and a humane approach. **Action called for**: This modelling must: • incorporate the best current evidence from Australia and proposals for small-scale piloting of approaches with promising evidence. It should identify where targeted research is most needed; • identify proposals for how practical collaboration can be fostered – as the basis for a systemic approach to suicide prevention. This applies not just across government departments and between federal and state governments. It also means collaboration at a local level between providers of health, welfare, employment, education, housing, legal and justice sectors, and also between providers and users of services and supports; and • determine priorities for investment. We know little about the cost-effectiveness of suicide prevention approaches, and we need to start by undertaking robust evaluation of existing initiatives. **Action called for***:* Existing community-based suicide bereavement support activities for families and support people must be scaled up and new ones encouraged – particularly in Aboriginal and Torres Strait Islander communities. **Action called for***:* Australia needs a national picture of the contributing factors to suicide attempts, starting with those most at risk, so we can work out sensitive responses to those groups, marshal resources and, over time, measure our success. It is vital	Prevention Program (NSPP) and some elements of the Taking Action to Tackle Suicide (TATS) package, over a seven year period from 2006-07. Some examples of findings include: • overall, project activities used a mix of approaches and targeted a broad range of groups known to be at higher risk • most projects reported having achieved their objectives. While a lack of outcome data made it difficult for projects to demonstrate their effectiveness, a diverse range of activities and a wide range of project achievements were cited. Jurisdictions: All states and territories responding to this recommendation outlined their commitment to, and detailed advice on, actions to reduce suicide. The Northern Territory Suicide Prevention Strategic Action Plan 2015-18 includes evaluation and reporting requirements. Queensland suicide prevention is a key priority of the Queensland Mental Health Commission, which provides funding for research and a suicide register, and supports an advisory group on suicide. Western Australia has developed a State Suicide Prevention Strategy which has been reviewed by Monash University, with funding grants provided for local prevention initiatives, including the development of partnerships with key sporting groups to improve awareness and provide funding for school strategies. The Australian Capital Territory Suicide Prevention Strategy 2009-2014 has been evaluated, and the Suicide Prevention Initiative (Let's Talk) evaluation has commenced. As well, a newly established Coronial Counselling Service for people bereaved by suicide is in the implementation phase. In South Australia, collaborative action is occurring locally in Suicide	a difference to their life and recovery. This research was used to inform the work of the 2014 National Review of Mental Health Programmes and Services, as outlined under recommendation 10.

2012 and 2013 Report Card Recommendations	What action was reported?	Our action:
to hear from those who have survived a suicide attempt and from their families and supporters about what helped and what made things worse at the time. To contribute to this effort, the Commission has initiated a small study by the Centre for Research Excellence in Suicide Prevention into peoples' experiences leading up to and following a suicide attempt.	Prevention Networks linked to local government areas and cost effectiveness studies have identified that Standby Response and Mates in Construction programmes are effective. NGOs: There is similarly significant activity in the nongovernment sector around suicide, suicide reduction, research and prevention. Several NGOs indicated that they provide services for families and carers, as well as those who are at risk of suicide, and have provided suicide intervention training for staff. Further research is needed to identify who is at risk and what is needed to reduce that risk. Suicide Prevention Australia is leading a National Coalition for Suicide Prevention which aims to halve suicide deaths by 2023 using a systematic, multi-strategic and evidence based approach. New suicide bereavement support services including the Standby Response Service have been implemented, which is a community based postvention programme providing a 24 hour coordinated response to people, families, friends, emergency and community responders, and whole communities affected by suicide. **National targets to reduce suicide and suicide attempts remain outstanding. A number of programmes have been implemented and evaluated, with mixed results as to effectiveness. Targeted research is still required, to ensure that funding is spent to greatest effect.**	

[i] National Mental Health Performance Subcommittee. The Fourth National Mental Health Plan Measurement Strategy. Canberra: Commonwealth of Australia; 2011.
[ii] Department of Health and Ageing. National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011. Canberra: Commonwealth of Australia; 2013.