Monitoring mental health and suicide prevention reform

National Report 2018

Australian Government
National Mental Health Commission

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Message from Lucy Brogden

Chair of the NMHC Advisory Board

Improving mental health and wellbeing in Australia is a continuing and collaborative effort.

This year I was delighted to be appointed as Chair of the NMHC. I would like to take this opportunity to thank the NMHC's outgoing chair, Professor Allan Fels AO, for his tireless contributions to improving mental health outcomes for all Australians. Professor Fels was the first chair of the NMHC, and I am honoured to continue to drive the work he commenced and contribute to achieving the NMHC's vision of ensuring mental health and wellbeing is a national priority.

We also farewelled Commissioners Professor Ian Hickie AM and Mr Samuel Hockey. Professor Hickie was appointed to the NMHC when it was established in 2012, and provided invaluable guidance and advice on the reporting and advisory role of the NMHC. As a young person with lived experience of mental illness, Mr Hockey brought a valuable perspective to our work at the NMHC. I thank both outgoing Commissioners for their dedication and commitment to improving mental health and wellbeing for Australians.

On 5th September 2018, the NMHC was pleased to announce the commencement of four new Commissioners: Ms Kerry Hawkins, Rabbi Mendel Kastel OAM, Ms Christina McGuffie and Professor Maree Teeson. We are pleased to have such a wide range of experience and knowledge to contribute to the work of the NMHC.

Since my time as a Commissioner and now Chair of the NMHC Advisory Board, I have witnessed necessary reforms in mental health and suicide prevention that seek to address some of the widely known challenges impacting the experiences of consumers and carers. While more work needs to be done, attitudes are changing and there is a strong culture of continuous improvement.

Significant reforms are currently underway in parallel across the mental health and disability sectors. These include the role of the Primary Health Networks (PHNs) in planning and commissioning mental health and suicide prevention services at the regional level. A regional approach to service planning and delivery is already delivering better outcomes. We are encouraged to see PHNs particularly adopting a co-design approach to their planning and commissioning. We continue to monitor and provide input into the roll out of the National Disability Insurance Scheme.

In August 2017, the *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) was endorsed by the Council of Australian Governments (COAG). The NMHC has a key role in reporting on the implementation progress of the Fifth Plan.

Transformation under these reforms will take time. The NMHC looks forward to working collaboratively across the different systems and the sector to support these reforms.

Prevention and early intervention are fundamental to any effort to reduce the impact of mental illness. A key priority for the NMHC is building the evidence base for the benefits of investing in promotion, prevention and early intervention initiatives. This evidence base must include not only the benefits for the individual's mental health, but also the wider societal and economic benefits such as improvements in productivity and efficiency.

We continue to monitor the implementation of key projects, including our work in the area of seclusion and restraint and the Equally Well project that focuses on the physical health of people living with mental illness.

The NMHC is working on developing and implementing a National Workplace Initiative, which will establish a foundation for all Australian businesses to provide psychologically safe workplaces that keep people well, support recovery and offer opportunities for more Australians to participate in work. Not only do mentally healthy workplaces benefit employees, they also benefit employers and the wider community. We believe that the National Workplace Initiative will provide the necessary practical guidance for supporting mental health and for promoting and sustaining a healthy workplace culture.

Thank you to the Minister for Health the Honourable Greg Hunt MP, the Australian Government, state and territory governments, and our key stakeholders who continue to demonstrate genuine commitment to reform.

Lucy Brogden
Chair of the NMHC Advisory Board

Message from Maureen Lewis

Interim CEO of the NMHC

I am proud to present the NMHC's *Monitoring mental health and suicide prevention reform: National Report 2018.*

Firstly, I would like to acknowledge and thank Dr Peggy Brown, former CEO of the NMHC. Dr Brown, alongside our fellow Commissioners and staff, has informed efforts to improve Australia's mental health and suicide prevention systems. Central to the NMHC's work is giving consumers and carers genuine opportunities to participate and engage in decisions that affect them in leading contributing lives.

This year we welcomed the 2018–19 Budget announcement of $12.4 million over four years to strengthen our role in identifying what is and is not working in mental health and suicide prevention systems, and to provide advice to governments and the community, to achieve better outcomes for people who need mental health support. The NMHC was charged with the responsibility of monitoring and reporting on the implementation of the Fifth Plan. To achieve this, the NMHC established an office in Canberra to ensure the NMHC's ongoing engagement with key policy-makers and Australian Government officials in the development of our reports.

The Australian Government's budget went further than this, with the investment of $338.1 million over the next four years in a range of commendable initiatives. This includes further investment in suicide prevention, digital mental health services, mental health services for aged care, mental health workforce capacity and social connectedness, and $125 million over 10 years for mental health research.

While we acknowledge there is much more to be done, we believe this firmly demonstrates a commitment to making the mental health of our nation a top priority and will further enable delivery of improved services and programs. We will continue to monitor and report on these initiatives, as well as the key mental health and suicide prevention reforms being implemented across Australia.

There have been many other achievements this year. Supporting the growth of leadership among consumers, carers, mental health professionals and others outside the traditional boundaries of the mental health sector is one of them. In collaboration with the University of Melbourne, consumers, carers and mental health professionals, we proudly launched the first Australian Mental Health Leaders Fellowship. We anticipate that these emerging leaders will be equipped to make a difference and better influence positive outcomes for mental health, in whichever setting they work in.

Finally, I would like to sincerely thank my colleagues at the NMHC, our Commissioners, fellow mental health commissions across Australia and New Zealand, and all organisations, individuals, consumers and carers who make ongoing and significant contributions to the mental health and suicide prevention sector. By working together we can continue to make real change at all levels of the system, and improve the lives of those impacted by mental illness.

Maureen Lewis
Interim CEO of the NMHC

About us

The National Mental Health Commission (NMHC) was established in 2012 and provides insight, advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems and acts as a catalyst for change to achieve these improvements. This includes increasing accountability and transparency in mental health by providing independent reports and advice to the Australian Government and the community.

Our vision

Our vision is that all people in Australia are enabled to lead contributing lives in socially and economically thriving communities.

We strive to achieve our vision by:

- ensuring mental health and wellbeing is a national priority
- increasing accountability and transparency through credible and useful public reporting and advice informed by collaboration
- providing leadership and information that helps to empower mental health consumers and carers
- working with others to influence decision-making, set goals and transform systems and supports to improve people's lives.

Executive Summary

Mental illness and suicide are significant public health issues both in Australia and internationally. Almost half of all Australians will experience a mental illness in their lifetime.

The nature of mental illness is complex and multidimensional. We know that mental illness affects not only mortality, but also people's social and emotional wellbeing. It influences people's ability to live a contributing life through personal, social and economic factors, and the ability to contribute and feel connected within a community.

The *Monitoring mental health and suicide prevention reform: National Report 2018* considers the status of Australia's core national mental health and suicide prevention reforms, and their impact on the wellbeing of consumers and carers. The key findings of the report are outlined below.

Key mental health and suicide prevention reforms

In 2014, the National Mental Health Commission (NMHC) conducted a national review of mental health programs and services: *Contributing lives, thriving communities – National Review of Mental Health Programmes and Services* (the Contributing Lives Review). Some recommendations from the Contributing Lives Review have commenced implementation, while a number have been incorporated in the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan).

Primary Health Networks (PHNs)

PHNs have a significant role in planning, commissioning and integrating mental health and suicide prevention services at a regional level. As they are well placed to take a holistic approach to meeting the needs of their regional population, PHNs can play an essential role in the commissioning of mental health and suicide prevention services through a stepped care model.

The NMHC supports the certainty of long-term funding for PHNs to allow time to develop long-term solutions and, in turn, to provide longer-term contracts through the commissioning process.

PHNs should continue to work collaboratively with local partners to develop strategies to ensure that their commissioning process is robust and minimises unintended consequences.

The NMHC will continue to monitor and report on the delivery of services under PHNs.

National Disability Insurance Scheme (NDIS)

The NDIS is a complex social reform and such transformation takes time and requires the joint effort of all governments. The NDIS was never intended to replace community mental health services, nor detract from the responsibility of other systems (such as health, education and justice) to respond to the needs of people with mental illness.

A key issue for the future will be how the NDIS interacts with other systems to provide coordinated support for people with a mental illness.

The NMHC notes the ongoing work of the National Disability Insurance Agency (NDIA) in responding to feedback from participants, their families and carers. The NDIA will be making a number of improvements to the NDIS participant pathway including working with Mental Health Australia to implement a psychosocial disability pathway. The NMHC will be monitoring the timely implementation of the psychosocial disability pathway and the rates of NDIS access for eligible individuals.

For people who are ineligible for the NDIS, supports will be available from the Australian Government through the Continuity of Support and National Psychosocial Supports measures. While there is clarity around the support available through these measures, the key issue will be how consumers access this support. PHNs have a significant role to play in implementing these measures. The NMHC will be monitoring how these measures are implemented.

The NMHC is concerned about the lack of information on the Provider of Last Resort arrangements (PLR) and would encourage the NDIA to release its PLR policy as a matter of urgency. Given the complex needs of the participants who are likely to be affected by thin markets, and the roll out of the full scheme nearing completion, clarification of PLR arrangements should be prioritised.

Suicide prevention

Suicide prevention initiatives currently being implemented in Australia may have a significant impact on the future directions of suicide prevention planning and investment.

In particular, the local area suicide prevention trials are an opportunity to gain insights about the process and outcomes of systematic implementation of suicide prevention programs targeted to local at-risk groups.

As the implementation of the initiatives is in the early stages, there are currently no outcomes available for reporting. However, the ongoing monitoring of these initiatives will be important to determine not only whether the initiatives are effective in reducing Australia's suicide rate, but also whether a more coordinated approach across governments has been achieved.

The trial sites are an important development, but they do not cover the whole country and do not have the capacity or responsibility to address issues such as data gaps. The NMHC remains concerned that, at all levels of government, significant gaps persist in the collection and distribution of key real-time data. There is also a lack of appropriate care and support for people in crisis, and insufficient training on suicide prevention for people working in the health, allied health and community sectors.

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan)

Reporting on the progress of mental health reform is essential to show that the commitments in the Fifth Plan are being honoured and are making a difference. To achieve this, the NMHC will produce an annual report on the progress of implementing the Fifth Plan actions and performance against the identified indicators. The first of these reports is expected to be delivered to the Council of Australian Governments (COAG) Health Council in October 2018. Subject to approval from the COAG Health Council, the report will be made public.

Mental health–related expenditure

Determining the true expenditure on mental health is complex, as costs are distributed across health and other sectors.

The most recent data available indicates that, in 2015–16, the national recurrent expenditure on mental health–related services was around $9.0 billion. Of this 59.8% ($5.4 billion) was funded by state and territory governments, 35.0% ($3.1 billion) by the Australian Government and 5.2% ($466 million) by private health insurance funds. This distribution has remained relatively stable over time; in 2011–12, 60.5% of national spending came from state and territory governments, 35.5% from the Australian Government and 3.9% from private health insurance funds.[1] This expenditure data does not include the broader costs of mental illness.

Looking at the direct expenditure on mental health only provides part of the information to assess whether expenditure on mental health is effective. Determining the true expenditure on mental health is complex, given the difficulty in capturing all the costs such as costs in other systems or costs borne by consumers.

In 2018–19, the NMHC will undertake further work to assess the level of mental health expenditure in Australia, including work to assess the ability to improve the capture of indirect costs.

Mental health workforce

Issues related to the mental health workforce include high staff turnover, the need for staff training in suicide prevention, the need to increase and develop roles such as peer workers, the need to improve Aboriginal and Torres Strait Islander representation in the workforce, and the challenges of working in rural and remote locations. In 2018–19, the NMHC will undertake further work on the issues confronting the mental health workforce.

Towards the elimination of seclusion and restraint

Working towards the goal of eliminating seclusion and restraint will require time, sustained and increased effort, and leadership at all levels. Further targeted work is needed to implement the cultural and practice changes that will ultimately lead to reducing and eliminating seclusion and restraint.

Throughout 2018–19, the NMHC will be working with the Australian College of Mental Health Nurses and other key stakeholders to develop a National Framework for Ensuring Safety in Care and Safety for Staff in Australian Mental Health Services.

Consumer and carer engagement and participation

Supporting consumers and carers to effectively engage and participate will remain a key focus of the NMHC's work. This will include consultation and engagement on a range of issues, from an individual accessing mental health services, to the contribution of consumers and carers to mental health service planning, delivery and engagement on mental health reforms. The NMHC will work with the National Mental Health Consumer and Carer Forum and the Safety and Quality Partnership Standing Committee to develop a consumer and carer engagement and participation guide. The guide will focus on strengthening the involvement of consumers and carers in safety and quality initiatives in mental health services, and enhance opportunities for partnerships with consumers and carers at all levels of decision-making.

Mental health outcomes

The Contributing Lives Review noted the need for an outcomes-focused mental health system, with more people getting the services they need, when and where they need them.

The National Outcomes and Casemix Collection data for the years of 2007–08 to 2015–16 indicates that the majority of consumers in both inpatient and community-based mental health settings experienced significant improvement in their mental health and psychosocial functioning.

The Your Experience of Service (YES) survey was designed to gather information from consumers about their experiences of care. It aims to help mental health services and consumers to work together to build better services. It is anticipated that pooled data from the YES survey will be available for three jurisdictions in 2019, providing valuable insight into the consumer experience of mental health services.

It is important that outcome measures are meaningful to the clinician, consumer and community, as well as being consistent across services and jurisdictions. Ongoing monitoring of outcomes for consumers and carers should remain a national priority.

Prevention and early intervention

Prevention and early intervention in mental health is clearly linked with improved long-term outcomes across all aspects of life.

The NMHC is seeking to build on the evidence base for the benefits of investing in promotion and prevention initiatives. Such investment can result in benefits for the individual in terms of their mental health, and economic benefits in the form of improvements in productivity and efficiency. This work will progress through the NMHC's Economics of Mental Health – Australian Best Buys project.

Housing and homelessness

Reforms in the area of housing and homelessness require collaboration between the Australian Government, state and territory government agencies, community sector services, and consumers and carers. The NMHC has engaged the Australian Housing and Urban Research Institute to develop a paper outlining practical next steps for bringing these stakeholders together and facilitating coordinated activity across the mental health, housing and homelessness sectors.

Physical health

The fact that Australians living with mental illness are experiencing poorer physical health and dying earlier than the general population is a national priority.

The Equally Well consensus statement focuses on the physical health of people living with mental illness. The NMHC established the Equally Well Implementation Committee (EWIC) in 2017 to lead the national implementation of Equally Well. This will involve partnering with private, public and community sectors, including consumers and carers. With this broad support, EWIC is well placed to link the physical and mental health sectors and ensure meaningful progress.

Improving the physical health of people living with mental illness and reducing early mortality is a Fifth Plan priority. The NMHC will continue to monitor this work to ensure Equally Well principles are embedded across systems and governments, and to assist in identifying shared measures of success that support the pursuit of equity in health.

Conclusion

The sheer scope and ambition of reforms described in this report is a reflection of the complexity of building contributing lives for people living with a mental illness.

