National Mental Health and Suicide Prevention Agreement

2022-2023

Annual National Progress Report Summary

Australian Government
National Mental Health Commission

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Acknowledgements

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands throughout Australia. We pay our respects to their clans, and to the elders, past present and emerging, and acknowledge their continuing connection to land, sea and community.

Acknowledgement of Lived Experience

We acknowledge the individual and collective contributions of those with a lived and living experience of mental ill-health and suicide, and those who love, have loved and care for them. Each person's journey is unique and a valued contribution to Australia's commitment to mental health suicide prevention systems reform.

About this report

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A note on language

The Commission acknowledges that language surrounding mental health and suicide can be powerful, emotive and at times contested. People make sense of their experiences in different ways, and there is no consensus on preferred terminology. The Commission has been conscious to use terminology throughout this report that is respectful of those whose experiences we are describing and is well understood by the audience reading this report. This report covers a broad range of topics in relation to mental health and suicide prevention. The language used to discuss these topics adheres to the language conventions outlined in the Life in Mind National Communications Charter, where applicable. The National Communications Charter represents a unified approach and promotes a common language in referring to issues around mental health, mental ill-health and suicide, with the intention of reducing stigma and promoting help-seeking behaviours. For this reason, and within the context of this report, the Commission aligns its terminology with the conventions in the Charter.

For instances where using certain terminology may misrepresent the source being cited, the terminology used by the source has been used. The Commission endorses the Mindframe Guidelines on Media Reporting of Severe Mental Illness in the Context of Violence and Crime and requests that media using this report do so in accordance with the Guidelines.

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Context

The National Mental Health and Suicide Prevention Agreement (National Agreement) came into effect in March 2022, with associated Bilateral Schedules signed by May 2022. The National Agreement is a key first step in Australia's mental health and suicide prevention reform agenda and builds on the policy and reform directions in the Fifth National Mental Health and Suicide Prevention Plan. It also recognises the recommendations from the Productivity Commission's Inquiry Report on Mental Health and the National Suicide Prevention Adviser's Final Advice.

The National Agreement commits to collaboration to address areas identified for immediate reform, including:

- reducing mental health and suicide prevention system fragmentation through improved integration
- addressing gaps in the mental health and suicide prevention system
- prioritising further investment in prevention, early intervention and management of severe mental health conditions.

The key outcomes sought through the implementation of the National Agreement are to:

- improve the mental health and wellbeing of the Australian population, with a focus on improving outcomes for 15 identified priority populations (noting that a person may fall into one or more of these groups), including First Nations peoples; LGBTQIA+SB people; and people who are (or were previously) in contact with the criminal justice system
- reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports
- provide a balanced and integrated mental health and suicide prevention system for all communities and groups
- improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress
- improve quality, safety and capacity in the Australian mental health and suicide prevention system.

In addition, the National Agreement identifies several high-level objectives that speak to collaboration, partnership and cooperation between the Commonwealth and the state and territory governments (the states), "with the aim of moving towards a unified and integrated mental health and suicide prevention system" (Clause 21).

While the National Agreement outlines broad objectives and outcomes, and commits to a range of high-level outputs, the Bilateral Schedules outline the specific outputs, services and initiatives for collaboration as jointly agreed between the Commonwealth and each respective state.

Annual reporting is a key accountability and transparency mechanism for the National Agreement. Reporting should inform understanding of how mental health and suicide prevention reform delivered through the National Agreement benefits the Australian community and whether it is delivering on its intended outcomes. This includes funding for specific initiatives in the associated Bilateral Schedules.

This report is the first annual progress report for the National Agreement. The report details progress achieved against the National Agreement between 1 July 2022 and 30 June 2023, including progress against the associated Bilateral Schedules and Schedule A to the National Agreement (which outlines key, cross-portfolio commitments and deliverables to improve mental health and preventing suicide across systems). This report has been developed by the National Mental Health Commission (the Commission) at the request of the parties to the National Agreement: the Commonwealth, represented by the Department of Health and Aged Care, the states represented by senior officials from relevant health or mental health agencies, with the delegated authority from Health Chief Executives to implement the National Agreement.

Progress information presented in this report is based on:

- Joint Bilateral Performance Reports (2022-23), developed and agreed by each state and the Commonwealth
- progress information supplied by Working Groups and Project Groups established under National Agreement governance structures (which include representatives from across the Commonwealth and the states), including progress ratings and free-text descriptions against relevant commitments
- service volume data for those services established through the Bilateral Schedules (e.g., number of clients, episodes and/or service contacts) provided by the Commonwealth Department of Health and Aged Care.

Report scope (Year 1)

Under the National Agreement and Bilateral Schedules, consistent templates and guidance for Joint Bilateral Performance Reports are required to be developed and agreed by all Parties (Clause 77). As the agency responsible for implementation of the National Agreement, the Commonwealth Department of Health and Aged Care undertook work in the reporting period to develop the first iteration of these templates, with input from the Commission. Draft templates requested detailed information against Joint Implementation Plans, including on progress, risks/issues, funding and performance indicator data.

On 23 August 2023, the Mental Health and Suicide Prevention Senior Officials Group (MHSPSO) agreed to the scope of the first Joint Bilateral Performance Reports and the first Annual National Progress Report. The agreed scope acknowledged that the first year of the National Agreement (2022-23) was an establishment year and noted that, as at August 2023:

- the full extent of the reporting templates was yet to be finalised with jurisdictions, which limited the detail possible for this report
- not all jurisdictions had an agreed Joint Implementation Plan in place to inform detailed reporting in the first year.

MHSPSO also agreed that the first Annual National Progress Report would focus on high-level progress updates against key National Agreement commitments and bilateral initiatives, case studies and service volume data where available.

This first Annual National Progress Report provides a starting point, which will be built upon year on year across the life of the National Agreement to provide an increasingly comprehensive picture of achievements and progress toward its specified outcomes. Future reports will capture additional detail on funding variations, progress and implementation, key risks and issues, and Key Performance Indicators (KPIs). Ultimately, the Annual National Progress Reports will inform the Final Review of the National Agreement, due by 30 June 2025.

