Reporting back and looking forward

Introduction


About the Commission

We are Australia’s first National Mental Health Commission, set up in 2012 to provide independent reports and advice to the community and government on what’s working and what’s not.

From day one the Commission’s view has been that we must think differently about mental health, to see mental wellbeing as important to the individual, their family, support people and community. This sees services not as separate elements to be used when needed. It sees that the interconnections between services, families, employers and co-workers, health providers, teachers and friends, together improve mental wellbeing and a sense of a life well lived.

Indeed, one of our strengths since inception has been our determination to take a whole of life, whole of government perspective to mental health, rather than treating it simply as a health issue. Despite the Commission no longer reporting to the new Prime Minister after the 2013 federal election, we will continue to take this approach. We look forward to working with the new Minister for Mental Health and his Cabinet colleagues to ensure that mental health reform does not drop in priority on the political, social and economic agenda.

We highlighted the scandal that the most severely mentally ill die at a rate that is two and a half times greater than the general population;26 and the shaming fact that Aboriginal and Torres Strait Islander peoples are twice as likely to die by suicide than other Australians.22 We were aghast that we still had no national picture of the extent to which we seclude and restrain people with mental health problems – a human rights issue that governments had, seven years beforehand, committed to reduce and eliminate.

A Contributing Life

We set ourselves, governments and the community a pressing task – to better understand and listen to what it means for people living with mental health difficulties and their support people to lead a contributing life – and to regularly and systematically listen to their experiences.

A contributing life means a fulfilling life enriched with close connections to family and friends, and experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering. It means having a home and being free from financial stress and uncertainty.21

The contributing life approach propels everything we do; it shapes the structure of the Report Card and its six chapters and frames how we work:

- we put people with lived experience and their families and supporters at the centre and always first
- we work across all areas that promote mental health and prevent mental illness and suicide – not just government and not just health but education, housing, employment, human services and social support
- we consider evidence and data, develop projects, seek new partners and report back to the community through this lens.
Our four priority areas
In 2012 we set out our big picture case for change; four priority areas for action that we must all do and keep doing.

We will not see real change unless these become part of everyday business. In 2013 these four priorities remained as drivers behind the Commission’s work:

1. Mental health must be a high national priority for all governments and the community
   • Mental health must be the business of the Prime Minister, Premiers and Chief Ministers
   • We must get a proper understanding of the value of good mental health to drive reform
   • Governments must meet their existing commitments
   • The mental health and wellbeing of Aboriginal and Torres Strait Islander peoples needs to be included as one of our national priorities

2. We need to provide ‘a complete picture’ of what is happening and closely monitor and evaluate change
   • Data must be rationalised and the right data collected
   • The Australian Government needs to commit to conducting reliable and regular national population surveys to measure progress
   • Governments must ensure that announced mental health funding is spent on mental health as promised

3. We need to agree on the best ways to encourage improvements and get better results
   • We must initially agree on what is good practice across all mental health and support services. This must be based on evidence. Services need to be effective, efficient, provide value and demonstrate improvement in the mental health and experiences of people using them and their families and support people
   • The new Activity Based Funding system should be designed to meet the needs of people with mental health difficulties regardless of whether services are provided in hospitals, in the community or elsewhere. Alternatives to hospital care must be a priority
   • The National Disability Insurance Scheme must fully cover the psychosocial disability that results from mental illness

4. We need to analyse where the gaps and barriers are to achieving a contributing life and agree on Australia’s direction
   • All governments must prioritise the development and implementation of a nationally agreed mental health service planning framework
   • Governments must be brave enough to set goals and targets for improving mental health and reducing suicide and be judged by the community on their results

We re-state here that in 2013 we want to hold up a mirror for all Australians to see what mental health services and supports are available and how effective they are in supporting people to achieve a contributing life.

As the new reporting arrangements for the Commission take effect, it will be critical to our agenda to influence and have impact across all relevant agencies and policy areas. A return to a single health policy focus will jeopardise the important initiatives previously recommended by the Commission. The Commission’s strengths lie in its independence and being an agent for change across all elements of a contributing life. This must continue if we are to truly hold up a mirror to the mental health system in Australia.

Before we can assess how supports and services are successful or effective, Australia must first establish a clear destination, targets to drive change and how we measure progress in getting there.