Transformation through such social reform takes time. It requires joint deliberate effort across all governments, systems and sectors to keep people living with mental illness at the centre of the reform efforts.

The NMHC is uniquely positioned to monitor the progress of these reforms and facilitate cooperation between the stakeholders involved.

The NMHC will continue to have an ongoing monitoring and reporting role in the key reforms of the NDIS, the PHNs, suicide prevention and the Fifth Plan.

In 2018–19, the NMHC priority areas for further work include mental health expenditure, the mental health workforce, reducing seclusion and restraint, supporting consumer and carer engagement, building participation in the national implementation of Equally Well, continued monitoring and reporting work on housing and homelessness, and progressing the Economics of Mental Health – Australian Best Buys project.

This report is only one mechanism that the NMHC will be using to monitor and report on Australia's mental health and suicide prevention systems. In the future, the NMHC expects to release reports in a variety of formats that focus on key areas that affect an individual's mental health and, more broadly, the mental health system.

The size of the problem

The prevalence and impact of mental illness and suicide in Australia

The prevalence of selected mental illnesses and suicide

Mental illness is defined as a diagnosable health condition that significantly affects how a person feels, thinks, behaves, and interacts with other people.[2] Mental illness can vary in severity and duration and can have a significant impact on the consumers and carers concerned.[2]

A person experiencing poor mental health or high levels of psychological distress may not meet the criteria for a mental illness[2], but their condition may still have a negative impact on their life. Poor mental health may also be associated with suicidality – the collective term for suicidal ideation, suicide plans and suicide attempts. While suicide is more common in people with a mental illness, it is not confined solely to this group.[2]

Although population estimates of mental illness prevalence and burden of disease are unable to represent the diversity of consumer and carer experiences, they can provide a sense of the quantum of need for mental health supports and services in Australia.

The remainder of this section outlines the prevalence of selected types of mental illness and suicide, the burden of disease associated with mental illness, and the incidence of psychological distress.

Mental illness in adults

It is estimated that close to half (45.5%) of the Australian population between 16 and 85 years of age will experience a common mental illness, such as anxiety, affective or substance use disorder, at some stage in their lifetime.

It is also estimated that 20.0% of the population experience a common mental illness each year. Of these, anxiety disorders (such as social phobia) are the most prevalent, affecting 1 in 7 (14.4%) people, followed by affective disorders (such as depression) (6.2%), and substance use disorders (such as alcohol dependence) (5.1%).[2]

Psychotic illness

Psychotic illnesses are characterised by distortions of thinking, perception and emotional responses, and include schizophrenia, schizoaffective disorder, bipolar disorder and delusional disorder. The most common of these illnesses is schizophrenia.[3] In a given 12-month period, people with a psychotic illness are estimated to be in contact with public specialised mental health services at a rate of 4.5 cases per 1,000 population.

The prevalence of psychotic illness is higher in males than in females (3.7 cases per 1,000 compared to 2.4 cases per 1,000).[3]

Mental illness and self-harm in children and adolescents

It is estimated that around 1 in 7 (13.9% children and adolescents between 4 and 17 years of age experiences a mental illness each year. Attention deficit hyperactivity disorder (ADHD) is the most common mental illness. In a survey in 2013–14, 7.4% of children and adolescents were assessed as having ADHD in the previous 12 months. Anxiety disorders are the next most common (6.9%), followed by major depressive disorder (2.8%) and conduct disorder (2.1%).[4]

Of the 13.9% of children and adolescents with a mental illness, almost one-third (30.0% or 4.2% of all 4–17-year-olds) had two or more disorders at some time in the previous 12 months.[4]

In the same survey, around 1 in 10 adolescents (10.9%) reported having ever self-harmed. About three-quarters of these adolescents (amounting to 8.0% of the adolescent population) harmed themselves in the previous 12 months. In addition, 7.5% of 12–17-year-olds answered "prefer not to say" to the first survey question on self-harm and were not asked subsequent questions. As such, the proportion of young people who have ever self-harmed may be higher than indicated in these estimates. Around 7.5% of young people between 12 and 17 years of age had seriously considered attempting suicide in the previous 12 months.[4]

Suicide

In 2017, 3,128 people died by suicide in Australia, making suicide the 13th leading cause of death.

Aboriginal and Torres Strait Islander people die by suicide 2.0 times more often than non-Indigenous Australians.

In the five years from 2013 to 2017, death by suicide was the leading cause of death for Aboriginal and Torres Strait Islander people between 15 and 34 years of age, and the second leading cause for those 35 to 44 years of age.[5]

Burden of disease

Burden of disease analysis provides a measure of the impact of illness and death from a disease compared to a disease-free life.

Mental and substance use disorders were responsible for 12.1% of the total burden of disease in Australia in 2011, representing the third most burdensome group of diseases behind cancer and cardiovascular diseases.

Mental and substance use disorders were also the leading cause of non-fatal burden, accounting for almost one-quarter (23.6%) of all years lost due to disability.[6]

Just over one-quarter (26.0%) of the burden due to mental and substance use disorders was attributed to anxiety disorders, and a similar proportion (23.5%) to depressive disorders. A further 12.2% was attributed to alcohol use disorders.[6]

Psychological distress

Psychological distress can be described as feelings of tiredness, anxiety, nervousness, hopelessness, depression and sadness. The Kessler Psychological Distress Scale measures these emotional states to determine a person's level of psychological distress.[7] Psychological distress can be experienced independent of a mental illness. For this reason, psychological distress is useful for measuring a person's general wellbeing. [8]

In 2014–15, 1 in 9 (11.7%) Australians reported having high or very high levels of psychological distress. This has remained relatively stable over time (10.8% in 2011–12). People living in areas of greatest socio-economic disadvantage were twice as likely to report high or very high levels of psychological distress compared to those living in the least disadvantaged areas (17.7% compared with 7.3%, respectively, in 2014–15). Women between 18 and 24 years of age had the highest rate of psychological distress of any age group or sex in 2014–15 (20.0%).[9]

In 2012–13 almost one-third (29.4%) of Aboriginal and Torres Strait Islander people reported high or very high psychological distress.

A higher proportion of Aboriginal and Torres Strait Islander women reported high or very high levels of psychological distress, compared to Aboriginal and Torres Strait Islander men (34.8% compared to 23.5%, respectively). Aboriginal and Torres Strait Islander people were nearly three times as likely as non-Indigenous people to experience high or very high levels of psychological distress.[10]

Conclusion

In response to the significant need for mental health supports and services in Australia, governments have invested substantial resources to improve the mental wellbeing of all Australians. Section 1 of this report will outline key contemporary reforms, and the progress made against them since the NMHC's Contributing Lives Review.[11]

Key mental health and suicide prevention reforms

Section 1

Introduction

In 2014, as tasked by the Australian Government, the National Mental Health Commission (NMHC) completed a review of mental health programs and services: *Contributing lives, thriving communities – report of the National Review of Mental Health Programmes and Services* (the Contributing Lives Review).

The Contributing Lives Review looked at the efficiency and effectiveness of mental health and suicide prevention programs and services. The NMHC made 25 recommendations on how to improve outcomes for people living with a mental illness (see Appendix 1).[11]

In November 2015, the Australian Government responded to the NMHC's recommendations. This response set out a three-year reform package that included commitments to:

- implement flexible funding via Primary Health Networks (PHNs)
- develop a digital mental health gateway
- integrate support for child mental health, linking health, education and social supports
- integrate early intervention services and supports for young people with or at risk of mental illness
- integrate Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing services
- implement a systematic regional approach to suicide prevention and develop a new national suicide prevention strategy
- package care arrangements to support clinical care coordination for people with severe mental illness and complex needs in primary health care settings
- develop the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan).[12]

What has happened so far?

As the three-year timeframe draws to a close, it is timely that the NMHC reports on progress against these commitments. Some of these recommendations have commenced implementation, while a number have been incorporated into the Fifth Plan. The NMHC will be monitoring the latter as part of its role on reporting on the implementation progress of the Fifth Plan. Box 1 outlines the progress to date of selected reforms.

The next chapters of this section of the report describe some of the key reforms and reports their progress, including the delivery of services through the PHNs (chapter 1), the National Disability Insurance Scheme (NDIS) (chapter 2), suicide prevention (chapter 3) and the Fifth Plan (chapter 4).

Box 1: Progress on selected reforms

Flexible funding through Primary Health Networks (PHNs)

The National Mental Health Commission recommended the scope of PHNs be extended to provide the regional architecture for equitable planning and purchasing of mental health programs and services, and for equitable access pathways.

From 1 July 2016, PHNs were provided with a quarantined flexible funding pool for commissioning primary mental health services. Additional funding of $85 million from 2016–17 to 2018–19 for services for Aboriginal and Torres Strait Islander people was also quarantined.[13] The PHN flexible funding pool is estimated to provide a total of $385 million in 2018–19.[14]

The digital mental health gateway

On 7 October 2017, a digital mental health gateway called Head to Health was launched. Head to Health is a website that helps people easily access evidence-based information, advice and digital mental health treatment options.[15]

As part of the 2018–19 Federal Budget, Head to Health received a further $4.7 million that will ensure its continued operation. This funding will also support the development and implementation of a Head to Health Telephone Support Service in 2019–20.[16]

Joined up support for child mental health

On 8 January 2018, the Australian Government Department of Health announced a $110 million investment in child and youth mental health.[17] This includes $46 million to beyondblue for its integrated school-based Mental Health in Education Initiative. With support from headspace and Early Childhood Australia, the Mental Health in Education Initiative will provide a single end-to-end school and service-based mental health framework. Covering the continuum from early childhood to secondary school, it will support mental health promotion and suicide prevention activity.[18]

Integration of Aboriginal and Torres Strait Islander services

In October 2017, the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 was launched.[19] The framework focuses on setting up a comprehensive and culturally appropriate model of stepped care. It is designed to complement the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan).

A National Suicide Prevention Implementation Strategy

An action under the Fifth Plan is to develop a National Suicide Prevention Implementation Strategy, which will operationalise elements of systematic suicide prevention. An overview of the systematic regional approach to suicide prevention is included in chapter 3 of section 1 in this report.[20]

The Fifth National Mental Health and Suicide Prevention Plan

On 4 August 2017, the Fifth Plan was endorsed by the Council of Australian Governments (COAG) Health Council. The Fifth Plan seeks to establish a national approach for collaborative government effort in eight priority areas over the period 2017 to 2022.[20] An outline of the Fifth Plan and its priority areas are discussed in chapter 4 of section 1 in this report.

Chapter 1:
Primary Health Networks (PHNs)

The NMHC's Contributing Lives Review found that the national mental health system was poorly planned, fragmented, badly integrated and lacked accountability.[11] The Australian Government responded by providing the newly formed PHNs with responsibility for planning, commissioning and integrating mental health and suicide prevention services at a regional level.[12]

What is expected under this reform?

The 31 PHNs do not directly provide services themselves, rather they plan and commission services using a stepped care model. Stepped care is a planning model that seeks to match individuals to the level and type of care they need, at the right time and in the right place. This means that PHNs are expected to offer a hierarchy of interventions across the continuum of care, from the least to the most intensive, matched to the individual's needs and with flexibility to move between levels according to the individual's needs at any given time.[21]

While the PHN role is crucial, it is nevertheless a single component of the complex mental health system that spans across all tiers of government and multiple other sectors. Under the Fifth Plan, all governments have committed to working together to achieve integrated planning for service delivery at a regional level, with PHNs working in collaboration with Local Health Networks to identify and address service gaps. The Fifth Plan also supports a person-centred care model, an approach that ensures consumers and carers shape the way that services are planned, delivered and evaluated.[20]

What has happened so far?

Key challenges for the PHNs in coordinating and commissioning services at a local level

A key challenge for PHNs in coordinating and commissioning services at a local level is the balance between national consistency and regional flexibility when applying a stepped care model.

To implement the stepped care model, PHNs need to develop their own approach to how the commissioned services will be delivered.[22]

The Australian Government Department of Health has funded the development of the National Mental Health Service Planning Framework (Service Planning Framework). This is a population-based planning tool designed to identify service demand, to assist in planning, coordinating and resourcing mental health services in both inpatient and community environments.[23]

While the Service Planning Framework is a crucial tool for service planning, a number of issues regarding training and use of the tool have been raised by PHNs. Delays in rolling out training for PHN staff in how to use the Service Planning Framework caused some early frustrations.

Some rural PHNs have found the Service Planning Framework is not readily applicable to rural and remote areas with more dispersed populations and Aboriginal and Torres Strait Islander populations. This issue has been acknowledged by the Service Planning Framework's developers (University of Queensland), who have been funded by the Australian Government Department of Health to update the tool to improve its applicability to Indigenous and rural and remote populations.[24]

The PHNs' service commissioning model uses a competitive process. This process has raised some concerns, including:

- the need for more transparency in the competitive commissioning process
- gaps in service provision – some successful new service providers have had delays in providing services because of the need to recruit staff, and at the same time unsuccessful providers have withdrawn their services
- some established local providers being replaced by new large providers without local knowledge
- loss of jobs, especially mental health nurses who worked with unsuccessful service providers (a number of examples in Victoria were cited)
- negative impacts on and, in some cases, probably irreparable harm to some existing relationships that were very well-established, particularly between general practice and mental health nurses.[25]

The NMHC acknowledges that some of these issues may be part of the transition to commissioning services using the stepped care model. However, some of these issues may be compounded by contract lengths for commissioned services.

In the recent Senate inquiry into rural and remote mental health services, organisations commissioned by PHNs with back-to-back one-year contracts highlighted the challenge to delivering programs and services in rural and remote regions, when funding is provided under 12-month contracts. This period is not long enough to demonstrate improved mental health outcomes or to retain staff.[25]

A number of projects have been funded by the Australian Government Department of Health to address issues that have emerged through PHNs' experiences in planning and commissioning services. These projects include the:

- national assessment and referral project – developing guidance and resources for the initial assessment and referral of clients presenting for mental health assistance in primary care
- low-intensity services accreditation project – developing recommendations for an agreed accreditation process for the delivery of low-intensity services to ensure they meet best practice quality and safety standards (undertaken by the Australian Psychological Society)
- experience measure for PHN mental health services – developing a nationally consistent approach to the measurement of consumers' experience of mental health services.[25]

The Australian Government Department of Health is also providing support to PHNs through mechanisms such as an online portal and SharePoint, which enable PHNs to share knowledge and resources and to discuss issues across the networks.[25] In addition, two national stepped care workshops were held in 2018 to allow PHNs to compare models, and identify issues or concerns related to implementing a stepped care model.

In 2018, the PHN Mental Health Advisory Panel (the Panel) finalised its report to the Australian Government on the progress of reforms by PHNs. The Panel will present its findings to the Australian Government who will then consider the Panel's report.

Engagement with stakeholders on service design

Local planning and development by PHNs must involve consumers and carers to ensure the stepped care model provides a range of services to match consumers' needs at any point in time.