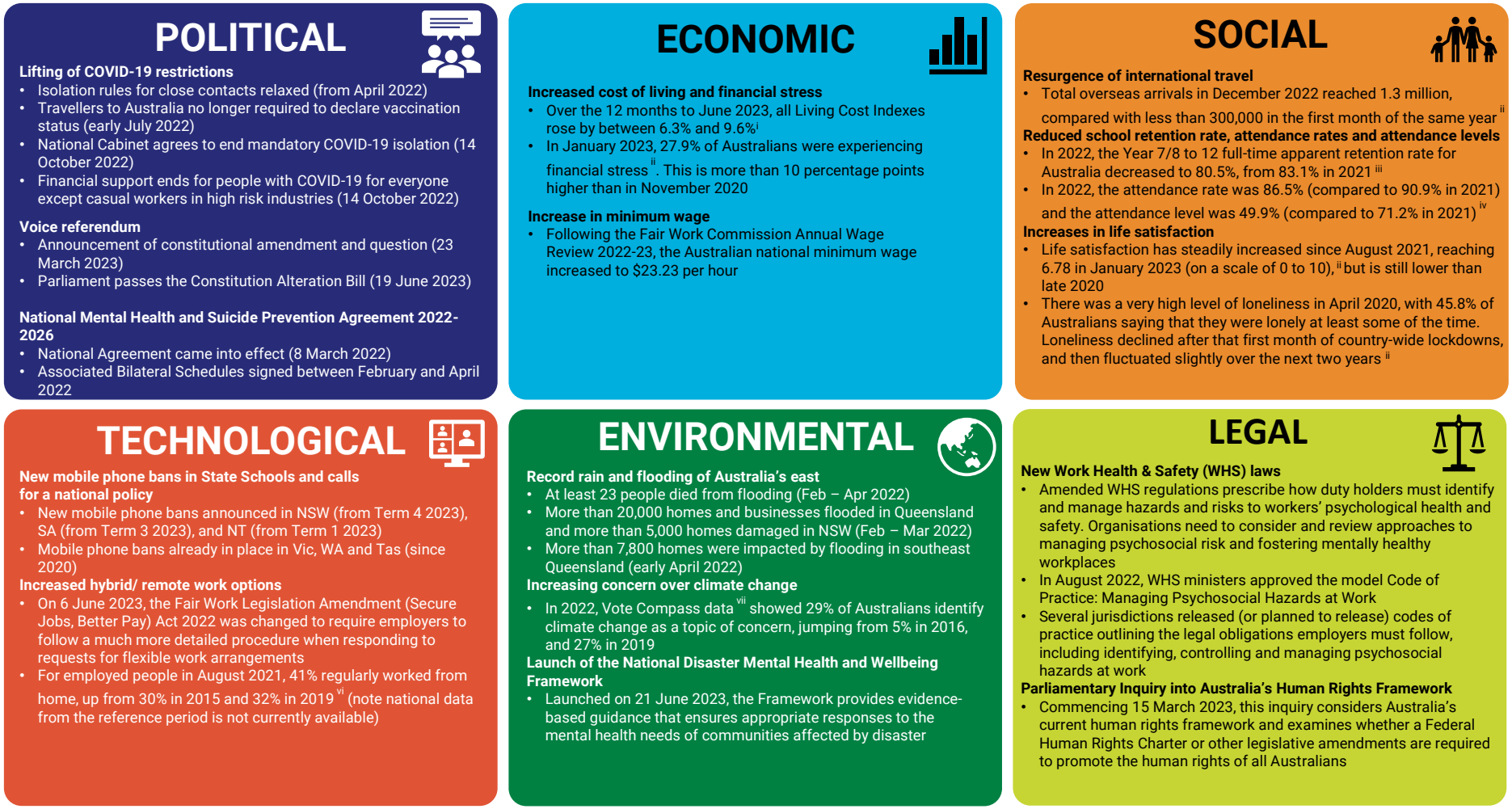
Impact of external factors

When reading this report and considering the information it contains, it is useful to keep in mind the influence of this broader context. Reform does not take place in a vacuum. The broader societal context and environments in which reform efforts take place, can have a substantial impact on both the progress and success of those reforms. For this reason, it is important to identify and track these broader changes and events as they emerge and evolve, to anticipate their implications for implementation and to shape future reform efforts. The Commission has committed to including this review of external factors in each subsequent Annual National Progress Report.

Figure 1[1] provides a snapshot of key political, economic, social, technological, environmental and legal changes and external shifts that have shaped—or had the potential to shape—the mental health and suicide prevention response ecosystem and/or the Australian population's mental health and suicide risk in the reporting period. The factors under the six headings were identified through peer-reviewed research publications, national data collections, media releases, budget papers, strategic plans and report.

[1]To inform Figure 1, the Commission undertook a PESTEL analysis of relevant events and changes. A PESTEL analysis is a scanning framework used to analyse and monitor macro-environmental factors (i.e., Political, Economic, Social, Technological, Environmental and Legal) that may impact a system's performance. The analysis was conducted through desktop review. Events and changes selected for this figure are based the reach and size of the expected impact and the strength of evidence showing a link between the event/change and mental health outcomes.

Figure 1. Environmental shifts from March 2022 to 30 June 2023



[i] Australian Bureau of Statistics. (2023, June). *Selected Living Cost Indexes, Australia*. ABS. https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/selected-living-cost-indexes-australia/latest-release
[ii] Biddle, N., & Gray, M. (2023). Taking stock: Wellbeing and political attitudes in Australia at the start of the post-COVID era, January 2023 ANU Centre for Social Research and Methods.
[iii] Australian Bureau of Statistics. (2023). *International travel recovers in 2022*. ABS. https://www.abs.gov.au/media-centre/media-releases/international-travel-recovers-2022
[iv] Australian Bureau of Statistics. (2022). *Schools*. ABS. https://www.abs.gov.au/statistics/people/education/schools/latest-release
[v] https://www.acara.edu.au/reporting/national-report-on-schooling-in-australia/key-performance-measures-for-schooling-in-australia#view1
[vi] Australian Bureau of Statistics. (2022, August). *Working arrangements*. ABS. https://www.abs.gov.au/statistics/labour/earnings-and-working-conditions/working-arrangements/latest-release
[vii] https://www.abc.net.au/news/2022-04-22/vote-compass-federal-election-issues-data-climate-change-economy/101002116

In addition to the changes reflected in Figure 1, Australia's mental health and suicide prevention policy landscape has also changed since the National Agreement came into effect. For example, from March 2022 to 30 June 2023, at the national level there has been:

- an Australian federal election and change of government (May 2022)
- changes to the cabinet governance structures overseeing the National Agreement, which was developed by the former Health National Cabinet Reform Committee (now National Cabinet)
- the first data release from the National Study of Mental Health and Wellbeing, 2020-2022 (July 2022)
- the delivery of the interim report for the Royal Commission into Defence and Veteran Suicide (August 2022)
- delivery of the 2022-23 Federal Budget, which took total Australian Government investment through the Health portfolio in mental health and suicide prevention to more than $6.8 billion in 2022–23 (October 2022)
- a review of the National Disability Insurance Scheme (commenced October 2022)
- the release of the National Plan to End Violence against Women and Children (October 2022)
- the release of the independent evaluation of the Better Access Initiative and subsequent changes to the initiative (announced December 2022)
- the release of the Strengthening Medicare Taskforce Report (February 2023)
- consultation for the midpoint review of the National Health Reform Agreement 2020-25 (NHRA) (March – May 2023)
- delivery of the 2023-24 Federal Budget, including $6.1 billion to lay the foundations for significant reforms to Medicare (May 2023).