In this Report Card we endorse the directions of the COAG Expert Reference Group which was asked to provide independent advice on a new set of whole of life outcome targets and indicators. The Group consulted widely, found areas of consensus and recommended a framework of national targets and indicators to governments in September 2013.

This framework captures many of the Commission’s own priorities and the areas that we believe will drive change – in more people reporting better wellbeing; in improving life expectancy and physical health; in more timely access to care and treatment and safe, stable and secure homes; in improvements in the experiences people and families have; in increased employment rates for people and supporters; in working to eliminate the use of seclusion and restraint; in reducing suicide and suicide attempt rates.

It reflects the community’s aspirations and the views of experts, including people with lived experience of mental health difficulties and their supporters. We urge governments to consider this work and respond.
Building upon the base established last year, our work in 2013 has been two-fold.

**Firstly** we have concentrated effort in working on the actions to which we committed in the 2012 Report Card, as well as in raising awareness of our findings and encouraging work by others.

**Secondly** we have focused on what we would say in the 2013 Report Card—through listening to people with lived experience, establishing our new priorities, talking with a range of stakeholders and experts, visiting services, reviewing evidence and data, as well as commissioning literature reviews.

We report back on what has happened this past 12 months and assess what that progress looked like.

The elements of a contributing life were well received, especially by people with lived experience of mental health issues and their families and support people.³

We were told that our strategy of putting the voices of people with lived experience to the front and centre of what we do is the most important aspect of our national leadership and reporting role.

Our contributing life approach has influenced national and local debate and policy thinking. Some non-government organisations and even a corporate foundation have used our work to support their advocacy efforts and in their development of policies and position statements.

### Reporting back

Where the 2012 Report Card priorities took us
In 2012 the Commission set out ten clear recommendations for governments and others to consider and accept.

We promised to detail responses to our 2012 recommendations in this year’s Report Card.

We are heartened by the actions taken by the non-government sector, business sector and first responders such as police.

We are disappointed in the lacklustre response from governments to the Report Card as a whole, but are encouraged by positive steps towards addressing some specific recommendations.

We are concerned that while separate initiatives were advanced in some key areas, in others nothing could be discerned.

So, what happened across the nation?

In giving a national assessment, the Commission wrestled with how to best identify those agencies, services or jurisdictions where change was evident; where people reported that their experiences had improved.

But to be frank – we could not find enough information to paint this picture.

Although we realise that it has only been twelve months, there is no excuse for not having made a start.

We were pleased to see that projects already initiated by governments and agencies continued and reached some success. But we still heard of services being closed, wound back or funds diverted.

In December 2012 COAG – the then Prime Minister, Premiers and Chief Ministers – welcomed the 2012 Report Card, said they would jointly respond to it and that their response would include national indicators and targets for mental health reform.

At the time of writing, no COAG response has been received.

The Commission therefore invited all governments to provide individual responses. These were gratefully received from Western Australia, the Northern Territory and Victoria. The Commonwealth, Tasmania, South Australia and the ACT declined to provide separate reports. Responses from New South Wales and Queensland had not been received at the time of writing.

The following table represents our best endeavours to find and report information from the public domain as at October 2013. A more detailed ‘report back’ is available on our website.

### Recommendation 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.**

**How we see progress:**

The Commission is HEARTENED but commitment to action by governments remains outstanding

**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.

**What action could we see nationally?:**

- While work is underway on national consumer and carer experiences of care tools, governments still need to commit to implement national tools to survey people’s experiences.
- Individual pieces of work are underway – but a co-ordinated and systematic approach is yet to be established.
- The Victorian and Western Australian governments have made particular efforts to engage people with lived experience in policy and service design, such as the Victorian Consumer and Carer partnerships and initiatives to prioritise women’s safety in in-patient units.

**Our action:**

- We piloted several methods to understand how best to obtain people’s views on what is important to achieving a contributing life. The findings of this pilot National Contributing Life Project will become a regular national qualitative survey.
- We developed, released and implemented a Paid Participation Policy to establish the ‘ground rules’ for engaging the expertise and advice of people with lived experience.
- We launched our Participation and Engagement Framework in September 2013 that will guide our activities and ensure diverse and genuine engagement and participation.
Recommendation 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.

How we see progress:
The Commission is DISAPPOINTED about the lack of leadership by our governments

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. There must be an agreement to this indicator with an implementation plan and investment strategy to achieve this.