The NMHC's *2017 National Report on mental health and suicide prevention* noted that some PHNs struggled to achieve meaningful engagement and participation with consumers and carers. A year later there has been marked progress and national workshops now include consumers and carers as workshop co-facilitators, presenters and workshop participants.

The PHN Mental Health Lived Experience Engagement Network (the Network) has been established to create an environment that supports the incorporation of lived experience in the work of PHNs. The Network is currently conducting a stocktake of PHN approaches to consumer and carer engagement activity, and will distribute these findings among PHNs. The Network also provides a forum for PHNs to share their ideas for good practice in co-design and incorporating consumers and carers within program commissioning cycles. In 2019, the Network will develop a best practice report on co-design with people with lived experience.

PHNs are also employing people with lived experience in peer worker roles to support the delivery of commissioned programs and services in a stepped care model. To support the development and promotion of the peer workforce, the NMHC has developed PHN peer workforce guidance, and will also be developing peer workforce development guidelines as a Fifth Plan action.

Engaging Aboriginal and Torres Strait Islander communities in regional planning

One of the priorities for PHNs is engaging Aboriginal and Torres Strait Islander communities and community controlled organisations in co-designing all aspects of regional planning for Aboriginal and Torres Strait Islander mental health and suicide prevention services. There has been some early success in building partnerships between PHNs and Aboriginal community controlled organisations (see Case study).

In contrast, some PHNs have primarily commissioned mainstream providers rather than community controlled health services to provide services to Aboriginal and Torres Strait Islander communities. Leading Aboriginal organisations consider this approach to be flawed, and believe it will result in poorer outcomes for Aboriginal and Torres Strait Islander people.

It is important for PHNs to recognise and support the cultural determinants of Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing, in addition to clinical approaches.[26] Recent research by the Lowitja Institute highlights the need for a specific definition of mental health for Aboriginal and Torres Strait Islander people, as mental illness is more likely to occur when social, cultural, historical and political determinants are out of alignment.[27]

Psychosocial support and NDIS

A pressing issue for PHNs is the inclusion of psychosocial support services in their commissioning work. The provision of psychosocial support services was initially out of scope for PHNs. The landscape changed when concerns were raised across the sector about people with a mental illness who may not receive support under the NDIS. PHNs will commission psychosocial support services to support people who are not able to receive support under the NDIS (see chapter 2).

Conclusion

The NMHC acknowledges the significant role that PHNs have in planning, commissioning and integrating mental health and suicide prevention services at a regional level, despite being a relatively new initiative in only its third year of implementation.

PHNs are well placed to take a holistic approach to meeting the needs of their regional population and can play an essential role in commissioning mental health and suicide prevention services through a stepped care model.

The NMHC supports the certainty of long-term funding for PHNs to allow time to develop long-term solutions and, in turn, to provide longer-term contracts through the commissioning process. The NMHC also supports the broader sharing by PHNs of their experiences beyond the current online portal and national workshops.

PHNs should continue to work collaboratively with local partners to develop strategies to ensure that their commissioning process is robust and minimises unintended consequences.

The NMHC will continue to monitor and report on the delivery of services under PHNs.

Case study: Western Queensland Primary Health Network – regional alliance to deliver culturally competent primary mental health care[28]

Western Queensland Primary Health Network (WQPHN) covers a region about three times the size of Victoria, and nearly 20% of their 76,000 population is Aboriginal and Torres Strait Islander. The sparse distribution of people in this region is among small towns, with few service providers and poor transport options.

An early priority for WQPHN was to partner with the four established Aboriginal and Torres Strait Islander Community Controlled Health Services (AICCHS). The Nukal Murra Alliance was established, founded on the common understanding that Aboriginal and Torres Strait Islander mental health and wellbeing and mainstream primary mental health services are both specialist areas of practice and are to be respected. This 'best of both worlds' approach led to connections across the two areas of practice. Direct investment in the AICCHS sector and promotion of co-commissioning resulted in expansion and better linkage of services, general practice and specialist providers to deliver culturally competent primary mental health care.

Chapter 2:
National Disability Insurance Scheme (NDIS)

The National Disability Insurance Scheme is designed to provide Australians who have a severe and permanent disability with choice and control over the services they need, and the certainty of lifetime support.

This chapter looks at the consequences of the scheme for people with a psychosocial disability and their supporters.

What is expected under this reform?

The goal of the NDIS is to improve social and economic outcomes for people with disability and their carers. It aims to do this through individually funded support for people with severe and permanent disability, and funding through information, linkages and capacity (ILC) building for people with disability in the community.[29]

The scheme moves beyond the traditional welfare model of support by operating on the basis of insurance principles – investing early, taking a lifetime approach, and promoting innovation in support design and delivery.

The NDIS replaces a disability support system that was unfair, fragmented, inefficient and underfunded. According to the Productivity Commission, the previous disability support system gave people with a disability little choice and no certainty of access to appropriate supports.[30]

The NDIS does not replace the support that is available in other systems such as health, education, justice, employment and housing. It is crucial that the NDIS interacts with and connects to existing systems to provide coordinated support for people with a mental illness.

In 2011, the Productivity Commission originally estimated that at full scheme the NDIS would support around 410,000 Australians with a disability.

Approximately 14%, or around 57,000, of these participants were expected to have a significant and enduring primary psychosocial disability.[30] Since then, the National Disability Insurance Agency (NDIA) has estimated that, accounting for population growth, at full scheme 460,000 Australians with a disability will be participants of the NDIS, of which 64,000 will have a primary psychosocial disability.[31] The NDIS is projected to be at 'full scheme' in 2019–20, except for Western Australia, which is expected to be at full scheme by 2020–21.

In relation to mental health, the roll out of the NDIS has been complicated. This is because of the late inclusion of mental health in designs for the scheme, unclear roles and responsibilities across and between systems (such as health) and governments, and the complex nature of mental illness and psychosocial disability.

At the systems level, the mental health and disability sectors in Australia are not well integrated, with different governance arrangements, funding measures, delivery models, and approaches to care and support. The NDIS brings these two sectors into much closer contact with each other, especially for people with functional impairments arising from a mental illness. This is a welcome change, but its implementation is proving challenging.

What has happened so far?

As of 30 June 2018, there were 183,965 active participants with an approved plan in the NDIS.[32] This equates to around 40% of the 460,000 participants expected to be in the scheme in 2019–20 – an ambitious target given that the full roll out of the scheme (with the exception of Western Australia) is less than one year away. Of those participants with an approved plan, 9,255 (5.4%) identified as Aboriginal and Torres Strait Islander.[32]

Participants with a psychosocial disability

There are 13,482 (8% of current participants) participants in the scheme with a primary psychosocial disability[32], compared to the projected 64,000 (14% of all participants) anticipated at full scheme. Currently, the national proportion of participants in the scheme with a primary psychosocial disability is lower than the projected rate, but the proportion varies between the states and territories. Two of the jurisdictions for this cohort (Victoria and the Australian Capital Territory) are closer to the projected 14% rate (see Table 1). The differences between the states and territories can be explained by the different phasing-in schedules of the participants in each jurisdiction.

It is anticipated that the proportion of participants with psychosocial disability is expected to increase as clients transition to the NDIS from existing Australian Government mental health programs (Partners in Recovery, Day to Day Living, Personal Helpers and Mentors, and Mental Health Respite: Carer Support).[33]

The Australian Government has implemented a streamlined access process to assist individuals to transition to the NDIS. However, to meet the roll out schedule for the NDIS, there is a risk that the NDIA may seek to make planning decisions quickly in short time frames. Of particular concern to the NMHC is the potential impact on people with a psychosocial disability who experience additional barriers to accessing and implementing plans.

The NMHC notes the recent Australian Government announcement that includes increased staffing for the NDIA and changes to the NDIS to improve the experience of people seeking to access the NDIS.[34] Further details about the proposed changes to improve the NDIS are discussed below. The NMHC will continue to monitor access rates and the quality of experience for people with a psychosocial disability who seek to access the scheme.

The NMHC has heard from some individuals that because the Australian Government mental health programs are transitioning to the NDIS, the scope of the services provided to consumers who are still in these programs is not always the same quality as previously experienced.

Individuals not engaging with the NDIS

The latest data shows that for individuals receiving existing state, territory and Commonwealth disability services, 20,483 were unable to be contacted, declined to enter the scheme, or withdrew from the access process.[32] This data is not broken down for individuals with a psychosocial disability, and it is not known why these individuals declined to transition to the NDIS or withdrew their request.

In their latest report[33], the NDIA states that it is undertaking a number of initiatives to connect with these individuals, including working with state and territory governments. This is an important cohort to understand, regardless of the disability type. The NMHC will be seeking to understand how many individuals within the cohort have a psychosocial disability and how they can be encouraged to transition to the NDIS.

Table 1: Active participants with psychosocial disability and approved plans as at 30 June 2018

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Numbers of participants with psychosocial disability across states and territories	6,284 (7%)	4,389 (11%)	1,276 (8%)	365 (8%)	227 (1%)	85 (2%)	798 (13%)	58 (7%)

Source: National Disability Insurance Agency, COAG Disability Reform Council quarterly report, 30 June 2018.

Support for individuals ineligible for the NDIS

For people accessing Australian Government mental health programs (Partners in Recovery, Day to Day Living, Personal Helpers and Mentors) who are not eligible for the NDIS, the Australian Government is providing $109.8 million over four years for PHNs to deliver equivalent support from 1 July 2019.[35] This is known as a 'continuity of support' arrangement for existing clients. It is expected that about 8,800 individuals from Partners in Recovery, Day to Day Living, and Personal Helpers and Mentors who are ineligible for the NDIS will receive continuity of support under this funding. Individuals from the Mental Health Respite: Carer Support program will receive continuity of support through the new Integrated Carer Support Service.[36]

The continuity of support funding will be delivered alongside the $160 million National Psychosocial Supports (NPS) measure targeted at people with severe mental illness who are not supported by the NDIS, but who are not in any existing Australian Government program.[35] The Australian Government's share of the NPS measure will be implemented through specific funding provided to PHNs.

These two announcements by the Australian Government provide certainty on the nature of support which will be available for individuals who are ineligible for the NDIS. However, consumers need information to help them navigate which services they might be able to access in the event they are not eligible for the NDIS.

It is important that the NDIS links with the health system to refer individuals to appropriate services if they are deemed to be ineligible for the NDIS.

The NMHC will be monitoring the implementation of these arrangements.

Involving PHNs in the provision of psychosocial services is a significant shift in policy, as the delivery of this support was originally outside of their scope. Although PHNs are well placed to take a holistic approach to meeting the needs of clients who are not eligible for the NDIS, they face challenges in commissioning psychosocial services and integrating these services into existing systems that provide support for people with a mental illness.

The NMHC will be seeking to understand what support the states and territories are providing for people who are ineligible for the NDIS, including support for people in existing state and territory programs which are or have transitioned.

Provider of Last Resort

The transition to a market-based system brings new challenges for delivering services in thin markets.

Where there is insufficient market supply of providers or in cases where providers have failed to provide care, the NDIA is responsible for providing alternative providers to scheme participants under the Provider of Last Resort (PLR) arrangements. In these cases, the NDIA will directly commission and procure disability supports for the participant.[37]

PLR arrangements are essential for the delivery of services to participants living in rural and remote areas, participants with complex needs, participants involved in the criminal justice system, participants from culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander participants. However, until the NDIS has transitioned nationally, states and territories are responsible for leading PLR arrangements.[37]

While the NDIA intends to lead an integrated response in collaboration with state and territory governments through the transition to the full scheme, the Joint Standing Committee's inquiry into the transitional arrangements for the NDIS found that the PLR arrangements remain unclear and incomplete.[38]

The inquiry noted that negotiations between the NDIA and state and territory governments over PLR arrangements have not yet progressed, and urged the NDIA to consider these arrangements well before the transition is complete. The committee also recommended that the NDIA publicly release its PLR policy as a matter of urgency. In its response to the inquiry, the Australian Government supported this recommendation.[39]

The NMHC is concerned about the lack of information on the PLR arrangements and would encourage the NDIA to release its PLR policy as a matter of urgency given the complex needs of the participants who are likely to be affected by thin markets.

NDIS Commission

The NDIS Commission was established in mid-2018 to improve the quality and safety of NDIS supports and services. As an independent agency, the NDIS Commission will regulate the NDIS market, support the resolution of complaints, and promote the NDIS principles of choice and control by empowering participants to exercise their rights as informed consumers.

The NDIS Commission will replace the individual quality and safeguarding arrangements that currently operate in each state and territory, commencing on:

- 1 July 2018 in New South Wales and South Australia
- 1 July 2019 in the Australian Capital Territory, the Northern Territory, Queensland, Tasmania and Victoria
- 1 July 2020 in Western Australia.[40]

The experience of consumers and carers

Unlike many other disabilities, psychosocial disability and mental illness are directly affected by life experiences. In some cases, this includes the experience of navigating the NDIS itself.

The NMHC has heard a variety of stories about people's experiences with the scheme. Many experiences have been positive, and in some cases life-changing, for both the participants and their carers. Unfortunately, some accounts of participants' attempts to engage with the scheme are less positive, with participants reporting significant distress as a result of a subsequent review of their plan or the inability to access services.

The NMHC's experience resonates with the findings of a plethora of reviews and reports released over the past three years highlighting implementation issues with the NDIS, particularly as it relates to mental health and psychosocial disability.

Some opportunities for improvement have been identified, including:

- clarifying the eligibility criteria for psychosocial disability
- holding face-to-face meetings when developing a plan (rather than telephone-based meetings)
- improving understanding and knowledge of planners and assessors on the needs of people with psychosocial disability
- ensuring that the tools used by the NDIA to conduct assessments are fit for purpose and deliver consistent results
- ensuring systems are in place so that participants only have to tell their story once
- introducing flexible packages to facilitate a timely adjustment to support when an individual's needs change in line with an episodic illness
- including families and carers more effectively in the assessment and planning processes
- reducing waiting times and delays in receiving plans and services
- ensuring that information about the NDIS is available as needed and that assertive outreach ensures that hard-to-reach cohorts are effectively engaged.

Improved experience for NDIS consumers and carers

The NMHC notes the ongoing work of the NDIA in responding to feedback from participants, their families and carers, and the mental health sector more broadly.

The NDIA will be making a number of improvements to the participant pathway that is scheduled to be rolled out across Australia in the second half of 2018. Improvements to the participant pathway include:

- clearer links to other systems to make sure individuals get the supports they need from other systems, such as housing, education and health

- stronger connections between NDIS Local Area Coordinators and NDIA planners
- improved disability awareness and cultural competency training for NDIA planners and Local Area Coordinators
- face-to-face planning support
- implementation of a 'complex support needs pathway' to assist participants with complex support needs and improve their access to services
- better connections between participants and providers, including improvements to the provider finder
- service enhancements for Aboriginal and Torres Strait Islander people; the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) community; people living in remote locations; and culturally and linguistically diverse communities
- improvements to systems, including updates to the participant and provider portals and the NDIS website.[41]

A new psychosocial disability pathway will also be implemented to address the needs of participants with a psychosocial disability. This follows a review undertaken by the NDIA which involved engaging Mental Health Australia to facilitate workshops with participants of the scheme and service providers.