Additionally, there has been a strong uptake of mental health services and governments have increased funding for services to respond to the mental health impacts of the COVID-19 pandemic. Increasing service demand has contributed to ongoing shortages in the mental health workforce, presenting challenges in the timely delivery of new initiatives.

Politically, there have been changes in Health and Mental Health Ministers at the Commonwealth level, as well as in South Australia, Queensland, Victoria and New South Wales since the signing of the National Agreement and Bilateral Schedules. Several mental health reform and policy initiatives outside of the National Agreement have occurred which may present both challenges and opportunities in progressing the implementation of National Agreement initiatives. Examples include new investments in mental health through state Budgets, priority work to address recommendations from reviews or inquiries (e.g., the Royal Commission into Victoria's Mental Health System and the Inquiry into the opportunities to improve mental health outcomes for Queenslanders), and implementation of state or territory-based strategic policies (e.g., the Tasmanian Suicide Prevention Strategy 2023-2027). The Victorian Bilateral Schedule is a noteworthy example of this, having been developed as a key part of the broader Victorian Government's response to the directions outlined in Victoria's Royal Commission's final report.

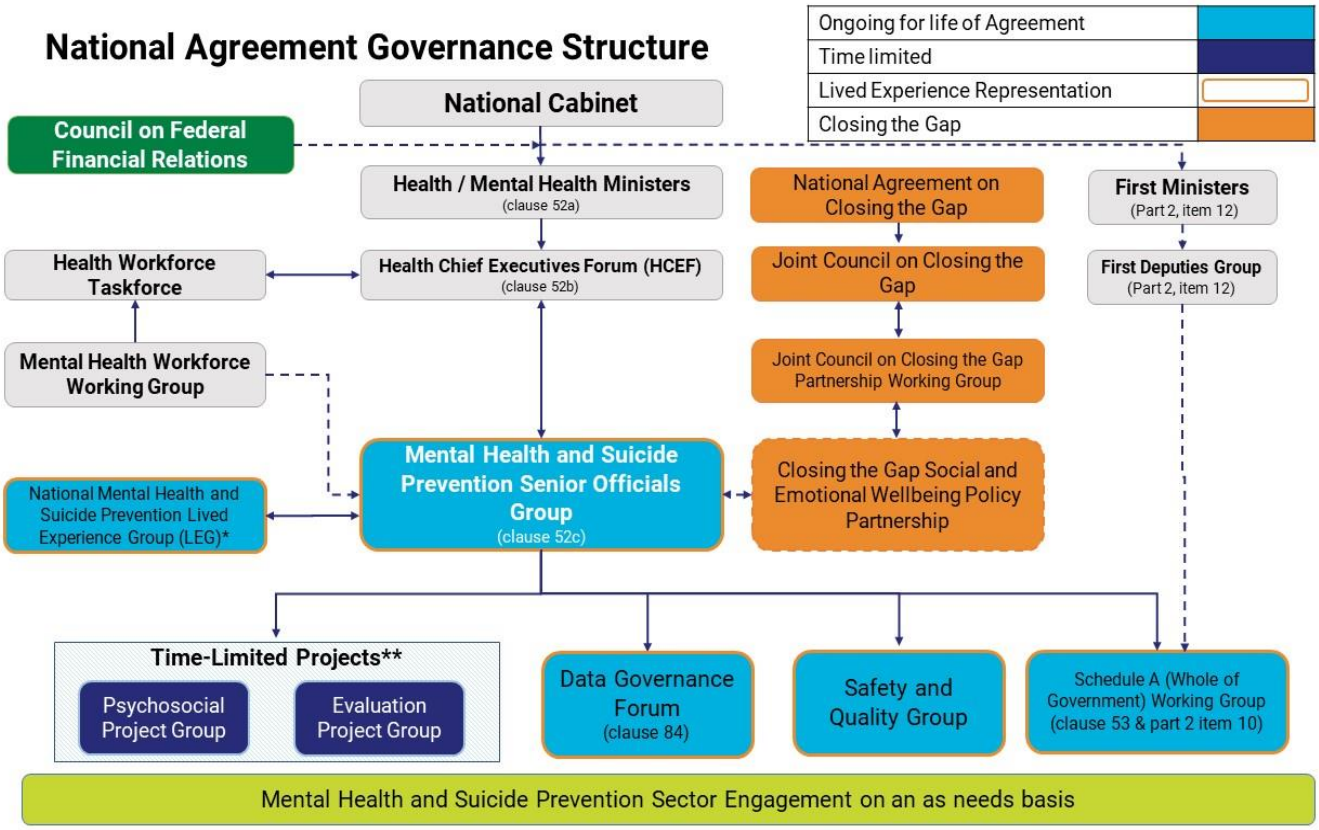
Governance structure

Figure 2 outlines the governance arrangements for the National Agreement. Health Ministers and relevant Mental Health Ministers from all jurisdictions collectively maintain responsibility for the National Agreement, with oversight from First Ministers, including through the National Cabinet as requested. Health Ministers and/or Mental Health Ministers will also provide implementation updates to the National Cabinet as required.

The Health Chief Executives Forum (HCEF), and where relevant Mental Health CEOs, have responsibility and accountability for the implementation of the National Agreement, which includes regular reporting to HCEF and Health Ministers. To support implementation of the National Agreement, governments have established MHSPSO, which comprises senior officials with responsibility for mental health and suicide prevention policy, programs and other relevant clinical expertise as required, as well as representatives from the Closing the Gap Social and Emotional Wellbeing Policy Partnership (SEWB PP), lived experience and First Nations representatives.

To progress key priority areas and assist with implementation of the National Agreement, MHSPSO has established a range of Working Groups and time-limited Project Groups.

Figure 2. National Agreement governance structure



* A Lived Experience Group has been established through an expression of interest process, run by Mental Health Australia.
** Lived experience representatives also participated in the work of the Psychosocial Project Group and Evaluation Project Group during the 2022-23 reporting period.