What action could we see nationally?:
• Current reported service treatment rates do not report upon timeliness or appropriateness of care.
• We understand that access to mental health services may be being considered as a performance indicator for reporting under the National Healthcare Agreement performance framework. But no clear action or statement as to a national unified strategy to increase access could be found.

Our action:
• The incoming Australian Government has given the Commission the task of undertaking a review of the mental health system, to identify where gaps and barriers are, and to see if money is spent effectively, efficiently and for the best outcome. This review will also include consideration of timely access to mental health supports across the population and lifespan.

Recommendation 3

Reduce the use of involuntary practices and work to eliminate seclusion and restraint.

How we see progress:
The Commission is HEARTENED by the co-operative approach across the country to openly report public service seclusion rates as a first step. But the Commission is DISAPPOINTED that we remain distant from our target to end the use of seclusion and restraint and will continue to push for action

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 Partnership Standing Committee, Disability Discrimination Commissioner, Australian Human Rights Commission and interested state mental health commissions.

What action could we see nationally?:
• Significant first steps were seen: all states and territories for the first time publicly released national seclusion data and made a commitment to ongoing national data collection and reporting.
• Real and sustained national action on the apparent decline in seclusion rates is awaited, particularly given the wide variation of rates.
• Governments are developing a consistent definition of restraint, and we urge that this is given priority so data can also be publicly reported in a comparable way.
• The United Nations Committee on the Rights of Persons with Disabilities raised concern in October 2013 about restrictive practices and recommended that Australia take immediate steps to end such practices.

• We established a National Seclusion and Restraint project in partnership with the Mental Health Commission of Canada, the Safety and Quality Partnership Standing Committee, Disability Discrimination Commissioner of the Australian Human Rights Commission and the involvement of state mental health commissions. The findings will be reported in 2014.
• A Core Reference Group of people with lived experience of mental illness and their families/supporters, academics, lawyers, human rights advocates, mental health professionals and first responders has been established to inform the project.
Recommendation 4

How we see progress: The Commission was ENCOURAGED by governments’ commitment to develop national targets and indicators for mental health reform. The Commission is DISAPPOINTED that while targets have been developed and submitted there is no commitment yet to adopt them.

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 and poor diet, and by increasing physical activity for people living with mental health problems.

ACTION called for: All government-funded mental health related programs 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 (through GPs and other primary health care organisations).

ACTION called for: All relevant services must give priority to tracking of both the physical and mental health needs of those with enduring mental illness.

What action could we see nationally?:
- No action on inclusion in chronic disease framework; however, psychosocial disability is now part of the National Disability Insurance Scheme (NDIS).
- A number of national initiatives that could provide opportunities for multi-disciplinary co-ordinated care have been started, including the NDIS, Medicare Locals and Partners in Recovery. These need to be rolled out in an integrated and careful way, with outcomes measured and reported.
- While physical health needs have been discussed by experts and state governments, including at a national summit in May 2013, there is no known progress from public reporting.
- NSW signed up to the principles of the Healthy Active Lives (HeAL) Declaration.

Our action:
- The Commission’s view is that national measures of success must include improving life expectancy and physical health.
- The 2013 Report Card endorses the directions in the COAG Expert Reference Group’s framework of national targets and indicators for mental health reform, which was submitted to governments in September 2013. This nominates measures to improve life expectancy and physical health, including addressing reductions in cardiovascular disease and smoking.

Recommendation 5

How we see progress: The Commission is DISAPPOINTED in the lost opportunity to include a mental health ‘Closing the Gap’ target.

ACTION called for: Mental health must be included as an additional target in the COAG ‘Closing the Gap’ program. 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 increase. There must also be better support for Aboriginal and Torres Strait Islander families. There must be regular reporting on progress.

What action could we see nationally?:
- No action seen to date, noting that additional ‘Closing the Gap’ targets were added in 2013 but these did not relate to social and emotional wellbeing, mental health or suicide prevention.
- A National Aboriginal and Torres Strait Islander Suicide Prevention Strategy was released in May 2013.
- No evidence available publicly to measure increased training and employment of Aboriginal and Torres Strait Islander peoples in mental health services. Progress is noted through the expansion of the National Empowerment Project which shows promise for better support of families.