From these consultations, Mental Health Australia recommended that the NDIA implement a psychosocial disability strategy which includes:

- pathway reform with a pre-engagement phase that includes assertive outreach and personalised NDIS engagement support
- the development of a staff competency framework that builds psychosocial disability skills within the NDIA
- reforms to the reference packages for people with a psychosocial disability to improve the quality of plans.[42]

The NMHC will be monitoring the timely implementation of the tailored psychosocial disability pathway.

Conclusion

The NDIS was never intended to replace community mental health services, nor to detract from the responsibility of other systems (such as health, education and justice) to respond to the needs of people with mental illness.

A key issue for the future is how the NDIS interacts with these systems to provide coordinated support for people with a mental illness.

For people who are ineligible for the NDIS, supports will be available from the Australian Government through the Continuity of Support and National Psychosocial Supports measures. While there is clarity around the support available through these measures, the key issue will be how consumers access this support. PHNs have a significant role to play in implementing these measures. The NMHC will be monitoring how these measures are implemented.

The NMHC recognises that the NDIA has a significant challenge in assessing individuals for their eligibility and making timely planning decisions to meet the roll out timetable, while at the same time implementing changes to the scheme to improve its functioning. The NMHC also acknowledges the focus of the NDIA on improving the experience for people with a psychosocial disability who are seeking to access the NDIS. However, the key to ensuring the participant experience is improved will be how soon changes can be made.

The NMHC is concerned about the lack of information on the PLR arrangements, and would encourage the NDIA to releases its PLR policy as a matter of urgency. Given the complex needs of the participants who are likely to be affected by thin markets, and the roll out of the full scheme nearing completion, clarification of PLR arrangements should be prioritised.

Transition to full scheme has entailed the particular challenge of scaling up to national coverage – that is, bringing geographically and circumstantially diverse populations into a fundamentally different scheme. Such transformation takes time and requires the joint deliberate effort of all governments.

Chapter 3:
Suicide prevention

Despite ongoing work to improve suicide prevention efforts in Australia, there has been no significant reduction in the suicide rate over the last decade.

The current approach to suicide prevention has been widely criticised as being fragmented, with unclear roles and responsibilities across governments.

In addition, a number of important gaps have been identified, including the absence of data on real-time suicide attempts and deaths, lack of appropriate care and support for people in crisis, and insufficient training for professionals providing services and support to people at risk of suicide. In response, the Australian Government has:

- established the National Suicide Prevention Leadership and Support Program. This program aims to deliver national suicide prevention activities, increase the capacity of individuals and communities to respond to suicide, and support research on suicide. Under the program, more than $43 million has been allocated to 16 projects from April 2017 to June 2019.[43,44] Funded projects include the National Leadership in Suicide Prevention Research Project led by The University of Melbourne; the Community Radio Suicide Prevention Project led by the Community Broadcasting Association of Australia; and the MindOUT National LGBTI Mental Health and Suicide Prevention Project led by the National LGBTI Health Alliance.[44]
- committed to funding a suicide prevention campaign trial, called the Better Off With You Campaign, targeted at people who experience suicidal ideation. This campaign aims to challenge the perception of people who are suicidal that they are a burden on other people.
- committed to providing $12 million over four years for a National Suicide Prevention Research Fund. This fund is designed to provide sustainable financial support for Australian suicide prevention research and to ensure outcomes have the greatest impact by addressing nationally agreed priorities.[45]

State and territory governments have also implemented initiatives under their respective suicide prevention strategies. For example:

- the Victorian Government is trialling the Hospital Outreach Post-suicidal Engagement (HOPE) initiative, an assertive outreach support program for people who are leaving hospital following a suicide attempt[46,47]
- the South Australian Government has established a Premier's Council on Suicide Prevention, which has been tasked with reducing the state's suicide rate by improving policy and services for people at risk of suicide.[48]

Governments have agreed to expand the latest iteration of the National Mental Health Plan to include a significant focus on suicide prevention. The plan was subsequently named the Fifth National Mental Health and Suicide Prevention Plan. Under the Fifth Plan governments have established a new governance committee, the Suicide Prevention Project Reference Group. This group has been tasked with developing a National Suicide Prevention Implementation Strategy that sets the directions for future planning and investment in suicide prevention, with the final strategy expected to be released by 2020.

Multiple governments and a single research institute have independently established four local area suicide prevention trials, across a total of 29 sites. The trials are:

- the National Suicide Prevention Trial (NSPT), funded by the Australian Government Department of Health (12 sites)[45]
- place-based suicide prevention trials, funded by the Victorian Government (12 sites)[46]
- the LifeSpan trial, funded by the Paul Ramsay Foundation and facilitated by the Black Dog Institute (four sites)[49]
- a place-based suicide prevention pilot funded by the Queensland Mental Health Commission (one site).[50]

The remainder of this chapter will focus on these local area suicide prevention trials, which are expected to inform future approaches to suicide prevention across Australia. [51,52]

What is expected under this reform?

Although the approaches adopted in each of these trials may vary, all of the suicide prevention trial sites have the shared purpose of bringing together important stakeholders to implement evidence-based suicide prevention initiatives in a systematic and coordinated way, with the goal of reducing the suicide rate in their community.

What has happened so far?

Although the information available about each of the trials varies, and all trials are in the early stages of implementation, there has been significant investment in the suicide prevention trials to date.

National Suicide Prevention Trial

The NSPT alone involves 11 PHNs covering 12 trial sites, with each site receiving approximately $4 million over four years (until June 2020).

Each of these trial sites is required to identify priority populations for targeted service delivery and is responsible for selecting and implementing a systematic model of suicide prevention that meets local needs.[45]

Seven of the 12 NSPT sites have identified Aboriginal and Torres Strait Islander people as one of their target populations, in recognition of the significantly higher rate of suicide in this population. Other target populations include men (six sites); youth (four sites); lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) people (two sites); fly-in-fly-out (FIFO) workers (one site); and ex–Australian Defence Force personnel (one site).

A number of systematic models of suicide prevention are being used at NSPT sites. Eight of the 12 sites elected to implement the LifeSpan model, three sites are implementing the European Alliance Against Depression (EAAD) model and one site is developing a custom model. Each of these models has different areas of focus. See Table 2 for a comparison of the models.

NSPT sites began planning and development in 2016–17, and commenced activities in 2017–18. All trial sites have developed and submitted individual work plans to the Australian Government Department of Health.

Victorian place-based suicide prevention trials

The Victorian Government has partnered with PHNs across Victoria to implement 12 place-based trials of suicide prevention starting in 2016–17. Each trial site is required to develop a plan based on their current assessment of the needs and concerns in their community. The plan must involve the simultaneous implementation of multiple evidence-based strategies (see Table 2) that are tailored appropriately to the local community. The Victorian Department of Health and Human Services is acting as a central coordination point and is providing support to each trial site.

As at 30 June 2017, each of the trial sites had commenced reviewing the high-risk priority groups in their communities and establishing how best to tailor interventions to support these groups and meet local needs.

LifeSpan trial sites

In December 2015, the Black Dog Institute received funding from the Paul Ramsay Foundation to deliver the LifeSpan approach to suicide prevention in four sites in New South Wales and to scientifically assess the impact of LifeSpan. The trial involves four sites implementing nine evidence-based strategies (see Table 2) in their local region simultaneously. Roll out of the four sites has been staggered; two sites started in September 2017 and two started in August 2018.[53] Each site has a two-and-a-half year trial period.

As at September 2018, all four sites had completed their establishment phase and commenced their implementation phase.[53]

Table 2: Comparison of focus areas of the models used in suicide prevention trials

LifeSpan model[49]	Victorian place-based trial framework[46]	European Alliance Against Depression (EAAD) model[54]
Improving emergency and follow-up care for suicidal crisis	Appropriate and continuing care once people leave emergency departments and hospitals	'Emergency cards' that guarantee direct access to professionals during crisis, distributed to high-risk groups
Using evidence-based treatment for suicidality	High-quality treatment for people with mental health problems	
Equipping primary care to identify and support people in distress	Training general practitioners to assess depression and other mental illnesses, and support people at risk of suicide	Equipping general practitioners to identify and treat depression and suicidality
Improving the competency and confidence of frontline workers to deal with suicidal crisis	Suicide prevention training for frontline staff every three years, including police, ambulance and other first responders	
Promoting help-seeking, mental health and resilience in schools	School-based peer support and mental health literacy programs	
Training the community to recognise and respond to suicidality	Gatekeeper training for people likely to come into contact with at-risk individuals	Educational workshops for community facilitators and stakeholders, including media
Engaging the community and providing opportunities to be part of the change	Community suicide prevention awareness programs	General public depression awareness campaign
Encouraging safe and purposeful media reporting	Responsible suicide reporting by media	
Improving safety and reducing access to means of suicide	Reducing access to lethal means of suicide	

Notes

Models have been presented to align the most similar components in a single row.

The EAAD model displays blank cells where it does not contain a named component that is similar to the other models.

Conclusion

Suicide prevention initiatives currently being implemented in Australia may have a significant impact on the future directions of suicide prevention planning and investment.

In particular, the local area suicide prevention trials represent an opportunity to gain insights about the process and outcomes of systematic implementation of suicide prevention programs targeted to local at-risk groups.

As the implementation of the initiatives is in the early stages, there are currently no outcomes available for reporting. However, the ongoing monitoring of these initiatives will be important to determine not only whether the initiatives are effective in reducing Australia's suicide rate, but also whether there is a more coordinated approach across governments.

The trial sites are an important development, but they do not cover the whole country and do not have the capacity or responsibility to address issues such as data gaps. The NMHC remains concerned that, at all levels of government, significant gaps persist in the collection and distribution of key real-time data. There is also a lack of appropriate care and support for people in crisis, and insufficient training on suicide prevention for people working in the health, allied health and community sectors.

Box 2: Suicide prevention reform for current and ex-serving members of the Australian Defence Force (ADF) and their families

On 28 March 2017, the NMHC presented to the Australian Government our *Review into the suicide and self-harm prevention services available to current and former serving ADF members and their families* (the ADF Review).[55] The ADF Review focused on the type and efficacy of the self-harm and suicide prevention services that are available, and looked at prevalence rates and potential barriers to accessing services.

The ADF Review found that, although many actions had been implemented to improve mental health and suicide prevention services and outcomes, a number of issues persist. The NMHC identified 23 recommendations for improvement to the services and systems in place to support current and former serving members of the ADF, and their families. The NMHC noted that many of these were not new or unique insights, but rather are issues that have been identified in previous inquiries and investigations.

In the Australian Government's response to the ADF Review in 2017, the Australian Government agreed with the NMHC that continued attention is needed to ensure efforts are effective in preventing suicide and self-harm among Australia's current and former serving personnel and their families.[56] Subsequently, the ADF Review was used to inform the Defence Mental Health and Wellbeing Strategy 2018–2023, that will target four areas:

1. Improving suicide prevention and mental health support for current serving ADF members, veterans and their families
2. Improving the transition process for ADF members moving from military life into post-service civilian life, and providing targeted support to families
3. Improving family support through engagement of families and family-sensitive practice
4. Transforming the Department of Veterans' Affairs systems, processes and organisational culture to better respond to the needs of Australia's veterans and their families.

The NMHC will continue to engage with the ADF as they implement the Defence Mental Health and Wellbeing Strategy 2018–2023 to improve the wellbeing of current and former serving members of the ADF, and their families.

Chapter 4:
The Fifth National Mental Health and Suicide Prevention Plan

The Fifth Plan builds on the foundation established by previous National Mental Health Plans and sets out a national approach for collaborative government effort over the period 2017 to 2022.[20]

What is expected under this reform?

The Fifth Plan sets out to achieve outcomes in eight priority areas that align with aims and policy directions in the National Mental Health Policy. These priority areas do not reflect all the aims and policy directions in the National Mental Health Policy but align with those that are well positioned for change in terms of both need and opportunity.

The priority areas in the Fifth Plan are:

- **Priority Area 1** – Achieving integrated regional planning and service delivery
- **Priority Area 2** – Suicide prevention
- **Priority Area 3** – Coordinating treatment and supports for people with severe and complex mental illness
- **Priority Area 4** – Improving Aboriginal and Torres Strait Islander mental health and suicide prevention
- **Priority Area 5** – Improving the physical health of people living with mental illness and reducing early mortality
- **Priority Area 6** – Reducing stigma and discrimination
- **Priority Area 7** – Making safety and quality central to mental health service delivery
- **Priority Area 8** – Ensuring that the enablers of effective system performance and system improvement are in place.[20]

The Fifth Plan is accompanied by an Implementation Plan that sets out who is responsible for the actions agreed in the plan, and how the plan will be implemented and coordinated across governments.

Actions within the Implementation Plan aim to achieve specific outcomes under each of the priority areas, set the direction for change, and provide a foundation for longer-term system reform.

The Fifth Plan also identifies 24 performance indicators, designed to collectively provide a picture of how Australia's mental health system is performing. These indicators range from measures of the health status of the population to measures of the delivery of mental health care.[20]

What has happened so far?

The NMHC is responsible for delivering an annual report, to be presented to health ministers, on the implementation progress of the Fifth Plan actions and performance against the identified indicators. To inform the report, the NMHC conducted a survey of stakeholders responsible for actions under the Fifth Plan Implementation Plan. Stakeholders were asked to report their achievements, barriers to progress, enablers of progress, and the level of engagement of consumers and carers in undertaking their Fifth Plan actions. The first report, describing the progress achieved as at 30 June 2018 and baseline data for the 13 available performance indicators, is expected to be delivered to the COAG Health Council in October 2018.

Conclusion

Reporting on the progress of mental health reform is essential to show that the commitments in the Fifth Plan are being honoured and are making a difference. The first of the NMHC's annual reports on the implementation progress of the Fifth Plan actions and performance against the identified indicators is expected to be made publicly available following COAG Health Council approval. The NMHC will continue to engage consumers, carers and other key stakeholders in its ongoing work to monitor the impacts of reforms under the Fifth Plan.

Mental health system performance

Section 2

The funding of mental health services in Australia is a shared responsibility between the Australian Government and states and territories.

State and territory governments fund and deliver public mental health services in hospitals, or fund services delivered in community settings.

The Australian Government funds mental health services through the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme and the Repatriation Pharmaceutical Benefits Scheme.

The Australian Government funds various programs and services that support people with a mental illness. This includes funding for PHNs to coordinate and commission services at a local level, the NDIS, income support, social and community support, and workforce participation programs.

Private hospitals, private insurers and non-government organisations also have a role in funding or delivering mental health services.

This section will consider the performance of the mental health system through inputs, outputs and outcomes. It will consider:

- inputs of expenditure to address and improve the mental health of Australians and how expenditure responds to service demands
- the size and composition of the mental health workforce and how workforce challenges are being addressed
- use of seclusion and restraint in mental health service delivery
- participation of consumers and carers and how they can be further supported to be involved in policy and service design to drive improved system outcomes
- use of performance measures such as the National Outcomes and Casemix Collection (NOCC) and Your Experience Survey (YES) to assess progress and achieve better outcomes.