Implementation progress

The following section provides an overview of progress that has occurred between 1 July 2022 and 30 June 2023 against:

- high level outputs specified under the National Agreement
- the shared commitment to Closing the Gap
- initiatives specified within the associated Bilateral Schedules
- Schedule A commitments.

Progress against National Agreement outputs

Under Clause 27, the National Agreement commits to 13 high level outputs that relate to reporting, data, policy development and implementation. The following outputs were due in the 2022-23 reporting period:

- development of Joint Commonwealth-State Implementation Plans (Joint Implementation Plans) under the Bilateral Schedules (Clause 27b)
- commencement of the analysis of psychosocial support services outside of the National Disability Insurance Scheme (Clause 27a)
- completion of the National Evaluation Framework (Clause 27e)
- completion of National Guidelines on Regional Commissioning and Planning (Clause 27i)
- completion of the National Mental Health Workforce Strategy and identification of priority areas for action by mid-2022 (Clause 27j).

Five Joint Implementation Plans under the eight Bilateral Schedules had commenced by 30 June 2023, with others still being jointly developed by the Commonwealth and states at 30 June 2023. While implementation of bilateral initiatives is progressing in the absence of agreed Joint Implementation Plans, these plans will be important in informing future monitoring and reporting on implementation progress.

Regarding the analysis of psychosocial support services, there was a modest delay in project commencement. From March to June 2023, procurement processes were undertaken for suppliers to undertake the analysis. However, the analysis is still due for completion by March 2024.

Still outstanding during the reporting period were the following outputs:

- completion of the National Evaluation Framework (Clause 27e)
- completion of National Guidelines on Regional Commissioning and Planning (Clause 27i)
- completion of the National Mental Health Workforce Strategy and identification of priority areas for action by mid-2022 (Clause 27j).

Extensions to timeframes for these three outputs were approved by MHSPSO. Specifically:

- The due date for completing the draft of the Evaluation Framework was extended from 20 June 2023 to 30 October 2023 due to delays in establishing appropriate governance and the need to allow sufficient time for broad sector engagement.
- The timeframe for the National Guidelines on Regional Commissioning and Planning was extended from mid-2023 to December 2023 due to the need to develop meaningful guidance and for sufficient consultations to take place. As a result, the Guidelines were commenced but not completed, and were considered ‘not on track’ in the reporting period.
- The timeframe for the National Mental Health Workforce Strategy’s development and identification of priority areas was extended from mid-2022 to December 2022 due to the change of Federal Government and subsequent delays to

endorsement processes. The Strategy was endorsed at the Health Ministers' Meeting in November 2022, with Victoria providing endorsement via correspondence in January 2023. Priorities for action have been captured in a multi-year Work Plan which was endorsed by the National Mental Health Workforce Working Group on 30 June 2023.

For the other high-level National Agreement outputs, working groups reported that implementation was progressing well, with most milestones and outputs considered 'on track.' They reported diverse and significant achievements in regard to implementation of broad commitments under the National Agreement, including:

- **Lived Experience** – The National Agreement commits Parties to embed the lived experience of mental ill health and/or suicide of consumers and their families and carers in the design, planning, delivery and evaluation of services (Clause 20a). Parties reported progress was made in 2022-23 to embed the views of lived experience in the governance of the National Agreement through the appointment of lived experience representatives on working and project groups.
- **Data commitments** – Under the National Agreement, Parties committed to a range of improvements to data collection, data sharing and data linkage. Parties reported progress in:
  - establishment of a Technical Implementation Plan writing group to guide development of priority data and indicators (Clause 27)
  - regular collection and sharing of agreed data items (Clause 89) and the commencement of a pilot data linkage project to link state/territory community mental health data to broader health systems data (Clause 90)
  - commencement of the development of performance monitoring and system monitoring information (Clause 88a).
- **National health reform** – Parties committed to a submission to the mid-point National Health Reform Agreement (NHRA) review, due to be completed by December 2023 (Clause 27l). A principles-based submission was provided to the NHRA Reviewers on behalf of MHSPSO on 5 June 2023.

The establishment of necessary governance structures to support implementation of commitments was another key achievement in this reporting period. Working groups and project groups had established Terms of Reference and multiple groups reported they were collaborating well to deliver their work plans.

In terms of barriers, slippage in timeframes was commonly reported across working and project groups for the reporting period. Importantly, as the National Agreement did not come into effect until March 2022 (instead of November 2021), MHSPSO agreed to adjusted deadlines for remaining deliverables in the first year from March 2023 to June 2023 to reflect this delay. These adjusted timeframes were agreed to by HCEF. Securing cost-shared funding for National Agreement outputs outside of the bilateral initiatives was also flagged as a key implementation challenge impacting commencement and implementation of key projects.

MHSPSO noted it had intended to hold an annual stakeholder engagement forum to build awareness and engagement amongst non-Government stakeholders. This did not eventuate in 2023 due to funding constraints. MHSPSO will consider how stakeholder engagement, transparency and accountability requirements may be improved in the next reporting period.

Shared commitment to Closing the Gap

Under Clause 110 of the National Agreement, Parties committed to work in partnership with First Nations peoples, their communities, organisations and businesses to improve First Nations mental health, social and emotional wellbeing, and access to, and experience with, mental health and wellbeing services. In the implementation of this Agreement, the Parties committed to:

(a) support the implementation of the Gayaa Dhuwi (Proud Spirit) Declaration

(b) ensure alignment with the National Agreement on Closing the Gap and associated Implementation Plans. This includes the reforms outlined at Clause 49(i) [clause regarding commitment to Closing the Gap reforms]

(c) ensure alignment with other relevant national commitments and agreements for Aboriginal and Torres Strait Islander mental health and suicide prevention including the National Aboriginal and Torres Strait Islander

Suicide Prevention Strategy, and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing

(d) recognise and enable leadership of Aboriginal and Torres Strait Islander peoples throughout the mental health, wellbeing and suicide prevention system

(e) collaborate with Aboriginal Community Controlled Health Services (ACCHS), organisations and other service providers wherever possible to improve Aboriginal and Torres Strait Islander access to mental health, wellbeing and suicide prevention services and deliver services in a culturally and locally appropriate manner.

In the reporting period, MHSPSO Members and the Closing the Gap Joint Council agreed that the Social and Emotional Wellbeing Policy Partnership (SEWB PP) would be the key governance mechanism to advise governments on improving First Nations mental health, social and emotional wellbeing and suicide prevention outcomes. To embed this arrangement, and to give true effect to all Closing the Gap Priority Reforms, two representatives from the SEWB PP and two First Nations representatives with lived or living experience of mental ill-health were appointed as MHSPSO members at the May 2023 MHSPSO meeting. At this meeting, SEWB PP members provided advice to MHSPSO members on shared commitments under Closing the Gap and the National Agreement, including greater opportunities to partner and drive genuine actions, ongoing collaboration and improve transparency in improving outcomes for First Nations peoples across the national service system. Specific actions highlighted for future action include refreshing the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-23, and developing First Nations funding commissioning models.