Our action:
- We contributed to the development of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.
- A Memorandum of Understanding was signed in August 2013 between the Commission and the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group, to seek and action opportunities for joint effort and collaboration.
- The Sydney Declaration, signed in March 2013 by international and national and state mental health commissions, identifies Indigenous mental health as one of five priority areas for collaborative effort and information exchange. It also commits to the Wharerata Declaration.
Recommendation 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.

**How we see progress:**

The Commission is **HEARTENED** by the work underway to look at uptake of the standards, but there is still so much we don’t know. We will continue to press for a national commitment to improved quality of care.

**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 Safety and Quality in Health Care to identify what it takes to get proper uptake of national mental health service standards and make them mandatory.

**What action could we see nationally?**

- No COAG response received to date on a national commitment to improved quality of care and reduction of adverse events.

**Our action:**

- We have partnered with the Australian Commission on Safety and Quality in Health Care to establish the level of adoption of the National Mental Health Standards by services, their usefulness and utility.

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Recommendation 7

Invest in healthy families and communities to increase resilience and reduce the longer-term need for crisis services.

**How we see progress:**

The Commission is **DISAPPOINTED**, while individual projects have been rolled out, there is no clear way to see or measure a national approach.

**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.

**What action could we see nationally?**

- No COAG response to the 2012 Report Card received; no national priority, focus or co-ordinated drive in the antenatal period and in first few years of life is known from public information.
- Victoria’s new Services Connect initiative aims to connect all human services for people and families.
- We have started to find out what is useful to families to build their resilience through the pilot National Contributing Life Project.
- We commissioned and released a report into what young people want and need to support their mental health.
- We have listened to and heard the stories of hundreds of individuals and families at Commission meetings across Australia about what they think needs to change to improve their life.

**Our action:**

- We have started to find out what is useful to families to build their resilience through the pilot National Contributing Life Project.
- We commissioned and released a report into what young people want and need to support their mental health.
- We have listened to and heard the stories of hundreds of individuals and families at Commission meetings across Australia about what they think needs to change to improve their life.
**Recommendation 8**

Increase the levels of participation of people with mental health difficulties in employment in Australia to match best international levels.

**How we see progress:**
- **The Commission is ENCOURAGED by the leadership shown by business**
- **The Commission is ENCOURAGED by actions that will result in a stronger peer workforce if taken up**
- **The Commission remains DISAPPOINTED about the lack of progress to improve current employment systems for people with complex needs**

**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 programs that increase the participation of people with mental health difficulties in employment. The Commission 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 programs, 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. Programs must provide long-term support for the employee, families and support people and the employer, with appropriate incentives and milestones.

**What action could we see nationally?:**
- No public evidence identified of more flexible national employment support programs, initiatives and benefits.
- Health Workforce Australia has undertaken a study into the peer workforce in Australia. The Commission has advised the project.

**Our action:**
- The Mentally Healthy Workplace Alliance was formed in 2012 and formally launched in July 2013. Firstly undertaking a call for evidence, the Alliance will turn its attention to participation/employment rates, building upon a foundation of evidence, evaluation and best practice.
- In August 2013, with the Australian National Council on Drugs and others, we advocated for Job Services Australia to work more effectively for people experiencing mental health issues, drug and alcohol problems and/or homelessness.
- We have funded Community Mental Health Australia to produce national training and development materials to support the Certificate IV in Peer Work.

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**Recommendation 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.

**How we see progress:**
- **The Commission is HEARTENED that new programs have been initiated, but will await their evaluation to assess impacts upon reducing homelessness**
- **The Commission is DISAPPOINTED that while this has been a national commitment since 2008, we still have no public reporting of exits into homelessness**

**Action called for:** All governments implement and report regularly on the existing COAG commitment of ‘no exits into homelessness’ 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.

**What action could we see nationally?:**
- Programs were initiated in the majority of states and territories.
- No evidence that governments have implemented or have plans to report regularly on their existing COAG commitment of ‘no exits into homelessness’.
- No public evidence found on improved discharge planning.
- Some positive discrimination initiatives seen, but not widespread.

**Our action:**
- Our view is that national measures of success must include people having ensured access to safe, stable and secure homes.
- The Expert Reference Group’s framework includes national targets and indicators in this area.
Recommendation 10

Prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting.

How we see progress: The Commission is ENCOURAGED by the number and range of initiatives in this area, with more to be done.