Chapter 1:
Mental health-related expenditure

Mental health expenditure refers to the costs incurred in the prevention and treatment of mental illness.

Expenditure is reported in terms of the person, institution or organisation (including various levels of government) who incurs the cost, rather than by who provides the funding.[57]

Mental health funding (who provided the funds) is a distinct but related concept to mental health expenditure and both concepts are important to understanding the financial resources used in the health system.

Quantifying the expenditure on mental illness in Australia is important to understand whether the expenditure is sufficient and whether it is improving outcomes for consumers. Robust data on expenditure and prevalence is also essential to inform judgments about the value of both public and private investments, as well as to show the interplay of changes in policy and funding over time.

How much is spent on mental health?

Providing an estimate of mental health expenditure is a difficult task.

There are multiple data sources and an endless variety of potential inclusions and exclusions to cover the full breadth of expenditure.

A broad view, as taken by the NMHC in the Contributing Lives Review, incorporates costs and expenditure beyond those traditionally used to define the 'mental health sector', such as the Disability Support Pension, Carer Payment and allowances.[11] This perspective recognises the nature of the investment required to achieve good mental health across the sector, and that the impact of reforms and system change in one domain can have both positive and negative effects in other domains.

Another method is to look at the impact of mental illness in terms of economic cost and lost productivity. One approach to capturing the estimated costs of mental illness in Australia maps expenses against mental health–specific services as well as the costs accrued in justice, housing, disability, employment and income support sectors. Using this method, the cost of mental illness in Australia has previously been estimated as equivalent to 4% of gross domestic product (GDP). Based on 2016–17 GDP data, this equates to approximately $70 billion.[58]

Some of the data required to take a broad perspective on mental health expenditure is not routinely publicly available. This report has used the data provided in the Australian Institute of Health and Welfare report *Mental health services in Australia*. This data does not include broader costs such as the Disability Support Pension, Carer Payment and allowances, or costs in other systems such as justice or housing.

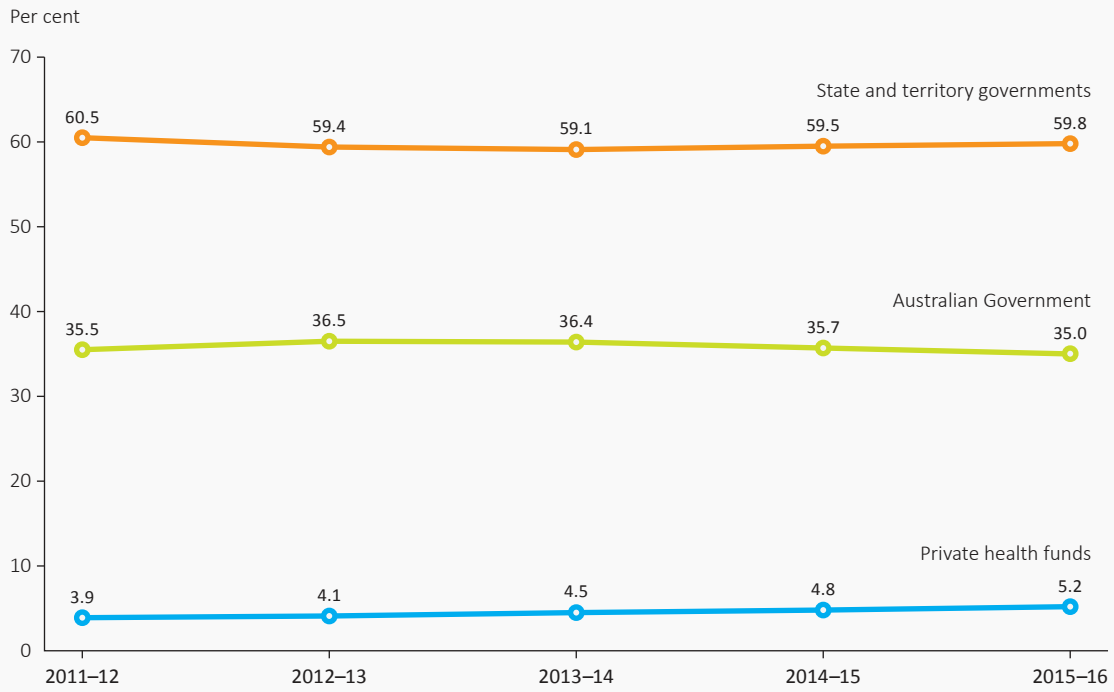
The most recent data available indicates that, in 2015–16, the national recurrent expenditure on mental health–related services was around $9.0 billion.[11]

Of this, 59.8% ($5.4 billion) was funded by state and territory governments, 35.0% ($3.1 billion) by the Australian Government and 5.2% ($466 million) by private health insurance funds.[1] This distribution has remained relatively stable over time; in 2011–12, 60.5% of national spending came from state and territory governments, 35.5% from the Australian Government and 3.9% from private health insurance funds (see Figure 1).[1]

Currently, data on suicide prevention expenditure, and program and service activity are not systematically collected and publicly reported at the national or state and territory levels. This may be partly addressed by data on suicide prevention activities at 12 PHN trial sites that is due to be reported in 2019–20.[59]

In 2015–16, the Australian Government's total expenditure under the National Suicide Prevention Strategy was $49.1 million, an increase from $1.9 million in 1995–96.[59]

Figure 1: Proportion of mental health–related expenditure, by source of funding, 2011–12 to 2015–16



Source: AIHW. Mental Health Services in Australia. Expenditure on mental health-related services; www.aihw.gov.au/mhsa

What does the amount of expenditure tell us about the mental health system?

The total government direct expenditure on mental health in Australia is billions of dollars annually, and has grown substantially over the last 20 years.[1] Figure 2 shows the growth in direct expenditure by the Australian Government and the states and territories on mental health services.

Despite this spending, the prevalence of mental illness has barely changed over the same period.[2]

A natural inference from this is that the expenditure is either insufficient or ineffective, or possibly both.

While this is unlikely to be entirely accurate, we need more information to answer the question effectively, including a better understanding of:

- where the money is spent, in terms of both direct and indirect costs (Figure 2 only includes direct expenditure on mental health services and does not capture indirect costs, such as social support payments including the Disability Support Pension, or expenditure in other systems such as education, justice or housing)
- the cost-effectiveness of current services and treatments
- the best balance of services and treatments to cater effectively for the broad spectrum of mental illness and the relative disease burden across urban, rural and remote Australia.

There are also a number of gaps in publicly available data which affect the ability to more fully understand mental health expenditure. These gaps in the data include:

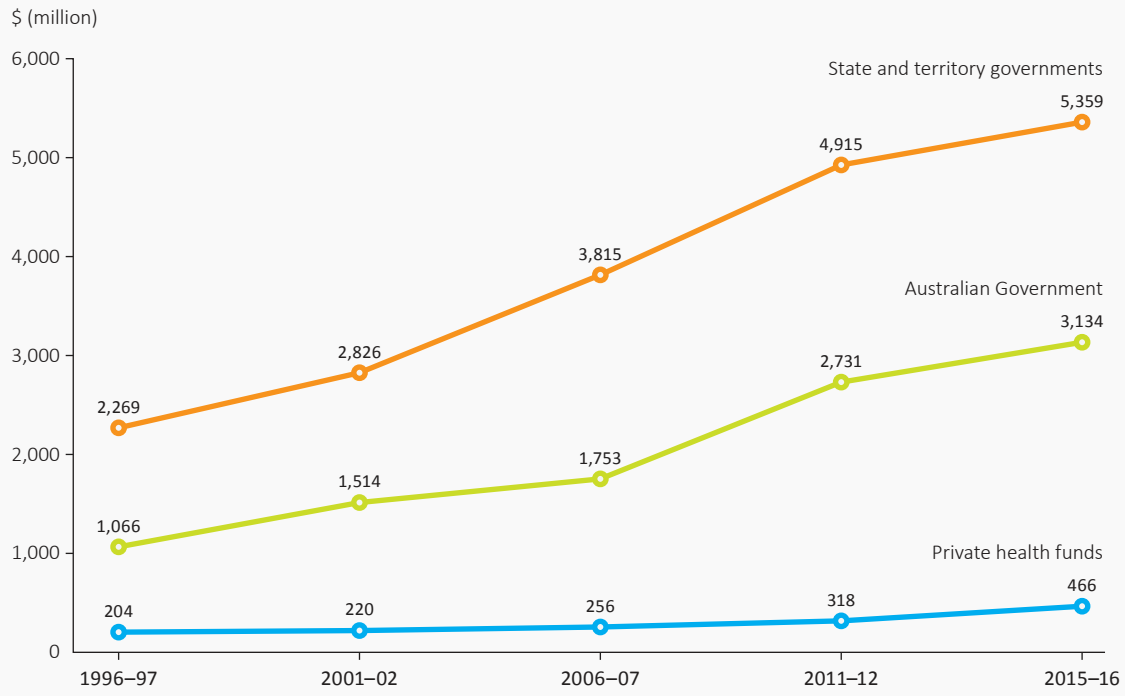
- major costs incurred by consumers, such as out-of-pocket costs associated with clinical services, pharmaceuticals, paid carers, ambulance and patient transport, counselling, insurance premiums, and excesses payable for treatment[60]
- specific disaggregation of non-Medicare funded mental health services delivered by health professionals, which flow through private health insurance
- data for Medicare-funded services marked as general practice items (data is limited to reporting of mental health–specific items)
- emergency department costs which are not routinely reported by reason for stay
- corporate expenditure on mental health programs such as the Employee Assistance Program
- lack of routine reporting on carer payments/allowance by disability type
- the complexity of accounting for spending related to mental health in other sectors such as housing, aged care, education and justice
- spending and service delivery in the community and non-government organisation sector
- PHN activity/investment that has not yet been fully quantified.

The way forward

Looking at the direct expenditure on mental health only provides part of the information to assess whether expenditure on mental health is effective. Determining the true expenditure on mental health is complex, given the difficulty in capturing all the costs (such as costs in other systems or costs borne by consumers).

In the next 12 months, the NMHC will undertake further work to assess the level of mental health expenditure in Australia, including work to assess the ability to improve the capture of indirect costs.

Figure 2: Expenditure on mental health–related services, by source of funding, 1996–97 to 2015–16



Source: AIHW. Mental Health Services in Australia. Expenditure on mental health-related services; www.aihw.gov.au/mhsa

Chapter 2:
Mental health workforce

Delivering safe and high-quality mental health services requires strong multidisciplinary teams, comprising a range of professionals from one or more organisations, with coordinated joint care planning and delivery of supports.

A multidisciplinary mental health workforce could consist of mental health nurses, general practitioners, psychiatrists, pharmacists, psychologists and allied health professionals, Aboriginal health workers, peer workers and health educators.

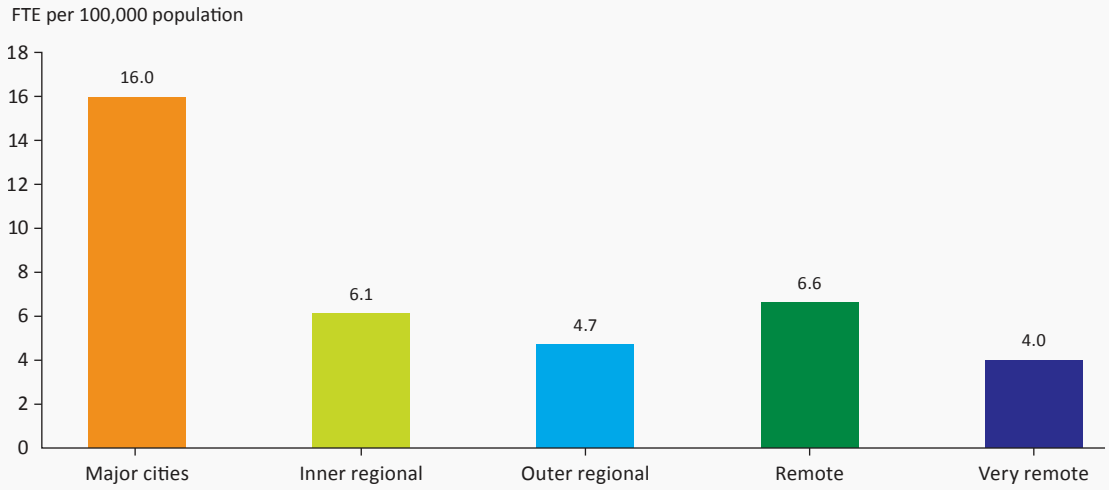
Who makes up the mental health workforce?

In Australia, the mental health workforce is engaged by public, private and community-managed organisations, within a range of settings including hospitals, community mental health services, educational settings and correctional facilities. These facilities are located across metropolitan, regional and remote areas of Australia.[1] However, uneven geographic distribution of the workforce remains an issue. This is illustrated, for example, by the distribution of psychiatrists across Australia's regions.

The World Health Organization's target for improving mental health outcomes is a workforce rate of 10 psychiatrists per 100,000 people.[61]

While this target is achieved for major cities in Australia, the distribution of staff across inner regional, outer regional, remote and very remote locations ranges from 4.0 to 6.6 full-time equivalent employed clinical psychiatrists per 100,000 population (see Figure 3). It is important to note that even where targets are achieved at the level of a major city, the distribution of staff within a major city may still be uneven.

Figure 3: Full-time equivalent (FTE) employed clinical psychiatrists, per 100,000 population, by remoteness, 2016



Source: AIHW. Mental Health Services in Australia. Mental health workforce; www.aihw.gov.au/mhsa

What are the challenges for the mental health workforce?

High staff turnover

The high turnover of mental health professionals is a factor that may affect future mental health workforce shortages.

Stress and burnout, an ageing workforce, excessive workloads, insecure tenure, limited career paths, and reduced time for training, mentoring and supervision are all contributing factors to high turnover.[62]

Many mental health professionals report limited opportunity to work at the top of their scope of practice[11], which limits career progression, variety in work experience and retention rates.[62] To deal with the uneven spread of the workforce, innovative supervision and support opportunities are required when mental health professionals are posted in regional and remote areas.[63] Mental health professionals operating in private practice may also experience isolation.[64]

A recent report by the Lowitja Institute recommended that support for Aboriginal and Torres Strait Islander mental health professionals should be a priority. Aboriginal and Torres Strait Islander health professionals often experience a lack of professional and employer support, particularly in relation to follow-up care. Providing this care would strengthen the wellbeing of the mental health workforce by addressing and preventing burnout.[27]

Training in suicide prevention

Working with suicidal clients can be stressful for mental health professionals. Self-perceived lack of competence in working with suicidal clients can increase practitioner anxiety, self-doubt, fear of litigation, and defensive practice, and clinicians may avoid working with people at risk of suicide entirely.[65, 66]

Training can increase the understanding and confidence of the workforce and ultimately improve the quality of service delivery, resulting in better client outcomes.[65, 67, 68, 69]

Health workers, emergency services workers and others who may come into contact with people at risk of suicide need to be able to access regular, consistent training in suicide prevention that is tailored to their role and/or the service they provide. It is also important to ensure that workforces receive training and support to better manage the impacts associated with their roles, and to consider self-care, supervision and support mechanisms.[70]

Working in rural and remote locations

The mental health workforce in rural and remote areas experience many challenges including fewer options for referral, lack of specialist services, lack of career opportunities, long hours with on-call requirements, and substandard accommodation.[62] Inadequate remuneration, lack of professional development opportunities, loss of anonymity in small communities, lack of opportunities for spouses and children, and professional isolation also contribute to difficulties in the recruitment and retention of experienced professionals.[71] Remote area workforce safety is also of particular concern, as staff may experience inadequate staffing levels, night calls and violence in the workplace.[72]

Aboriginal and Torres Strait Islander representation in the workforce

For Aboriginal and Torres Strait Islander people, strong Aboriginal community controlled health services are an important component of a culturally responsive mental health and social and emotional wellbeing system.[19]

Aboriginal community controlled health organisations are the largest overall employer of Aboriginal and Torres Strait Islander staff (including health professionals and health workers) with most of the estimated 6,000 staff Australia-wide being Indigenous.