Given the appointment of First Nations representation to MHSPSO was agreed in early May 2023, decisions by MHSPSO that related to First Nations outcomes were limited during this reporting period. Engagement with First Nations communities, peoples and community-controlled services was undertaken in the design and implementation of some bilateral measures in the reporting period. All MHSPSO Members are committed to progressing actions under the National Agreement and Closing the Gap in future reporting periods.

Progress against Bilateral Schedule Initiatives

The National Agreement is supported by Bilateral Schedules with all states, which include funding to implement and deliver specific initiatives at the state level, totalling $1.8 billion over 2021-22 to 2025-26. Joint Commonwealth and state investment under the Bilateral Schedules focuses on providing community-based services to address gaps in the mental health and suicide prevention system, and includes varying commitments such as adult, youth and child mental health services, perinatal measures and suicide prevention services. Bilateral Schedule commitments vary between the states, depending on the negotiated outcome with the government of the day.

In terms of the Bilateral Schedules, notable achievements within the reporting period include:

- establishment of five new Head to Health centres and satellite clinics which commenced operation in Lismore (1 August 2022), Central Coast (1 January 2023), Canterbury (30 January 2023), Liverpool (1 May 2023) and Hawkesbury (30 June 2023)
- planning and establishment of new Head to Health centres and satellite clinics in Shellharbour, Dubbo, Wagga Wagga, Bathurst, Young, Muswellbrook, Cairns, Mount Gambier, Northern Adelaide, Mount Barker, Port Pirie, outer Hobart, Devonport, Burnie and Katherine
- six Victorian Government Adult and Older Adult Local Mental Health Services commenced operation from December 2022
- establishment of three new health and wellbeing hubs for infants, children and families in Brimbank, Loddon and Southern Melbourne, which was also recommended by the Royal Commission into Victoria's Mental Health System
- successful transition of the existing Beyond Blue, The Way Back Support Service sites to an adapted The Way Back model in Queensland, New South Wales, ACT, Tasmania and the Northern Territory
- scoping, planning and consultation for Head to Health Kids Hubs in New South Wales, Queensland, Western Australia, Tasmania, Northern Territory and the ACT (with several services due to commence operation in the 2023-24 Financial Year)

- establishment of an Early Intervention Service for Eating Disorders in the ACT (20 February 2023)
- commencement of a pilot of a multidisciplinary Community Clinic for eating disorders in Hobart (June 2023)
- expansion of the Hospital Outreach Post-suicidal Engagement (HOPE) initiative in Victoria.

Other key achievements include the launch of the Head to Health phone service, finalisation of the headspace enhancement funding model and finalisation of the Head to Health Kids Hubs model of care. Several early milestones were also achieved in progressing key initiatives designed to provide more seamless and integrated mental health care, such as engagement between the Commonwealth and the states to support new joint regional mental health and suicide prevention plans and establishment of the Perinatal Mental Health Jurisdictional Data Working Party.

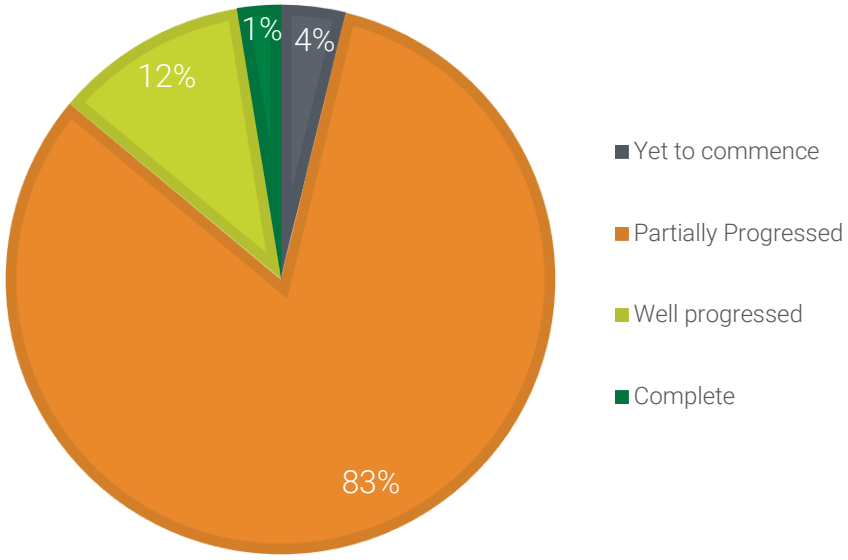
Overall, implementation progress against Bilateral Schedule initiatives has been mixed, with good progress in some areas and slower progress in others. Of the 81 bilateral initiatives reported against, 78 were assigned a rating that was agreed by the Commonwealth and the respective state:

- one was identified as 'complete'
- nine were assigned a 'well progressed' rating
- 65 were assigned a 'partially progressed' rating
- three were assigned a 'yet to commence' rating, however, were considered 'on track'.

Figure 3 shows the proportion of bilateral initiatives categorised as yet to commence, partially progressed, well progressed and complete. When considering the proportion of initiatives rated as 'partially progressed,' it should be noted that:

- The Bilateral Schedules were signed late in the 2021-22 financial year, meaning there has been just over one financial year of implementation.
- During the reporting period, time and effort was required to establish governance structures to support the agreed collaborative approach for implementing bilateral initiatives, including co-commissioning arrangements between the Commonwealth, states, and Primary Health Networks in each state.
- The Commonwealth and respective states were required to identify and agree on appropriate locations for services before implementation of initiatives could commence.
- Some initiatives are not expected to be completed until 2025-26 given the staged implementation approach (i.e., new centres continuing to open until 2025-26).

Figure 3. Bilateral initiatives by progress rating[1]



1. Note figures exclude the three bilateral initiatives given disparate progress ratings by the Commonwealth and respective jurisdiction.