Action called for: Develop local, integrated and more timely suicide and at-risk reporting and responses. Developing and rolling out well co-ordinated community-based, culturally appropriate, early response systems and suicide prevention programs which promote community safety, reach the most vulnerable, and using up-to-date information from the ‘first responders’ such as police officers, occupational health workers, ambulance officers and mental health workers.

Action called for: Programs 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.

What action could we see nationally?

- Turning Point Alcohol and Drug Centre is being funded to pilot a surveillance system for overdose and suicidal behaviour in Victoria, NSW, Queensland, ACT and Tasmania. This uses ambulance call-out data to distinguish patterns in suicides and suicide attempts, including across sub-populations or geographic regions. This project could shed light on these issues, help timely responses and contribute to national reporting. Sharing of results would help with policy and planning.
- Several new initiatives started by states and territories.
- Mix of evidence-based programs implemented, with others yet to be evaluated. More work remains.

Our action:
- We have commissioned the Centre for Research Excellence in Suicide Prevention to undertake a 12-month project on people’s experiences of suicide attempts. This will start to gain a better insight to people’s experiences in the lead-up to and after a suicide attempt, and what helped and what hindered.
- Our view is that national measures of success must include reducing suicide rates and the number of suicide attempts.
- The proposed national targets and indicators for mental health reform submitted to governments by the Expert Reference Group include addressing the national suicide rates and suicide attempts. We expand on this in Recommendation 18 in this Report Card.

We have held up a mirror and seen that much good work is underway. But we also see that we are getting further behind each year.

Lives continue to be lost to suicide.

People continue to be discharged to homelessness.

Crisis services continue to provide the only option when prevention and intervening early would be better for everyone.
Looking forward
Our direction in 2013

Across our range of conversations this year, the importance of prevention and early intervention was emphasised again and again.

We also heard that there are opportune times for intervention across all ages and throughout a person’s recovery journey. This makes sense economically and socially, where burdens from illness or consequent disability are lifted from individuals, families, employers, schools and communities.

We continued to hear that services and agencies need to work together for the person, focused on the whole person, working with the person and their supporters; that families want to be that – supportive families, not care co-ordinators.

The themes of the 2013 Report Card

In 2013 the Commission remains focused upon seizing opportunities for people living with a mental health difficulty and their families and supporters to lead a contributing life.

This year we investigate and spotlight new issues for close scrutiny and action.

Many people who have experience of poor mental health – which, after all, is half of the people we know – have also encountered some barrier to living the life they would like.

The case for investing early

Promotion and prevention must be priorities. They make sense.

Impacts from mental health difficulties faced by children and young people are substantial for them, their families and society – in under-achievement in education, early contact with the justice system and future employment.

Promoting resilient, mentally healthy communities, and preventing people becoming unwell or disconnected, are key to investing early in families and children.

A staggering fourteen per cent of Australia’s children and young people have a mental health problem. 59 About fifty per cent of mental health problems emerge by the mid-teens, and around 75 per cent by age 25. 60 Earlier onset is associated with longer duration of untreated illness, and poorer lifetime health outcomes. 58

Only 25 per cent of young people with mental health problems receive treatment of any kind – and only 15 per cent of boys and young men. Young people living with mental illness are less likely than their classmates to complete secondary or tertiary education. 61 Suicide is the leading cause of death among our young people. 21

It doesn’t have to be this way. We can work to lift this weight from young people and their families.

The key is investment in prevention and intervening early for new parents, all families and young people.

We shine a light upon the lives of the most disadvantaged people in our communities. This can be through economic or social circumstances and because of the impacts of their mental illness.

The highest barriers are often faced by:

• people with mental illness in prisons and ex-prisoners
• young people in juvenile justice systems
• people struggling with mental illness and difficulties with drug and alcohol use.

Discrimination just adds to their exclusion.

Not intervening early cements their disadvantage.

This cannot be subject to the short-termism of election cycles. It requires sustained vision and commitment. To fail to invest in children and young people’s mental health is to fail them.

To fail to invest across the lifespan is to fail everyone.

We believe that timely interventions must be available when a person’s mental health difficulty is emerging for the first time or re-emerging during the person’s recovery journey.

All of the factors that can lead to or deny a contributing life do not exist or operate in isolation. They are part of an everyday life, and are affected by the transitions and changes we meet along the way.
Our 2013 recommendations

In 2012 we made ten recommendations for action. Since then 3.2 million Australians have experienced a mental health problem and at least another 2,200 people have died by suicide.