Across Australia, there are only about 170 Indigenous medical practitioners, 730 allied health professionals and 2,190 nurses.[73] One of the priorities of the Fifth Plan is for governments to plan and invest in promoting and growing the workforce of Indigenous doctors, nurses and allied health professionals.

In October 2017, the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 was introduced.[19] This framework complements the Fifth Plan and contributes to the vision of the National Aboriginal and Torres Strait Islander Health Plan 2012–2023.

Peer workforce

The mental health peer workforce is an important element of the wider mental health workforce and of the multidisciplinary team environment.[20] The challenges faced by the peer workforce are similar to the broader mental health workforce, but can be amplified for a number of reasons. The peer workforce faces stigma and discrimination, which can lead to the peer worker role not being valued in all services. There is a lack of resources to meet demand, lack of peer supervision and professional development opportunities, inappropriate and complex award structures and remuneration, and minimal opportunity for career progression. There is also a lack of accurate data to monitor and evaluate the growth and effectiveness of the workforce.

The peer workforce requires support from governments to ensure a safe working environment free from stigma and discrimination, with adequate support structures, to guarantee the workforce grows and retention rates improve.[74]

Increasing and developing the mental health peer workforce will support the staffing mix of broader clinical and community services, improve awareness of recovery-orientated and trauma-informed service delivery, and lead to more positive outcomes and experience of service for consumers, carers, family and friends.

Additionally, governments could consider supporting the creation of a national peer work association, or similar, to further professionalise the peer workforce.

The way forward

The NMHC will undertake further work on the issues confronting the mental health workforce as an area of focus for the next 12 months. It is an important issue for the NMHC given the strong link between safe and high-quality mental health service delivery and the size and composition of the workforce.

As part of Fifth Plan reporting, the NMHC will report on a number of actions under the Fifth Plan that relate to the mental health workforce. These actions include development of a Workforce Development Program to guide strategies that address future workforce supply and drive increased recruitment and retention of skilled staff. Governments will also develop peer workforce development guidelines.[20]

Chapter 3:
Towards the elimination of seclusion and restraint

Everyone accessing a mental health service has a right to receive safe and evidence-based care and to be treated with dignity and respect. This means that best practice standards and guidelines on reducing restrictive practices must be adopted across the nation.

While there are some signs of progress, more needs to be done. The NMHC repeats its call to all governments to review their use of restrictive practices and increase their efforts towards eliminating the use of seclusion and restraint.

What is the current situation?

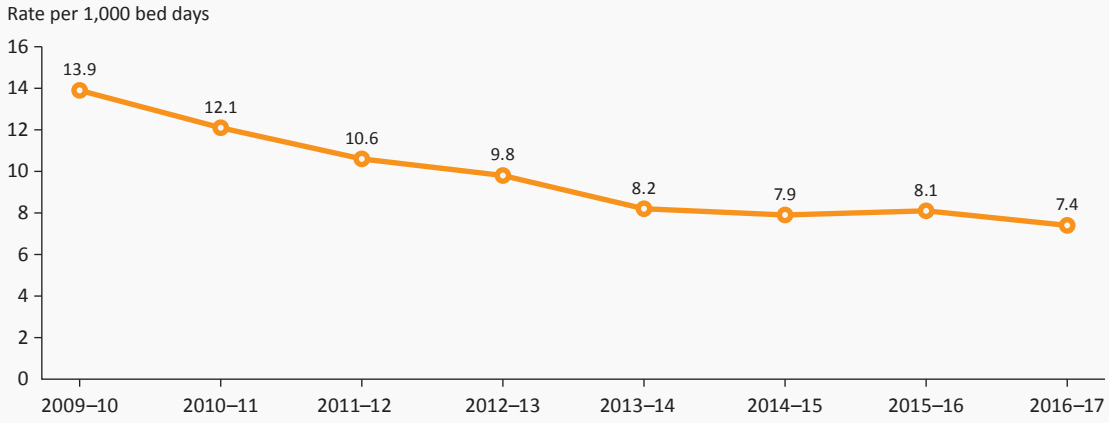
Seclusion refers to the confinement of an individual in a room or area from which free exit is prevented. Restraint refers to the restriction of an individual's freedom of movement by physical or mechanical means.

There is widespread agreement that the use of seclusion and restraint is not only a human rights issue, but also has no therapeutic value, results in emotional and physical harm for both consumers and staff, and can be a sign of a system under stress.[1]

The seclusion and restraint rate in Australia's public sector acute mental health hospital services is declining. In 2016–17, there were 7.4 seclusion events per 1,000 bed days in public sector acute specialised mental health hospital services, down from 13.9 in 2009–10 (see Figure 4). There were also 8.3 physical restraint events per 1,000 bed days (compared to 9.2 in 2015–16) and 0.9 mechanical restraint events per 1,000 bed days (compared to 1.7 in 2015–16). While there are some promising signs, the average duration of seclusion (5.8 hours in 2016–17) remains high, and seclusion rates overall could be improved.[1]

Following recent renewed focus in this area, it is encouraging to see action being taken to reduce the use of seclusion and restraint. For example, the responses of both the New South Wales and South Australian governments to recent inquiries demonstrate a commitment to implement, fund and monitor all the recommendations from the reviews conducted into the tragic events in their respective states.

Figure 4: Rate of seclusion events in public sector acute mental health hospital services, 2009–10 to 2016–17



Source: AIHW. Mental Health Services in Australia. Restrictive practices; www.aihw.gov.au/mhsa

The way forward

Working towards the goal of eliminating seclusion and restraint will require time, and sustained and increased effort and leadership at all levels. Further targeted work is needed to implement the cultural and practice changes that will ultimately lead to reducing and eliminating seclusion and restraint.

The NMHC strongly supports work that will:

- ensure the consumer and carer voice is central to all change strategies
- promote the importance of clinical leadership in effecting change
- adopt a national approach to the regulation of seclusion and restraint
- agree to uniform definitions, targets and reporting frameworks
- ensure monitoring and reporting of seclusion and restraint practices and interventions are prioritised by the executives of health services
- provide adequate resources to address staff ratios, the physical environment and equipment
- invest in staff by training and educating mental health practitioners about multi-intervention strategies.

The NMHC urges all jurisdictions to use the *National principles to support the goal of eliminating mechanical and physical restraint in mental health services*[75] and the *National principles for communicating about restrictive practices with consumers and carers*.[76] These principles are intended to guide and support the development and review of detailed jurisdictional operational guidelines as appropriate across a range of service settings. The principles are intended to apply to all mental health services in Australia.

Throughout 2018–19, the NMHC will be working with the Australian College of Mental Health Nurses and other key stakeholders to develop a National Framework for Ensuring Safety in Care and Safety for Staff in Australian Mental Health Services. This follows previous work to identify factors that affect the decisions of frontline workers such as mental health nurses to use seclusion and restraint. This work indicated that, despite best practice techniques being available to reduce or eliminate seclusion and restraint, national system-wide implementation is inconsistent.[77] The planned framework will acknowledge that different environments require different responses, but that all need to address leadership and promote a culture of safety.

Chapter 4:
Consumer and carer engagement and participation

Meaningful engagement and participation of consumers and carers is critical to improving mental health outcomes. When people are actively included in decision-making processes, there are benefits not only to their own recovery and health, but also improvements to services and systems in health and community sectors.[78]

The engagement and participation of consumers and carers continues to gain focus throughout mental health and related sectors in Australia.[79] Increasingly there are mechanisms for engagement and participation being implemented at the service level as well as regionally, for example, through some PHNs. At a national level, the Fifth Plan recognises the importance of collaborative partnerships with consumers and carers, and commits all governments to a process of equitable and authentic co-design with consumers and carers in the implementation of Fifth Plan actions.[20]

What consumer and carer engagement is underway?

Engagement and participation activities with consumers and carers currently underway in the sector are numerous and varied. These activities include consultation and collaboration with consumers and carers to develop frameworks, guidelines, models and policies to support and improve mental health and wellbeing. Consumers and carers can also engage and participate in the sector through mechanisms such as the National Mental Health Consumer and Carer Forum, the PHN consumer and care advisory groups, and the Private Mental Health Consumer and Carer Network.

The NMHC's Engage and Participate in Mental Health Project reviewed the available frameworks and mechanisms for supporting and enhancing opportunities for engagement and participation. The project involved over 1,000 consumers, carers, families, support people and other stakeholders who shared their knowledge and experience.[79]

Genuine and inclusive engagement and participation has its challenges. Barriers to engagement and participation include inadequate resourcing, power imbalances, only involving a small number of individuals, and the use of language that people may either not relate to or be shamed by.[79] However, a growing understanding of the benefits of engagement and participation has seen progress being made. Some of these benefits include a stronger sense of citizenship, personal benefits of involvement in one's own recovery, wider social connections and networks, and a reduction in stigma.

The way forward

Supporting consumers and carers to effectively and safely engage and participate will remain a key focus of the NMHC's work. The NMHC will work with the National Mental Health Consumer and Carer Forum and the Safety and Quality Partnership Standing Committee to develop a consumer and carer engagement and participation guide. The guide will focus on strengthening the involvement of consumers and carers in safety and quality initiatives in mental health services, and enhance opportunities for partnerships with consumers and carers at all levels of decision-making.

Chapter 5:
Mental health outcomes

The Contributing Lives Review noted the need for an outcomes-focused mental health system, with more people getting the services they need, when and where they need them.[11] It is reasonable for consumers and carers to expect that contact with mental health services will improve their mental health and wellbeing.

It is critical that mental health service providers can measure patient outcomes and the quality of their services. Use of patient-rated outcome measures and clinician-rated outcome measures will ensure that services can track changes in the patients' clinical symptoms and outcomes. Not only will these measures aid in consumer choice, they will also assist in monitoring service quality and effectiveness of treatment, and aid in clinical decision-making.[80]

How are mental health outcomes measured?

In 2002, in response to the Second National Mental Health Plan, the National Outcomes and Casemix Collection (NOCC) was established as one means of measuring whether mental health care leads to a change for a consumer. NOCC is a national collection of clinician- and consumer-rated measures of consumer symptoms and functioning at key points of care within public specialised clinical mental health services.[80]

NOCC data for the years of 2007–08 to 2015–16 indicates that the majority of consumers in both inpatient and community-based mental health settings experienced significant improvement in their mental health and psychosocial functioning.

In the inpatient setting, more than 70% of consumers experienced significant improvement after completed episodes of care (see Figure 5), compared to more than 50% in the community mental health setting.

These results indicate that, nationally, services are generally achieving positive outcomes.[1]

However, it is important to note that the data showed a consistent proportion of consumers who displayed no significant change or a significant deterioration in outcomes following mental health care in both inpatient and community settings. This outcome warrants further investigation.

While the NOCC is largely focused on clinician-rated outcomes, it is crucial that the consumer's perspective regarding their experience of care is also considered. In 2010, the Australian Government Department of Health funded the national Consumer Experiences of Care project to develop a new consumer experience of care measure for use in public mental health services.[81] Led by the Victorian Department of Health, the project was supported by an Expert Advisory Group drawn from the Mental Health Information Strategy Standing Committee. This project developed and produced the Your Experience of Service (YES) survey that was subsequently made available for use in the sector in 2015.[1]

The YES survey is designed to gather information from consumers about their experiences of care. It aims to help mental health services and consumers to work together to build better services.[1] Box 3 provides a summary of YES survey data collected in New South Wales in 2016–17. It is anticipated that pooled data from the YES survey will be available for three jurisdictions in 2019. This pooled data should provide much needed insight into the consumer experience of mental health services.

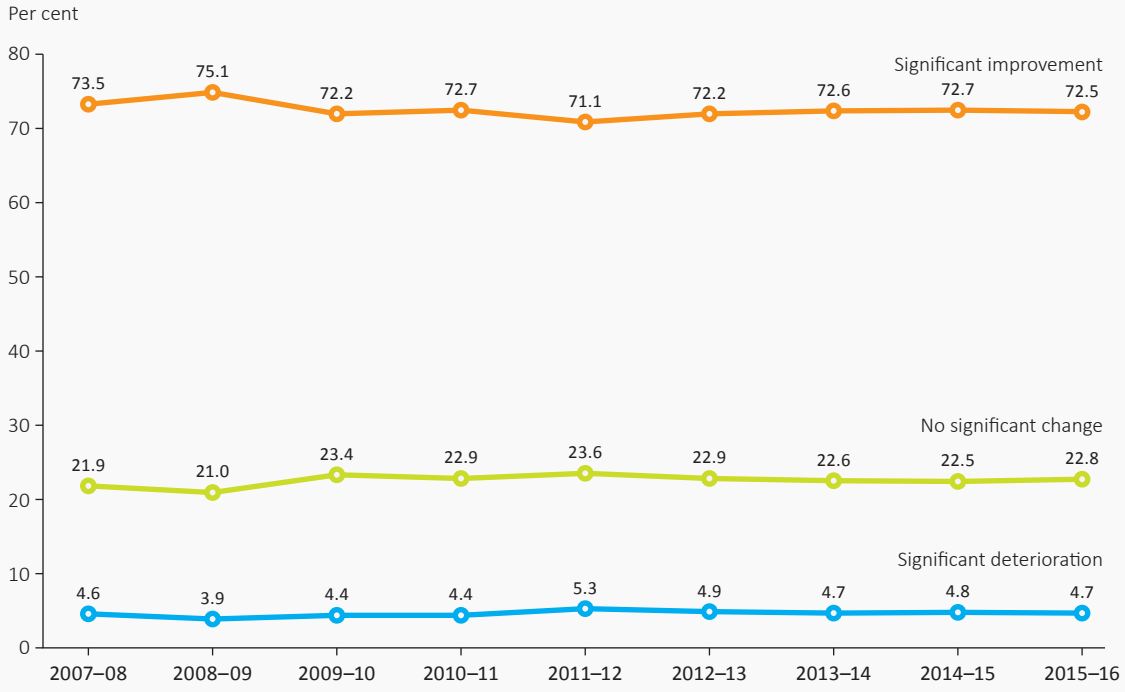
The way forward

Despite the positive results discussed above, improvements to services can always be made. It is important that outcome measures are meaningful to the clinician, consumer and community, as well as being consistent across services and jurisdictions. Ongoing monitoring of outcomes for consumers and carers should remain a national priority.[83]

Box 3: Your Experience of Service survey results

New South Wales has committed to providing all consumers of mental health services with the opportunity to provide feedback on their experience of care. New South Wales has achieved this through the Your Experience of Service (YES) survey and has made YES survey data available for the last two years. More than 22,000 YES questionnaires were returned in 2016–17 in New South Wales. Most people reported a positive experience of care, with around two out of three people reporting their experience as either 'very good' or 'excellent'. People treated in hospitals reported a less positive experience than those who received community care. Importantly, Aboriginal and Torres Strait Islander people reported less positive experiences in community services, but this was not seen in hospital settings. When compared to other age groups, people under 18 years old reported a more positive experience in community care, but a more negative experience in hospital care.[82]

Figure 5: Change in consumers' outcomes, completed inpatient care, 2007–08 to 2015–16



Source: AIHW. Mental Health Services in Australia. Mental health indicators; www.aihw.gov.au/mhsa

Social determinants of health

Section 3

Some of the most powerful root causes of health inequalities are the social conditions in which people are born, grow, work, live and age, as well as the systems that shape the conditions of daily life.