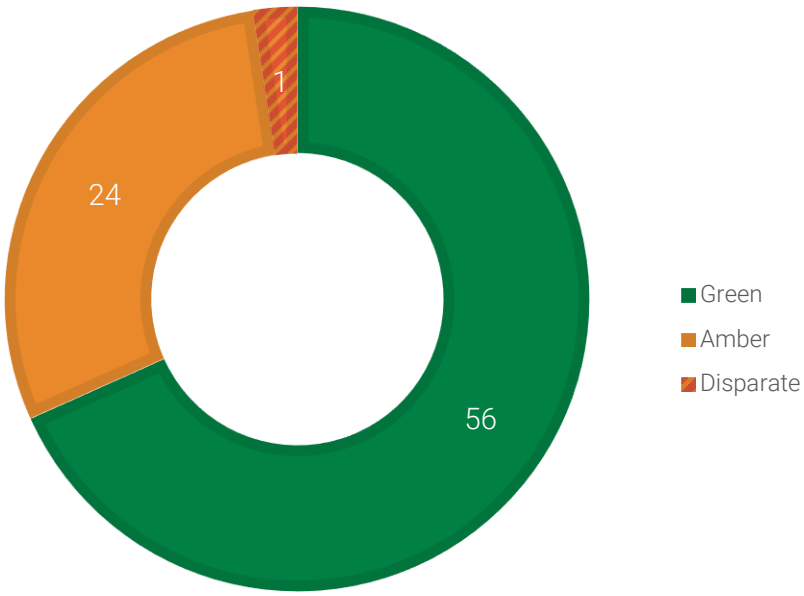
Of the 81 bilateral initiatives, the remaining three initiatives were given differing progress ratings by the Commonwealth and the respective state. It is important to note some of the differences in progress ratings may be explained by different interpretations of the available response options (e.g., "well" progressed versus "partially" progressed), as opposed to a misalignment in understanding of current progress and timelines.

States identified a range of mechanisms through which they are collaborating with the Commonwealth and/or other key stakeholders to achieve the objectives of the National Agreement. These included:

- establishment of Steering Committees, Reference Groups, Councils and Working Groups to support coordinated action
- establishment of Communities of Practice for sharing knowledge, experiences and strategies for successful implementation
- conducting engagement and consultation processes, including collaborative workshops and focus groups bringing together a range of representatives across the system
- formal agreements concerning joint commissioning arrangements and working relationships
- developing measurement tools (e.g., surveys) to identify existing levels of integration and support planning
- co-commissioning of services
- development of communications (e.g., key messages documents for service providers) regarding how services should work together.

For each bilateral initiative, the Commonwealth and respective state jointly assigned an overall risk rating (i.e., green: on track, amber: some issues or delays to achieving milestone, red: significant delays or risks to initiative). As displayed in Figure 4, most (56) of the 81 bilateral initiatives were jointly assigned a **green** risk rating, while 24 were jointly assigned an **amber** risk rating. One initiative was given disparate risk ratings by the Commonwealth and respective jurisdiction: the Commonwealth assigned a **red** risk rating, while the state assigned an **amber** risk rating.

Figure 4. Bilateral initiatives by risk rating



In providing context for the amber risk ratings, many stakeholders identified delays in the delivery of key milestones and/or project commencement. It was noted that timelines for projects had been impacted due to longer than anticipated timeframes required for:

- establishing funding arrangements
- decision-making due to government changes
- establishing partnerships to support implementation
- release of strategic guidance to inform initiatives
- recruiting staff to oversee implementation of initiatives
- provision of data.

In addition to supplying risk ratings for each bilateral initiative, Parties were asked to indicate whether there were any significant variations from milestones or timeframes from the agreed Joint Implementation Plans. There were 35 bilateral initiatives where progress was significantly behind what was forecast. Of these, 25 were jointly reported as having milestones/timeframes adjusted and agreed between the Commonwealth and the state to achieve better outcomes, while 10 were jointly identified as having milestones/timeframes not met or extended due to delays.

Reasons for delays included the re-direction of resources, challenges in recruiting and retaining critical workforces, and the need for consultation. In some cases, it was unclear why certain milestones or project enablers were delayed due to the high-level approach to reporting adopted in year one. Identifying the current barriers that are slowing progress should be a key priority moving forward, and ensuring appropriate mitigation strategies are in place to promote timely delivery.

There were six instances of Parties having different views on the status of milestones and timeframes. While these inconsistencies may reflect different interpretations of the available response options and/or the Commonwealth providing a national perspective of the initiative, they may also indicate a misalignment in understanding of expectations and timelines for initiatives. Clear, consistent and ongoing communication between all Parties to the National Agreement

concerning responsibilities and timeframes should be a priority moving forward. In addition, reporting guidance should be further refined to ensure greater clarity of the progress ratings and their meaning.

Progress against Schedule A commitments

Schedule A of the National Agreement outlines key deliverables for cross-portfolio efforts and includes commitments for jurisdictions to implement across seven whole-of-government areas: homelessness; education; workplaces; financial counselling; justice; substance use; and family, domestic and sexual violence, including child maltreatment. There is no funding in the National Agreement associated with implementing Schedule A.

The Schedule A Working Group was established in August 2022 to support the implementation of the Schedule. At its first meeting, the group agreed to a Work Plan to guide undertakings in its first year of operation.

Over the reporting period, the Schedule A Working Group met four times and considered the Schedule A commitments relating to workplaces, education and housing and homelessness. Overall, the Working Group indicated that all commitments had commenced and were on track. Specifically, Schedule A Working Group members reported that they had:

- shared best practice examples and/or case studies concerning:
  - mental health supports and suicide prevention in school settings
  - mental health and suicide prevention literacy and capability of public sector workforces
  - legislative reform for work-related psychological health to ensure psychological health and safety.
- considered and discussed:
  - approaches to improving school aged children's social and emotional wellbeing
  - integrated service delivery and prevention of discharge into homelessness
  - national data sharing principles that support the collection, linkage and sharing of data and reporting on people discharged with mental illness or suicidal ideation from hospitals, correctional facilities and other institutional care settings into a situation of homelessness
  - how best to engage with the consultation process for the National Housing and Homelessness Plan.

Overall, while the Schedule A Working Group has made several achievements in the reporting period—particularly in facilitating information sharing and knowledge exchange—it is important that this sharing translates into collaborative cross portfolio action to address current gaps. Of note, the Schedule A Working Group is the only National Agreement governance group that brings together representatives from different portfolios for the specific purpose of extending mental health and suicide prevention reforms beyond the health system into broader government supports and services. The group will therefore be a key mechanism in addressing some of the National Agreement's aims, including integrating health and non-health services and systems so that consumers, families and carers experience seamless treatment, care and support.

Maintenance of investment

The National Agreement requires parties to maintain or increase their existing levels of investment in mental health and suicide prevention over the life of the Agreement. While publicly available mental health expenditure data was not yet available for the reporting period, available data from the Report on Government Services shows that in 2021-22, around $11.6 billion in real recurrent expenditure was allocated to services for mental health nationally (across the Commonwealth and jurisdictions). This is an increase from the recurrent expenditure on mental health and suicide prevention services in 2018-19 ($10.7 billion). Updated figures will be included in future Annual National Progress Reports and compared against baseline figures.