So these recommendations remain just as valid this year as they were last year. We re-state them here.

In 2013 we add a further eight for action.

We will re-visit all recommendations every year until we have evidence of change that can be seen in the lives of people living with mental health problems and their supporters.

Our recommendations are stepping stones towards a vision that all people in Australia achieve the best possible mental health and wellbeing.

In 2013 we add a further eight for action.

We want to see healthier people, fewer people institutionalised in our prisons, less disadvantage and stronger Aboriginal and Torres Strait Islander communities. We want our young people to have a contributing future; families to thrive; a society that does not discriminate on the grounds of mental illness, race, disability or sexual preference. We want strong resilient mentally healthy communities, schools and workplaces.

Next year we hope we can give a positive report back on how these recommendations were addressed by us, our governments and service and support providers.

Recommendation 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: 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.

Recommendation 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: 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. There must be an agreement to this indicator with an implementation plan and investment strategy to achieve this.

Recommendation 3:
Reduce the use of involuntary practices and work to eliminate seclusion and restraint.

Action: 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: 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 Partnership Standing Committee, Disability Discrimination Commissioner, Australian Human Rights Commission and interested state mental health commissions.
**Recommendation 4:**
All governments must set targets and work together to reduce early death and improve the physical health of people with mental illness.

**Action:** Enduring mental illness must be given the status of a chronic disease to give it higher national focus and support.

**Recommendation 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:** Mental health must be included as an additional target in the COAG ‘Closing the Gap’ program. 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.

**Recommendation 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:** 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 Safety and Quality in Health Care to identify what it takes to get proper uptake of national mental health service standards and make them mandatory.

**Recommendation 7:**
Invest in healthy families and communities to increase resilience and reduce the longer-term need for crisis services.

**Action:** Employment support programs, 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. Programs must provide long-term support for the employee, families and support people and the employer, with appropriate incentives and milestones.

**Recommendation 8:**
Increase the levels of participation of people with mental health difficulties in employment in Australia to match best international levels.

**Action:** The National Mental Health Commission will pull together a taskforce including industry, government and community leaders, to actively promote effective government and workplace programs that increase the participation of people with mental health difficulties in employment. The Commission will partner with key industry and community groups to Call for Evidence and work together to advance the adoption of good practice in Australia.
Co-existing mental illness and substance misuse

People who experience co-existing mental health difficulties and substance misuse can live contributing lives if they are able to access appropriate services and support for both issues. These people are too often discriminated against and treated as though they are less worthy of help. Their needs must be responded to in a comprehensive, integrated way wherever they present. Workers on the ground are often not supported to work in this way. That may be because of siloed structures, inadequate funding or constraints on professional development and supervision.

 Recommendation 11:
 People with co-existing mental health difficulties and substance use problems must be offered appropriate and closely co-ordinated assessment, response and follow-up for their problems.

**Action:** 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:** Programs 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.

**Action:** Funding must facilitate these actions, not create barriers to them.

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**Recommendation 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:** All governments implement and report regularly on the existing COAG commitment of ‘no exits into homelessness’ from statutory, custodial care and hospital, mental health and drug and alcohol services for those at risk of homelessness.

**Action:** 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:** 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.

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**Recommendation 10:**
 Prevent and reduce suicides, and support those who attempt suicide through timely local responses and reporting.

**Action:** Develop local, integrated and more timely suicide and at-risk reporting and responses. Developing and rolling out well co-ordinated community-based, culturally appropriate, early response systems and suicide prevention programs which promote community safety, reach the most vulnerable, and using up-to-date information from the ‘first responders’ such as police officers, occupational health workers, ambulance officers and mental health workers.

**And in 2013 we add a further action...**

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2013 Recommendations
Early intervention

We support early intervention and acknowledge the significant recent investment in these initiatives for young people. It is important that these services are given enough time to bed in. We need to build in robust evaluation with outcome measures and accountability of these services to young people and their families and supporters. The concept of early intervention for people at any age or stage of life should remain a high priority.

Recommendation 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: People using services, their families and supporters must be engaged with co-design, evaluation and monitoring of early intervention initiatives.

Action: Continuous practice improvement must be driven by the findings of ongoing independent rigorous evaluation and appropriate accountability.