These conditions are collectively referred to as the social determinants of health.[84] Social determinants can strengthen or undermine the health of individuals and communities.[85]

Evidence from the World Health Organization shows that actions to address four social determinants of health, which include early childhood development, fair employment and decent work, social protection, and the living environment, are likely to have the greatest impact on health.[86] There is significant overlap between these areas and the domains under the NMHC's Contributing Life Framework. The Contributing Life Framework is a curated set of social determinants that guide a whole-of-person, whole-of-system, whole-of-life approach to improving the mental health of Australians (see Figure 6).

The term 'contributing life' first appeared in the NMHC's *2012 National Report card on mental health and suicide prevention* and is defined as a life enriched with close connections to family and friends; good health and wellbeing to allow those connections to be enjoyed; having something to do each day that provides meaning and purpose – whether it be a job, supporting others or volunteering; and a home to live in, free from financial stress and uncertainty.[87] In short, it means thriving, not just surviving.

This section will discuss a number of social determinants from the World Health Organization and the Contributing Life Framework; future reports will focus on other social determinants. The focus of this section is on prevention and early intervention, which is critical to improving long-term outcomes across education, employment, social relationships, community participation and family life. This section also looks at the importance of having stable housing and the interaction of physical health with mental illness.

Figure 6: Contributing Life Framework

Chapter 1:
Prevention and early intervention

Experiences during the early years of life can have lifelong effects on a person's achievements, social adjustment, physical and mental health, and life expectancy.

There is overwhelming evidence to show how important infancy, childhood and adolescence is to determining opportunities and outcomes for people throughout the lifespan.[11]

Mental illness in infancy, childhood or adolescence can have enduring consequences if left unresolved, including reduced social and economic outcomes in adulthood.[88]

Adverse outcomes of mental illness can include reduced self-esteem or confidence, reduced educational and occupational opportunity, increased risk of substance abuse, increased family conflict, family breakdown and homelessness.[88] Prevention and early intervention in infant, child and adolescent mental illness are crucial for addressing these adverse outcomes and preventing and reducing mental illness in adulthood.

What is the state of play?

The prevalence of mental illnesses among children is significant, even among very young children.

Estimates show that in 2013–14 approximately 560,000 Australian children and adolescents between 4 and 17 years of age had a mental illness.[4]

Research has shown that the first symptoms of mental illness typically precede the full onset of the illness by two to four years[89,90], and that poor mental health in childhood and adolescence can lead to mental illness in adulthood. With more than half of lifetime mental illness developing before the age of 14 years[91], prevention and early intervention at the earliest stage can make a huge difference.

Prevention and early intervention strategies implemented in infancy and early childhood are more effective in addressing risk factors, limiting the severity or progression of the illness, reducing symptoms, and reducing adverse impact on development.[88,90] This is particularly significant for diagnostic groups that have relatively high prevalence in adulthood if not identified and treated earlier, such as conduct disorders, anxiety disorders, depression, and self-harm and suicide.[88]

Parents and primary caregivers play a critical role in prevention and early intervention. However, it is essential that they are equipped with the tools to identify and support children at risk of mental illness.

A recent poll conducted by The Royal Children's Hospital Melbourne found that the majority of Australian parents are not confident in identifying or responding to signs of a mental illness in their child.[92]

Despite the overwhelming evidence in favour of early intervention, about one-third (35%) of parents reported that a child's mental illness might be best left alone to work itself out over time.[92]

The poll also found that less than half of parents (44%) reported being confident they would know where to go for help if their child was experiencing social, emotional or behavioural difficulties.[92] More work needs to be done to ensure that the mental health workforce is appropriately trained to educate and empower families to support children's mental health.

Evidence shows that mental illness not only affects academic performance at primary, secondary and tertiary levels[93,94], but also levels of participation and attendance at school. The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing found that mental illness had significant effects on school attendance. For 4–17-year-olds, absences due to major depressive disorder averaged 20 days per year, and absences

due to anxiety averaged 12 days per year.[4] Absences were even higher in adolescents, with 12–17-year-olds missing, on average, 23 days per year due to major depressive disorder and 20 days per year due to anxiety.[4] The effect of mental illness in adolescence on school attendance and participation could potentially be prevented through early detection and intervention in childhood.

In 2017, the Australian Government provided funding for a new integrated school-based Mental Health in Education initiative for Australian children from early learning centres to the end of secondary school.[95] An additional $46 million was provided in 2018 to continue this initiative.[96] Although this investment is significant, more work needs to be done to establish mental health support much earlier in the life cycle – for new mothers and families, for infants and in early childhood.

The way forward

Prevention and early intervention in mental health is clearly linked with improved long-term outcomes across all aspects of life. By addressing the critical gap for 0–12-year-old children through local and integrated community action, children's development and wellbeing will be holistically supported and optimised.

A national approach to improve coordination and integration of services among different providers is fundamental to enabling a healthy start to life for children. Integrating maternal and child health services into 'childspaces', or children's wellbeing centres, is one such example that could be explored by PHNs in collaboration with local communities.[11]

Childspaces would essentially wrap services around the needs of the child. They would bring together a range of services to deliver evidence-based, cost-effective practice for infant and child mental health, including support for parents and primary caregivers. Placing these services in accessible locations such as schools or early childhood centres would help remove barriers to care, and also reduce stigma and discrimination associated with accessing mental health services.

By investing in the early years of life, we pave the way for better outcomes in later life. Improving mental health from early childhood results in increased participation in education and the workforce, and higher job productivity, supporting stronger economic growth.

The NMHC is seeking to build on the evidence base for the benefits of investing in promotion and prevention initiatives. Such investment can result in benefits for the individual in terms of their mental health, as well as economic benefits in the form of improvements in productivity and efficiency. This work will progress through the NMHC's Economics of Mental Health – Australian Best Buys project.[97]

Chapter 2:
Housing and homelessness

The feeling of safety, stability and security that comes from having a home is a fundamental part of leading a contributing life.[87] Due to the isolation and trauma associated with homelessness, the lack of a home may make a person more vulnerable to mental illness.[98]

What is the state of play?

Data from the Specialist Homelessness Services (SHS) collection indicates that the number of people with a current mental health issue who are accessing specialist homelessness agencies is increasing. The number of people with a current mental health issue receiving assistance from SHS increased by 73.0% between 2011–12 and 2016–17. Over the same period, the number of Aboriginal and Torres Strait Islander clients increased by 139.3%.[1]

The way forward

In 2017, the NMHC conducted a national consultation on housing issues in relation to mental health, and subsequently engaged the Australian Housing and Urban Research Institute (AHURI) to research opportunities and tools to leverage policy in this area.[58] In brief, the research findings noted the need for:

- better policy integration between housing, homelessness and mental health sectors
- scaling up of effective existing programs that integrate housing and mental health
- early intervention to stabilise people in their existing tenancies and avoid evictions
- improved hospital discharge planning to avoid discharging people into homelessness.[99]

Such reforms will require sustained and cross sectoral collaboration between the Australian Government, state and territory government agencies, community sector services, and consumers and carers.

In addition to the forthcoming final report on the above findings, AHURI's work with the NMHC will also deliver a Prospectus Paper. The paper will outline practical next steps for bringing together stakeholders and facilitating coordinated activity across the mental health, housing and homelessness sectors.

In 2018–19, the NMHC will continue its support for these efforts, and maintain a focus on monitoring and reporting of developments in this area.

Chapter 3:
Physical health

People living with mental illness experience poorer physical health and die earlier than the general population. Improving physical health for people living with a mental illness, and reducing mortality as a consequence, is a priority under the Fifth Plan.[20]

In 2017, the NMHC released the *Equally Well consensus statement* that articulates a vision to improve the physical health outcomes of people living with mental illness, with public support of all governments.[100]

What is the state of play?

Mental health and physical health are inextricably linked. The evidence regarding the reduced life expectancy for people living with a mental illness is clear. [20, 101, 102, 103]

There is evidence that the mortality gap has been widening for people with severe mental illness over the last few decades[104], and that people across the continuum of severity of mental illness are experiencing poorer physical health outcomes than the general population.[105]

Australians living with a mental illness typically do not have the same level of access to, or experiences with, physical health care services. Recent research has identified barriers to people living with a mental illness accessing quality physical health care and support. These barriers include:

- less professional support to manage their condition and lower confidence to do so (compared to people with other chronic conditions)
- lack of affordability, with some people forgoing some types of treatment due to cost and difficulties paying medical bills
- acceptability of services, with people experiencing lower levels of trust in services
- availability of services, including waiting periods for primary or specialist appointments and perceived availability of after-hours care
- appropriateness of services, including problems with coordination of care, communication, absence of written plans, and lack of involvement of consumers in decision-making
- approachability of services, including people having no affiliation with a regular doctor and experiences of poor care and not being treated with respect.[106]

Aboriginal and Torres Strait Islander people living with mental illness experience multiple layers of risk and discrimination leading to poor physical health outcomes. The NMHC notes that the challenges for people living with mental illness in negotiating and accessing the health system are compounded for Aboriginal and Torres Strait Islander people.

The way forward

The fact that Australians living with mental illness are experiencing poorer physical health and dying significantly earlier than the general population is a national priority. No single initiative, organisation, workforce or government can comprehensively address the problem. Therefore, collective action under the shared vision of the Equally Well initiative is imperative.

The NMHC established the Equally Well Implementation Committee (EWIC) in 2017 to lead the national implementation of Equally Well. This will involve partnering with private, public and community sectors, including consumers and carers. With this broad support, EWIC is well placed to link the physical and mental health sectors and ensure meaningful progress.

Improving the physical health of people living with mental illness and reducing early mortality is a Fifth Plan priority. The NMHC will continue to monitor this work to ensure Equally Well principles are embedded across systems and governments, and to assist in identifying shared measures of success that support the pursuit of equity in health.

Concluding statement

The sheer scope and ambition of reforms described in this report is a reflection of the complexity of building contributing lives for people living with a mental illness.

Transformation through such social reform takes time. It requires a joint deliberate effort across all governments, systems and sectors in keeping people living with mental illness at the centre of reform efforts.

Acting as a catalyst for change, the NMHC will continue to have an ongoing role in monitoring and reporting on Australia's mental health and suicide prevention reforms.

In 2018–19, the NMHC priority areas for further work include mental health expenditure, the mental health workforce, reducing seclusion and restraint, supporting consumer and carer engagement, building participation in the national implementation of Equally Well, continued monitoring and reporting work on housing and homelessness, and progressing the Economics of Mental Health – Australian Best Buys Project.[97]

This report is only one mechanism that the NMHC will be using to monitor and report on Australia's mental health and suicide prevention systems. In the future, the NMHC expects to release reports in a variety of formats that focus on key areas that affect an individual's mental health and, more broadly, the mental health system.

Appendices

Appendix 1:
Summary of Australian Government response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services

NMHC's Contributing Lives Review		Australian Government response
Strategic direction	Recommendation	Selected reform commitment* (Response report section number)
1. Set clear roles and accountabilities to shape a person-centred mental health system	1. Agree the Australian Government's role in mental health is through national leadership and regional integration, including integrated primary and mental health care.	At the national level, the Australian Government will seek the support of states and territories to implement arrangements for regional planning and integration, building the capacity of PHNs to lead these efforts in partnerships with Local Health Networks (LHNs) and other key stakeholders including non-government organisations (including those providing community based mental health and alcohol and other drug services), Aboriginal and Torres Strait Islander organisations and consumers (4.1). The Australian Government reaffirms its commitment to leading national mental health policy direction, particularly in those areas where a national approach is efficient and effective. This national leadership role will, as the National Mental Health Commission suggests, translate to supporting effective change and integration at a regional and local level. This will involve strengthening and broadening the Commonwealth's leadership role from a funder of and participant in mental health reform to actively facilitating enduring change at a national and regional level by promoting key partnerships, evidence and accountability (4.6).
	2. Develop, agree and implement a National Mental Health and Suicide Prevention Plan with states and territories, in collaboration with people with lived experience, their families and support people.	The Government will move to immediately implement a new national suicide prevention strategy (5.7).
	3. Urgently clarify the eligibility criteria for access to the NDIS for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 system of community supports.	Establishment of joined up assessment processes and referral pathways to ensure those consumers with severe and complex mental illness receive the clinical and disability services they need (5.1). The Government will give priority to resolving the fragmentation of service delivery for people with severe and complex mental illness who are being managed in primary care, and address their need for coordinated clinical care and social supports by enhancing regionally based clinical assessment arrangements for people with severe and complex mental illness and linking these to Local Hospital Networks and NDIS assessment and referral to help match people to the service pathway which best meets their needs (5.8).
2. Agree and implement national targets and local organisational performance measures	4. Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.	Continued development and promotion of specific consumer focused performance measurement tools will also be embedded in efforts to monitor, review and improve programme efforts (4.1).
	5. Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health.	Mental health is also a high priority within the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (5.6).
	6. Tie receipt of ongoing Australian Government funding for government, NGO and privately provided services to demonstrated performance, and use of a single care plan and e-Health record for those with complex needs.	Essential to regional integration efforts will be a robust system of communication between providers and with consumers, including moving towards shared use of digital records, utilising myHealth Record (4.2). Promoting the use of a single e-health record to link services and enhance communication between providers and consumers with mental illness (5.8).