Progress against National Agreement outcomes: measuring change and impact

While it is too early to assess the National Agreement's performance against its objectives, there has been significant work over 2022-23 to create the necessary enablers to achieve these aims. In particular, the majority of the governance structures have been established and stakeholders were largely positive about the extent to which these arrangements are encouraging collaboration across governments.

Jurisdictions noted they had welcomed the opportunities to engage with other jurisdictions, share information and discuss key strategic issues. Case Studies and status updates provided by jurisdictions further demonstrated the important work already occurring under the Bilateral Schedules to reduce system fragmentation and promote lived experience engagement.

Within this reporting period, MHSPSO established the Mental Health and Suicide Prevention Data Governance Forum (DGF) to oversee and facilitate implementation of the data and performance measurement commitments specified in the National Agreement. To measure progress against the National Agreement outcomes, parties are required to develop and report on a range of indicators, outcome measures and KPIs which reflect the objectives and goals of the Agreement. As at 30 June 2023, the DGF was finalising a Technical Implementation Plan to guide development of priority data and indicators for endorsement by MHSPSO. The Technical Implementation Plan will outline the actions required to frame and develop performance information to support the National Agreement commitments. The Plan was not available for this reporting period due to the timeframe required between the execution of the National Agreement and the establishment of the DGF.

Annual reporting ensures accountability and transparency in achieving improvements across and beyond the mental health and suicide prevention systems. Moving forward, evaluation activity, results and shared learning will also be critical to understanding the impact of the National Agreement and its initiatives, and to inform ongoing improvements and reforms.

Available data for operational services under bilateral initiatives

For each initiative in the Bilateral Schedules, the Commonwealth and states are required to agree on the minimum data specifications and reporting process to monitor service activity. Minimum data specifications were yet to be officially agreed by all jurisdictions within the reporting period. While data is being collected for all operational services, all jurisdictions are working to align data collections between Primary Health Networks, state-funded services and non-government organisations. Once agreed, minimum data will include key demographics, referral information (if applicable), client outcomes and experience.

For this reporting cycle, available service volume data for operational services under Bilateral Initiatives in this reporting period were provided by the Commonwealth Department of Health and Aged Care. The **Appendix** provides an overview of the data.

Lived experience engagement

Working groups and project groups were largely positive about the extent to which governance arrangements included lived experience representation. Several states also highlighted the effort occurring at the local level to ensure implementation of bilateral commitments is appropriately informed by lived experience (e.g., co-design and consultation in the planning, design and implementation of initiatives).

Jurisdictions noted several examples of good practice in involving lived experience perspectives in the National Agreement's implementation, including:

- the appointment of lived experience members on MHSPSO and seven working/ project groups
- collaboration with the established National Mental Health Consumer and Carer Forum
- nationwide co-design to develop aftercare best practice guidelines
- partnership with lived experience peak bodies and representative organisations in delivery of the lived and living experience workforce development program
- lived experience input on co-design and commissioning approaches for suicide aftercare and peer call back services
- lived experience involvement in commissioning local services and governance for regional planning.

While most jurisdictions considered implementation of the National Agreement's implementation was meeting the needs of identified vulnerable population groups and being appropriately informed by lived experience, some stakeholders identified opportunities to strengthen this. In particular, it was noted that some National Agreement initiatives aim for minimum standards of services being safe or accessible. They identified that this could be strengthened by working with communities to establish services that are valued, trusted and culturally appropriate, and strengthening consumer and carer participation in governance structures. The Commonwealth noted lived experience representation will be strengthened in the next reporting period through the establishment of the Lived Experience Group.

Further and more robust analysis of progress from lived experience perspectives will be important in understanding whether activity under the National Agreement is translating into the expected benefits for consumer and carers. Noting gaps in publicly available and representative national data, work under the DGF to develop priority data and indicators regarding consumer and carer experiences of care will be important in facilitating this.

Conclusions

The National Agreement commits to significant reform of the mental health and suicide prevention system in Australia. While many commitments are yet to be implemented for a range of reasons outlined above, there has been significant work over the past year in establishing the necessary governance structures and relationships to enable successful implementation.

Considering the challenges highlighted in this reporting period, the Commission suggests that the following actions are undertaken by the Commonwealth and states:

- finalisation of the remaining Joint Implementation Plans as a matter of priority
- early consideration and agreement between jurisdictions on the templates and guidance applied for future **J**oint Bilateral Performance Reports that:
  - appropriately capture more comprehensive information on progress, risks, and ongoing or emerging challenges against agreed Joint Implementation Plans
  - clearly define progress categories and other response options
  - include performance data for deliverables to facilitate targeted improvements
  - are completed and provided to the Commission by the end of August each year to allow for national synthesis and analysis.
- consistent and ongoing communication and engagement between the various governance groups (coordinated by MHSPSO) and the jurisdictions to ensure roles and responsibilities for the implementation of commitments are clearly identified and stakeholders are aligned in their views on governance, responsibilities, timeframes and milestones
- establishment of a mechanism to build awareness and engagement amongst non-Government stakeholders
- ensure future Schedule A work plans move beyond information sharing activity towards specific and achievable actions to improve integration across health and non-health systems
- ensure consistent approaches in administering measures of consumer and carer experiences (e.g., the Your Experience of Service survey) and encourage use of measures across all jurisdictions to enable national level monitoring.

Work on embedding First Nations peoples voices in the implementation of the National Agreement will be a major focus next reporting period.

The importance of retaining a sharp focus on delivering timely outcomes to improve consumer and carer experiences of the mental health and suicide prevention system is clear. The need for stakeholders to amplify their collaborative efforts for system reform will increase year on year as the broader environment in which the National Agreement is being implemented becomes increasingly complex with intersecting issues, events and emergent challenges as referred to in the analysis at **Figure 1**.

The Commission would like to thank all stakeholders for their valuable contributions to this report.