Peer workforce

Delivering recovery-focused services must involve growing andproperly supporting our peer workforce. Without exception, the peer workforce includes both people with lived experience and personal carers. To do this, we need clear employment provisions and working conditions, training opportunities, professional capabilities and workforce development strategies, including supervision and mentoring requirements. All must be standardised nationally.

Recommendation 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: 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.

Action: This framework must identify a target and implementation strategy for the employment of peer workers in all support and treatment settings.

Including families and support people

People with lived experience of mental health issues, either personally or as a support person, tell us that the most important enabler to a contributing life is strong and supportive relationships and connections. However, what we have heard is that families and support people, when coming into contact with services, are too often excluded and perceived as irrelevant.

Recommendation 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: The Certificate IV Peer Work training materials developed by Community Mental Health Australia must be rolled out nationally when available.

Action: Effective approaches to the meaningful inclusion of families and informal support people exist, and these must be harnessed and incorporated into a national practical guide.

Action: 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.
Recommendation 16: All Australians need access to alternative (and innovative) pathways through school, tertiary and vocational education and training.

There are already many good examples of these which must be recognised, valued and scaled up. This is crucial to engaging people who are disconnected and for whom ‘mainstream’ institutional structures form barriers to a contributing life.

Action: 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.

The justice system and mental health

The Commission knows of examples of contact with the criminal justice system and diversion schemes being an opportunity for people with a mental health problem to start on the path to a contributing life. All too often, however, this contact is not only damaging to their mental health but also to whole-of-life outcomes.

People who experience mental health problems who are in contact with any part of the criminal justice system and their families and support people need approaches which support their mental health needs and improve personal outcomes, and which also reduce recidivism rates.

The Commission finds that there are strong human rights, health and economic arguments to address these failings. It is in the community’s interest for the criminal justice system to respond appropriately to mental health issues while a person is in corrections services, to prepare them to rejoin the community and to follow up with them on their release. The criminal justice system should not create or contribute to further mental health problems, and must provide opportunities for assessing and addressing mental health issues.

Transitions through education

All transitions and changes can be challenging, but particularly so for people living with mental health problems. Our years in kindergarten, school, vocational college, TAFE, apprenticeships and university see some of life’s biggest transition points. Our education and training systems know this and support us through these. However, people with mental health difficulties may need additional support and more innovative pathways so they keep connected.

Transitions and changes occurring in education and training must not leave people with mental illness behind, but rather create opportunities to keep them engaged in education, employment or training to live productive and contributing lives. This is especially important for young people living with mental illness, from disadvantaged backgrounds, those who live in rural and remote areas, and Aboriginal and Torres Strait Islander peoples.

Action: 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.

Community understanding

While concerted efforts mean that Australians are becoming more aware of and talking more about mental health and suicide, the Commission continues to hear about individual and systemic discrimination and misunderstanding. In particular, people living with certain illnesses, such as psychoses, continue to face entrenched discrimination, which only adds to their marginalisation.

Recommendation 15: The Commission calls for the implementation and ongoing evaluation of a sustained, multi-faceted national strategy for reducing discrimination.

This should encourage positive and affirmative action by every person, family, service, school, workplace and community to help others to live a contributing life. It must be centred on community-level initiatives, and be targeted at areas and groups most resistant to change and where there is the most potential to bring about improvement, consistent with the evidence.

Action: We will continue to work with others to consider ways to end the vilification of people with mental illness.

Action: 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.
Our 2013 recommendations

A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention

These include:

- diversion services to create pathways for people with mental health problems away from prison and into support and treatment;
- justice reinvestment for Aboriginal and Torres Strait Islander peoples and people with mental health issues who are in contact with the justice system; and
- arrangements that give better rights protection, supported transitions and follow-up for people with mental health issues in custody, prison and forensic facilities when they are released or discharged. These must include step-down forensic services and supported community accommodation.

**Recommendation 17:** Where people with mental health difficulties, their families and supporters come into contact with the justice system and forensic services, practices which promote a rights and recovery focus and which will reduce recidivism must be supported and expanded.

**Suicide prevention**

It is unacceptable that at least 2,200 lives are lost to suicide in Australia each year. Suicide affects young people disproportionately and as a result is a leading cause of healthy life years lost in our country. It compounds and reflects existing patterns of disadvantage in Australian society.