NMHC's Contributing Lives Review		Australian Government response
Strategic direction	Recommendation	Selected reform commitment* (Response report section number)
3. Shift funding priorities from hospitals and income support to community and primary health care services	7. Reallocate a minimum of $1 billion in Australian Government acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.	Outlays on hospital funding should reduce over the medium to long term through embedding early intervention in mental health reform and better planning and targeting primary and community care services. This will be a priority issue for the Commonwealth to take to negotiations with states and territories in the context of the Fifth National Mental Health Plan and to monitor throughout the implementation of the Plan (4.4).
	8. Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes and services and integrated care pathways.	The Government will provide both leadership and flexible funding at a regional level by building the capacity of PHNs to lead, plan and integrate the delivery of mental health services at the local level in consultation with LHNs, non-government organisations, Indigenous organisations and NDIS providers. PHNs will commission all regionally delivered Commonwealth mental health programmes for the Department of Health into the future, providing a flexible pool from which to target needs against a stepped care approach (5.1).
	9. Bundle up programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters.	The Australian Government will respond to fragmentation and inefficiencies through a new regional approach to integrated service planning and delivery, across the spectrum of services. This new approach will be supported by commissioning of services through a new flexible funding pool which will progressively roll together primary mental health care programmes. Responsibility for this pool of funding will sit with PHNs (4.2).
	10. Improve service equity for rural and remote communities through place-based models of care.	PHNs provide core architecture for health service integration and are already playing an important role in commissioning mental health programmes such as Access to Allied Psychological Services (ATAPS) and Mental Health Services in Rural and Remote Areas (MHSRRA) which offer a payment approach that allows targeting of mental health services to priority groups. Additional mental health programme funding will be redirected to PHNs from 2016 to enable commencement of their enhanced role in mental health and suicide prevention activity. Over time, an increased pool of programme funding will be redirected to PHNs to commission services to target local needs, including the need for innovative and integrated service delivery in rural areas (5.1).
4. Empower and support self-care and implement a new model of stepped care across Australia	11. Promote easy access to self-help options to help people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.	The new role for PHNs, including the flexible funding pool, together with the new digital mental health gateway, will provide core infrastructure upon which to refocus existing primary mental health care programmes to achieve better targeted stepped care services to meet consumer needs (5.3).
	12. Strengthen the central role of GPs in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule and staged implementation of Medical Homes for Mental Health.	The Government will maintain its investment in primary mental health care, but will redesign existing programmes over a three year period to better match different levels or 'steps' of consumer need by strengthening support to GPs in undertaking assessment to ensure people are referred to the service which best targets their need, particularly in relation to the assessment of people with severe and complex mental illness (5.3).
	13. Enhance access to the Better Access programme for those who need it most through changed eligibility and payment arrangements and a more equitable geographical distribution of psychological services.	The Government will maintain its investment in primary mental health care, but will redesign existing programmes over a three year period to better match different levels or 'steps' of consumer need by exploring options for the modification of the *COAG Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative* (Better Access) to better target the needs of people with moderate to severe mental illness (5.3).
	14. Introduce incentives to include pharmacists as key members of the mental health care team.	The Australian Government response does not explicitly mention the role of pharmacists in managing mental illness. However, the NMHC acknowledges that in the Sixth Community Pharmacy Agreement, the Australian Government allocated funds for the Staged Supply Programme, which is a service that is particularly targeted to patients with a mental illness or drug dependency.

NMHC's Contributing Lives Review		Australian Government response
Strategic direction	Recommendation	Selected reform commitment* (Response report section number)
5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life	15. Build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties.	The Government will work across portfolios to join up child mental health programmes to reduce the impact of mental illness on children. This will be achieved through the following interconnected activities: • a single integrated end to end school based mental health programme • easy access for children and young people to telephone and web-based information and advice • a national workforce support initiative assisting clinical and non-clinical professionals and services who work with children, to identify, support and refer children, to identify, support and refer at risk and to promote resilience building (5.1). The Government will explore opportunities to use available youth mental health funding to provide early intervention for a broader group of young people who present to primary care services with severe mental illness or at risk of such (5.5).
	16. Identify, develop and implement a national framework to support families and communities in the prevention of trauma from maltreatment during infancy and early childhood, and to support those impacted by childhood trauma.	The National Framework for Protecting Australia's Children is also an important element in framing government responses to the mental health needs of a particularly vulnerable group of children and young people. Actions within the Third Action Plan under the Framework have a focus on early intervention and prevention, including in the early years of life. The Government will work across portfolios to join up child mental health programmes to reduce the impact of mental illness on children, commencing with the early years and going through to adolescence (5.4).
	17. Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.	The Government will also look to undertake communication activities which develop greater sector awareness of the availability and effectiveness of digital mental health services, and reduce the stigma associated with having a mental health issue (5.2). The Commonwealth will increase access to culturally sensitive mental health services for Aboriginal and Torres Strait Islander people and work with PHNs to better plan and integrate services in the comprehensive primary healthcare context (5.6).
6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people	18. Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.	Work will immediately commence on integrating Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing services (5.1). The Australian Government will increase access to culturally sensitive mental health services for Aboriginal and Torres Strait Islander people and work with PHNs to better plan and integrate services in the comprehensive healthcare context (5.6).
7. Reduce suicides and suicide attempts by 50 per cent over the next decade	19. Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.	The Government will move to immediately implement a new national suicide prevention strategy with four critical components: • national leadership and infrastructure including evidence based population level activity and crisis support services; • a systematic and planned regional approach to community based suicide prevention, which recognises the take-up of local evidence based strategies. This approach will be led by PHNs who will commission regionally appropriate activities, in partnership with LHNs and other local organisations; • refocusing efforts to prevent Indigenous suicide; and • working with state and territory governments to ensure effective post discharge follow up for people who have self-harmed or attempted suicide, in the context of the Fifth National Mental Health Plan (5.7).

NMHC's Contributing Lives Review		Australian Government response
Strategic direction	Recommendation	Selected reform commitment* (Response report section number)
8. Build workforce and research capacity to support systems change	20. Improve research capacity and impact by doubling the share of existing and future allocations of research funding for mental health over the next five years, with a priority on supporting strategic research that responds to policy directions and community needs.	The Australian Government will also play a key role in supporting professionals, providers and organisations through the provision of key national and regional data and tools, and through supporting the coordination and translation of mental health research efforts (7).
	21. Improve supply, productivity and access for mental health nurses and the mental health peer workforce.	The Government will give priority to resolving the fragmentation of service delivery for people with severe and complex mental illness who are being managed in primary care, and address their need for coordinated clinical and social supports by enhancing services delivered by mental health nurses (5.8).
	22. Improve education and training of the mental health and associated workforce to deploy evidence-based treatment.	The Government will work across portfolios to join up mental health programmes to reduce the impact of mental illness on children. This will be achieved though partnership approaches at a regional level between clinical and non-clinical support services, including Family Mental Health Support Service providers, supported at a national level by the workforce support initiative (5.4).
	23. Require evidence-based approaches on mental health and wellbeing to be adopted in early childhood worker and teacher training and continuing professional development.	Specific priorities for regional service integration and delivery led by PHNs will include development of region-specific, cross-sectoral approaches to early intervention to support children and young people with, or at risk of, mental illness (5.1). The Government will work across portfolios to join up child mental health programmes to reduce the impact of mental illness on children, commencing with the early years and going through to adolescence. This will be achieved through a national workforce support initiative assisting clinical and non-clinical professionals and services who work with children to identify, support and refer children at risk and to promote resilience building. This initiative will particularly support providers working with children who would benefit from early intervention, including those who have experienced trauma, and will support professionals in working with parents and families of these children (5.4).
9. Improve access to services and support through innovative technologies	24. Improve emergency access to the right telephone- and internet-based forms of crisis support, and link crisis support services to ongoing online and offline forms of information/education, monitoring and clinical intervention.	A key reform element of the response will be utilising Australia's innovative digital mental health services to offer a new, easy to access gateway to services, and to make it easy to connect with the particular service which best matches the needs of the consumers (4.5).
	25. Implement cost-effective second and third generation e-mental health solutions that build sustained self-help, link to biometric monitoring, and provide direct clinical support strategies or enhance the effectiveness of local services.	The Gateway will bring together and streamline access to existing evidence based information, advice and digital mental health treatment and will connect people to the services they need through a centralised telephone and web portal. It will promote use of low cost and evidence based interventions for consumers who would most benefit from them. Enhancements to the Gateway will be explored to more comprehensively reflect the potential for digital service delivery in mental health over time, to support fully integrated information and service pathways becoming available for both consumers and service providers (5.2).

* Responses have been selected for brevity and may not represent the Australian Government's full commitment against each recommendation.

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Appendix 2:
Acronyms and abbreviations

AICCHS	Aboriginal and Torres Strait Islander Community Controlled Health Services
AIHW	Australian Institute of Health and Welfare
ACT	Australian Capital Territory
ADF	Australian Defence Force
ADHD	Attention Deficit Hyperactivity Disorder
CEO	Chief Executive Officer
COAG	Council of Australian Governments
EAAD	European Alliance Against Depression
EWIC	Equally Well Implementation Committee
FIFO	Fly-in-fly-out workers
Fifth Plan	The Fifth National Mental Health and Suicide Prevention Plan
GDP	Gross domestic product
GP	General practitioner(s)
ILC	Information, linkages and capacity
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and queer
LHN	Local Hospital Network
NSW	New South Wales
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
NOCC	National Outcomes and Casemix Collection
NPS	National Psychosocial Supports
NSPS	National Suicide Prevention Strategy
NSPT	National Suicide Prevention Trial
NT	Northern Territory
MHA	Mental Health Australia
MHSRRA	Mental Health Services in Rural and Remote Areas
PHN	Primary Health Network
PLR	Provider of Last Resort
Qld	Queensland
SA	South Australia
SHS	Specialised Homelessness Services
Tas	Tasmania
Vic	Victoria
WA	Western Australia
YES	Your Experience of Service

Appendix 3: Glossary

Affective disorders

Affective disorder is a category of mental illnesses. The common feature among affective disorders is mood disturbance. Depression, dysthymia and bipolar affective disorder are all types of affective disorder.

Anxiety disorders

Anxiety disorders are a category of mental illnesses that are marked by the experience of intense and debilitating anxiety. Panic disorder, social phobia, agoraphobia, generalised anxiety disorder, post-traumatic stress disorder and obsessive compulsive disorder are all types of anxiety disorder.

Australian Mental Health Leaders Fellowship

The Australian Mental Health Leaders Fellowship is a national program that supports the development of leadership skills among emerging leaders with a passion and commitment to mental health. These leaders include consumers, carers, mental health professionals and others outside the traditional boundaries of the mental health sector, including emergency service workers, students and early career researchers, and professionals in industry, finance and the justice system.

Burden of disease

Burden of disease is the quantified years of healthy life lost, either through premature death or living with a disability due to illness or injury. Burden of disease is a measure of the impact of a disease or injury on a population.

Carer

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

Co-design

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

Community supports

Non-clinical services, provided in a community setting, that assist people with a mental illness to live meaningful and contributing lives. These may include services that relate to daily living skills, self-care and self-management, social connectedness, housing, education and employment.

Consumers

People who identify as having a living or lived experience of mental illness, irrespective of whether they have a formal diagnosis, who have accessed mental health services and/or received treatment. This includes people who describe themselves as a 'peer', 'survivor' or 'expert by experience'.

Current mental health issue

A derived category used in the Specialist Homelessness Services (SHS) Collection. SHS clients are identified as having a current mental health issue if any of the following apply:

- the client indicated at the beginning of a support period that they were receiving services or assistance for their mental health issues, or had received them in the last 12 months
- the client's formal referral source to the specialist homelessness agency was a mental health service
- the client reported 'mental health issues' as a reason for seeking assistance
- the client's dwelling type either a week before presenting to an agency, or when presenting to an agency, was a psychiatric hospital or unit
- the client had been in a psychiatric hospital or unit in the last 12 months
- at some stage during the client's support period, a need was identified for psychological services, psychiatric services or mental health services.

Depression

Depression is a mental illness characterised by periods of low mood and significant impairment due to symptoms such as loss of interest and enjoyment, reduced energy and concentration and changes in sleep and appetite.

Early intervention

Identifying signs and risks of mental illness early followed by appropriate, timely intervention and support which can reduce the severity, duration and recurrence of mental illness and its associated social disadvantage.

Lived experience

In this report, lived experience refers to people who have either current or past experience of mental illness as a consumer and/or a carer.

Local Health Network (LHN)

An LHN is a legal entity established by a state or territory government in order to devolve operational management for public hospitals, and accountability for local service delivery, to the local level. An LHN can contain one or more hospitals.

Mental health

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

Mental illness

Mental illness is a wide spectrum of diagnosable health conditions that significantly affect how a person feels, thinks, behaves, and interacts with other people. Mental illness can vary in both severity and duration. In this report 'mental illness' is used in place of 'mental health problem', 'mental health disorder', 'mental ill-health' and 'mental health disease'.

National Disability Insurance Scheme (NDIS)

The NDIS provides individualised support packages for eligible people with permanent and significant disability, their families and carers. Roll out commenced on 1 July 2016 and is expected to be complete by 2020.

National Mental Health Service Planning Framework

A model that allows users to estimate need and expected demand for mental health care and the level and mix of mental health services required for a given population. The model can be used to help plan, coordinate and resource mental health services to meet Australia's population needs.

Non-government organisations (NGOs)

Private not-for-profit community-managed organisations that receive government funding specifically for the purpose of providing community support services.

Peer workforce

The supply of people who are employed, either part-time or full-time, on the basis of their lived experience, to provide support to people experiencing a similar situation.

The people who make up the peer workforce may be called peer workers, consumer workers, carer workers and/or lived experience workers.

Performance indicators

A concise list of indicators used to measure effectiveness in achieving outcomes.

Poor mental health

Low levels of mental health that are not diagnosable.

Prevalence of mental illness

The proportion of people in a population who meet diagnostic criteria for any mental illness at a given time.

Primary Health Network (PHN)

A PHN is an administrative health region established to deliver access to primary care services for patients, as well as co-ordinate with local hospitals to improve the operational efficiency of the network. The six key priorities for targeted work for PHNs are: mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

Private hospital

A privately owned and operated hospital, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and paramedical practitioners.

Psychosocial disability

A term used in the context of the National Disability Insurance Scheme (NDIS) to describe a disability arising from a mental illness, that is likely to make the person eligible for an individual support package under the scheme.

Public hospital

A hospital controlled by a state or territory health authority. In Australia, public hospitals may offer free diagnostic services, treatment, care and accommodation.

Recovery

Recovery is different for everyone. For the purposes of this report, recovery is defined as being able to create and live a meaningful and contributing life, with or without the presence of mental illness.

Restraint

The restriction of an individual's freedom of movement by physical or mechanical means.

Seclusion

The confinement of an individual at any time of the day or night alone in a room or area from which free exit is prevented.

Social and emotional wellbeing

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

Socio-economic disadvantage

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

Stepped care

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

Stigma

Stigma is a mark of shame, disgrace or disapproval on the basis of an individual's characteristics, which results in that individual being rejected, discriminated against, and/or excluded from participating in a number of different areas of society.

Substance use disorders

Substance use disorders are a category of mental illnesses that relate to problems arising from the use of alcohol or drugs.

Suicide

Deliberately ending one's own life.

Thin market

Is a market where the number of providers or consumers is too small to support the competitive provision of services.

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