Appendix

Table 1. Number of centres, clients and service contacts for key bilateral initiatives[1], by jurisdiction (2022-23)

State/Territory	Number of centres	Number of clients	Number of service contacts	Data Source[1]
Head to Health Centres and Satellites				
Qld	2	784	3,254	PMHC MDS
NSW	6	1,271	11,600	PMHC MDS
SA[2]	1	8,354	Unavailable[3]	State data
ACT	1	338	2,273	PMHC MDS
Vic[4]	1	471	3,491	PMHC MDS
Tas	1	503	5,067	PMHC MDS
NT	1	741	5,411	PMHC MDS
Universal Aftercare				
Qld	8	3,041	21,416	PMHC MDS
NSW	9	2,620	34,359	PMHC MDS
ACT	1	151	1,464	PMHC MDS
WA	Not Operational	Not Operational	Not Operational	State data
Tas	2	372	6,888	PMHC MDS
NT	1	92	535	PMHC MDS
SA	Not Operational	Not Operational	Not Operational	State data
StandBy Postvention Support[5]				
Qld	N/A	608	1,659	Standby
NSW	N/A	621	1,566	Standby
Vic	N/A	508	1,126	Standby
NT	N/A	19	76	Standby
Head to Health kids and child services				
Qld		Not Operational	Not Operational	
NSW		Not Operational	Not Operational	
SA		Not Operational	Not Operational	
ACT		Not Operational	Not Operational	
Vic	3	421	1,756	State Data
WA		Not Operational	Not Operational	
Tas		Not Operational	Not Operational	
NT		Not Operational	Not Operational	

1. Primary Mental Health Care Minimum Data Set (PMHC MDS) data was extracted by the Department of Health and Aged Care on 18 September 2023.
2. Data presented for South Australia is for the Adelaide Urgent Mental Health Care Centre which is part of the Head to Health initiative and offers an alternative to presenting at hospital Emergency Departments for a mental health crisis. The figure provided is for the period 1 March 2022 to 30 June 2023.
3. Service contact data was unable to be provided in this round of reporting due to limitations of the current state reporting.
4. Head to Health Pop Up clinics were initially established in Victoria to provide additional support to people of all ages impacted by the COVID-19 pandemic. Head to Health Pop Up clinics are transitioning to the new Local Adult and Older Adult Mental Health and Wellbeing Services and have not been included in this reporting. Victoria has one Head to Health centre delivering PHN commissioned Head to Health services which is reported here.
5. Service contacts reflects how many people 'reached in' to the program – which is recorded as a general enquiry. The number of clients reflects how many people received individual support. The number of centres for the StandBy program is reported as not applicable (N/A) because the services are delivered under an outreach, rather than centre-based model.

Table 2. Number of centres, clients and service contacts for bilateral initiatives unique to single jurisdictions (2022-23)

Bilateral Initiative	State/Territory	Number of centres	Number of clients	Number of service contacts	Data Source
Universal Aftercare Hospital Outreach Post-suicidal after Engagement (HOPE) program	VIC	2	5,076	7,042	State data
Adult and Older Adult Local Mental Health Services	VIC	6	1,559	2,833[1]	State data
Early intervention Community Support Programs (Gaps in system of care)[2]	Qld	9	Individual sessions – 823 Group sessions - 230	8,051	State data collection
Integration hubs[3]	TAS	1	-	374	State data

1. Service contacts may be under-reported. For some providers, service contacts were not mandatory for reporting and some services have not reported any. Changes to future reporting will include service contacts for all service providers.
2. One early intervention community support program was unable to report data in 22/23. The provided data is for the 8 operational centres who were able to provide data in this reporting period.
3. Services commenced in April 2023. When a consumer attends the hub, the majority attend for a brief period (<15 minutes) and are not considered to be a registered client/patient of Statewide Mental Health Services. For this reason, data that could uniquely identify and count consumers is not collected.

Acronyms and abbreviations

ACCHS	Aboriginal Community Controlled Health Services
ACT	Australian Capital Territory
DGF	Mental Health and Suicide Prevention Data Governance Forum
HCEF	Health Chief Executives Forum
HOPE	Hospital Outreach Post-suicidal Engagement
KPI	Key Performance Indicator
MDS	Minimum Data Specifications
LGBTQIA+SB	Lesbian, gay, bisexual, transgender, queer, intersex, asexual, sistergirl and brotherboy
MHSPSO	Mental Health and Suicide Prevention Senior Officials Group
National Agreement	National Mental Health and Suicide Prevention Agreement
NHRA	National Health Reform Agreement
NMHC	National Mental Health Commission
NSW	New South Wales
NT	Northern Territory
PHN	Primary Health Network
PMHC MDS	Primary Mental Health Care Minimum Data Set
Qld	Queensland
SA	South Australia
SEWB PP	Closing the Gap Social and Emotional Wellbeing Policy Partnership
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Glossary

Accessible
The ability of people to obtain required or available services when needed within an appropriate time. Factors include providing appropriate cultural, disability, affordability, socio economic status, and location accessibility.

Commissioning
Commissioning is an evidence-based, cyclical approach to planning and purchasing services that involves assessing community needs to inform planning and designing services; selecting, overseeing and engaging with providers; managing contracts and undertaking ongoing monitoring and evaluation of delivery and outcomes (also see 'Regional Commissioning').

Consumer
A person living with mental illness who uses, has used or may use a mental health service.

Early intervention
The early identification of risk factors and provision of timely treatment, care or support for people experiencing early signs and symptoms of mental illness. It aims to prevent the incidence, severity and impact of mental illness.

Lived experience
Mental illness - People with lived experience are people who identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness. People with lived experience are sometimes referred to as consumers and carers.

Suicide - People who think about suicide, people who have attempted suicide, people who care for someone with suicidal behaviour, people who are bereaved by suicide, and people who are impacted by suicide in some other way, such as a workplace incident.

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

Mental health workforce
Distinguishes between people who work exclusively in the mental health sector (for example Aboriginal and Torres Strait Islander mental health workers, mental health nurses, psychologists and psychiatrists) and those working in other health settings who frequently treat, interact with, care and support people experiencing suicidality, mental distress and/or ill-health (for example allied health, general practitioners and nurses). Particularly for suicide prevention, this also extends to people working in other settings who are likely to have regular contact with people experiencing suicidality, mental distress and/or ill-health as part of their role (for example aged care workers, educators, drug and alcohol workers, housing and justice services workers). Peer workers with a lived experience of mental health and suicide are also included in this definition.

Postvention
Postvention services aim to support individuals and communities bereaved or impacted by suicide through the grieving process, and to reduce the possibility of imitative suicidal behaviour.

Prevention
Action taken to prevent the development of mental illness, including action to promote mental health and wellbeing and action to reduce the risk factors for mental illness.

Regional commissioning
Regional commissioning (sometimes referred to as collaborative commissioning or joint commissioning) refers to the ways in which organisations work together to commission services, to make the best use of limited resources to avoid duplication of effort and achieve better outcomes for the local community.

Self-harm
Deliberately hurting oneself without conscious suicidal intent.