In addition, there were an estimated 65,300 suicide attempts in 2007 reported by the Australian Bureau of Statistics. The biggest risk factor for suicide is a previous suicide attempt. We have limited understanding of what people experience leading up to and after a suicide attempt.

An internationally tried and tested way to focus minds and encourage co-operation and action is to introduce a national target for a reduction in the suicide rate. The COAG Expert Reference Group on mental health reform has proposed a reduction in the national suicide rate by 10 per cent in four years and 50 per cent in ten years.

The Commission supports this ambitious goal.

This Report Card shows how little we know about people’s experiences leading up to and after a suicide attempt.

Research Excellence in Suicide Prevention has initiated a small study by the Centre for Islander communities.

**Recommendation 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:** 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:** 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:** 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 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 undertaken a small study by the Centre for Research Excellence in Suicide Prevention into peoples’ experiences leading up to and following a suicide attempt.

**Action:** Programs 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.

**Action:** State and territory governments must scale up diversion schemes, justice reinvestment, and transition support.

**Action:** State and territory governments must provide better mental health programs to those who come into contact with the justice system, so that people have their mental health improved rather than diminished.
The 2013 Report Card chapters

Thriving, not just surviving
One person, diverse needs: living with a mental illness as well as the challenges from difficulties with alcohol and drug use
Link to chapter

Governments, community agencies, and public and private services must do away with historical silos and isolated approaches. We can have a cycle that leads opportunity to another opportunity, rather than disadvantage leading to further disadvantage. A stark example of a stubbornly fragmented approach is how we support people with co-existing mental health and substance use problems. All too often, the presence of one of those challenges means exclusion from services designed to support the other.

Only seven per cent of people with co-existing mental illness and substance misuse have received support for both problems, yet studies have shown that up to 70 per cent of people presenting to mental health or substance use services can experience both issues.

Maintaining connections with family, friends, community and culture
Strengthening community understanding
Link to chapter

If we see equal opportunity for a contributing life as a human right, we can start to recognise and remove the barriers to accessing the building blocks for such a life. This begins with recognising and dismantling entrenched institutional and individual discrimination through strengthening community understanding.

About a quarter of the first participants in a Commission snapshot survey this year said that social discrimination got in the way of them feeling connected to family, friends, culture or community.

Ensuring effective care, support and treatment
Approaches that support recovery, including early intervention
Link to chapter

If the right support is available at the right time, and everyone knows about it and has an equal chance to access it, the vicious cycle of illness and disadvantage can be interrupted or averted. We focus on how this can happen in the chapter about early intervention.

Fourteen per cent of Australia’s children and young people have mental health problems. Young people with mental illness are less likely than their classmates to complete secondary or tertiary education. Fifty-two per cent of 20-24 year olds with a disability from a psychological illness had not completed Year 12 or higher qualifications, compared to 25 per cent of their classmates who did not have a mental illness. For this group of young people with a mental illness, 55 per cent are either in full- or part-time employment or full- or part-time studying, in contrast to 81 per cent of their classmates who do not experience a mental illness.

Something meaningful to do
Transitioning from education to independence
Link to chapter

We all experience times of change and transition. If a young person begins to experience difficulties with their mental health, it’s vital that they are supported to get through periods of difficulty – especially during transition points. We look at what is needed to build strong foundations for a contributing life in education to independence.

Young people aged 15-24 years who have a mental illness and completed up to Year 11 at school, have lower rates of engagement in work or study than their classmates who did not have a mental illness. For this group of young people with a mental illness, 55 per cent are either in full- or part-time employment or full- or part-time studying, in contrast to 81 per cent of their classmates who do not experience a mental illness.

Feeling safe, stable and secure
The justice system and mental health
Link to chapter

We know that people with mental illness are over-represented in our prisons. We know that people can turn their lives around with the right supports. It can be done. The justice system and mental health chapter talks about how we can do this.

Nationally, one third of prisoners with a mental health condition have been in prison five or more times, compared to 26 per cent of prisoners with no condition.

Preventing suicide
What works in suicide prevention?
Link to chapter

Sometimes people can get locked into a situation which feels impossible and hopeless. This can culminate in one of 65,300 suicide attempts and 2,200 reported deaths from suicide every year in Australia.

In our suicide prevention chapter, we look at what we know about what works to prevent suicide and how we can stop this tragedy happening for any more people and families.

Every year, suicide takes more than twice as many lives in Australia as traffic accidents.