Monitoring the performance of
Australia's mental health system

National Report Card 2024

Australian Government
National Mental Health Commission

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Acknowledgements

Acknowledgement of Country

The National Mental Health Commission (the Commission) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters on which we live, work and learn.

Recognition of Lived Experience

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

Contributors

The Commission acknowledges the assistance and cooperation of the Australian Bureau of Statistics and Australian Institute of Health and Welfare.

A note on language

The Commission acknowledges that language surrounding mental health and suicide can be powerful, emotive and at times contested. People make sense of their experiences in different ways, and there is no consensus on preferred terminology. The Commission has been conscious to use terminology throughout this report that is respectful of those whose experiences we are describing and is well understood by the audience reading this report. This report covers a broad range of topics in relation to mental health and suicide prevention.

Data collection activities and reports use terms like 'mental or behavioural conditions' and '12-month mental disorder' to clearly define the scope of the mental health experience(s) under consideration. This publication uses the same terms as used in these original sources to not misrepresent the findings. The Commission endorses and follows the Mindframe guidelines *Our Words Matter* and *Images Matter.* The Commission also endorses the Mindframe *Guidelines on Media Reporting of Severe Mental Illness in the Context of Violence and Crime* and requests that media using this report do so in accordance with the Guidelines.

Support

Support is available if you or someone you care for is in need of assistance. For information on support go to: www.mentalhealthcommission.gov.au/find-support

About this report

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Foreword

I am pleased to present the National Mental Health Commission's National Report Card 2024 on mental health and wellbeing.

In the National Report Card 2023, we adopted a refreshed approach to annual reporting on the state of Australia's mental health system. We drew together a number of meaningful indicators to inform our assessment of how the system is faring in supporting the mental health of people in Australia.

The National Report Card 2024 reflects on the 2024 calendar year and builds on the foundations and whole-of-life scope established in the National Report Card 2023. It provides data updates across the core indicators identified. In this year's report we have incorporated supplementary data collected up to and throughout the 2024 calendar year to provide a more detailed and contemporary picture of how key outcomes are tracking over time. Where possible, we also present a more detailed view for particular community groups, including those living in regional or remote areas and First Nations people.

Our National Report Card 2023, published one year ago, highlighted record levels of mental ill health and a lack of improvement in the system's effectiveness in meeting demand, reinforcing the urgent imperative to address the needs of people with mental health challenges, particularly for our younger generations. In 2024, we have seen life satisfaction and psychological distress remain steady, however there has been a slight decline in sense of control across the population between 2019 and 2023. We have also seen a steady rise in financial stress and in the proportion of people in Australia delaying mental health care due to cost in the last 4 years. Disappointingly, many social factors impacting mental health are not showing improvement (e.g., loneliness and experiences of discrimination) and positive experiences of mental health care have remained stable. There are some encouraging signs of progress, including a continuing reduction in seclusion and restraint between 2022-23 and 2023-24, and more people with a mental disorder accessing care in 2020-2022 compared to 2007. However, there is no question there is a long way to go—our younger generations continue to report heightened psychological distress and financial stress, and have a much higher prevalence of mental health challenges relative to the rest of the population.

Currently, there are significant gaps in national reporting on the performance of Australia's mental health system. In collaboration with our partners, we are committed to continually evolving and growing our framework over time to ensure a strong, data-driven evidence base that provides a complete picture of how the system is performing. As an initial step, over the coming months, the Commission will be working closely with Mental Health Australia and the sector to explore possible expansions to our framework.

I would like to thank the Australian Institute of Health and Welfare, the Australian Bureau of Statistics, Mental Health Australia, the National Mental Health Consumer Alliance, Mental Health Carers Australia and Gayaa Dhuwi for their valuable contributions to inform this report, along with all our partners across the mental health sector and governments. We look forward to continuing our work together to build on our reporting framework and create a comprehensive national picture of system performance. There is still a long way to go but we are ambitious for the future and committed to continuing work with our partners across the mental health sector and governments to inform meaningful change and ensure we are reporting on what matters most to Australians.

David McGrath
Chief Executive Officer of the National Mental Health Commission

Executive Summary

The National Mental Health Commission's (the Commission) National Report Card for the 2024 calendar year (RC2024) applies a reporting framework to objectively monitor the performance of Australia's mental health system. As the second Report Card to apply this framework, our analysis focuses on what progress has been made across the core indicators since the release of the National Report Card 2023, while also drawing on supplementary data from other sources.

Our reporting framework

The National Report Card framework organises information and data under 3 broad domains:

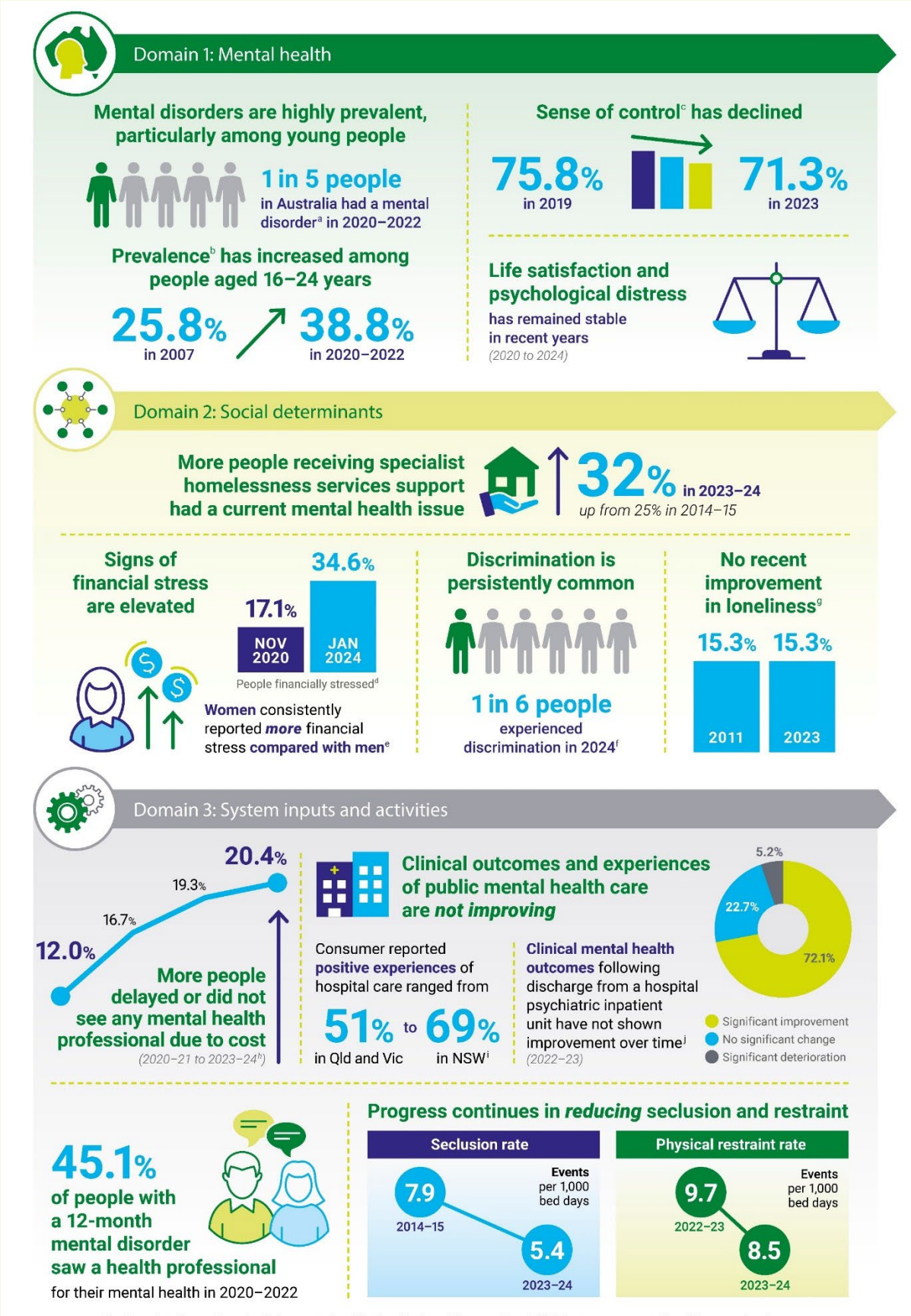
- **Domain 1: Mental health** – the status of key mental health and wellbeing outcomes for people with lived experience of mental health challenges.
- **Domain 2: Social determinants** – the broader social factors that have an impact on the mental health of people in Australia, as well as the whole of life outcomes for people with lived experience.
- **Domain 3: System inputs and activities** – the performance of system activities that impact mental health outcomes for people in Australia.

RC2024 reports on the performance of a core set of indicators across Domains 1 and 2. The indicators were chosen because they represent nationally available, robust and reliable data that align with other relevant frameworks that measure aspects of how the system is performing in meeting the needs of people with mental health challenges.

For Domain 3, RC2024 provides an overview of the type of data available and findings against some example measures commonly used to understand system performance. Recognising the significant gaps in national reporting, the Commission has commenced work with Mental Health Australia and the sector to identify opportunities to expand this set of measures to support a more holistic assessment of system performance.

What the data tells us

Figure 1. Snapshot of RC2024



Further details and analysis is contained in the National Report Card 2024 at www.mentalhealthcommission.gov.au

Figure 1 Notes

[a] people aged 16-85 years who met diagnostic criteria for a mental disorder and had sufficient symptoms of that disorder in the 12 months before completing the survey (i.e., a 12-month mental disorder)
[b] proportion of people who had a 12-month mental disorder
[c] proportion of people reporting a high sense of control over events in their life
[d] proportion of people finding it difficult or very difficult to cope on their present income
[e] 37% of women found it difficult or very difficult to cope on their present income (compared to 32% of males) in January 2024
[f] 17% of adults in Australia experienced discrimination because of their skin colour, ethnic origin or religion over the past 12 months in 2024 (compared to 17% in 2018)
[g] the proportion of people aged 15 years and over reporting loneliness remained relatively steady between 2011 (15.3%) and 2023 (15.3%), with a slight increase in 2021(16.6%).
[h] people needing mental health support who delayed or did not see a health professional for their mental health due to cost
[i] data presented is for 2022-23. In 2015-16, proportions were 46% (Qld), 53% (Vic) and 67% (NSW). Data collected in NSW, Vic and Qld only.
[j] the proportion of psychiatric care episodes with significant improvement at discharge from a hospital psychiatric inpatient unit has been stable between 2013-14 (72.9%) and 2022-23 (72.1%)

Domain 1: Mental health

The prevalence of mental disorders is high.

The latest *National Study of Mental Health and Wellbeing* shows that in 2020-2022, an estimated 4.3 million people aged 16-85 years (21.5%) experienced a mental disorder in the previous 12 months according to diagnostic criteria. Mental disorders were most common among young people aged 16-24 years, and there was a substantial increase in prevalence for this cohort between 2007 (25.8%) and 2020-2022 (38.8%).

Life satisfaction and the proportion of people reporting high and very high psychological distress remained reasonably steady, however there has been a slight decline in sense of control.

Life satisfaction and the proportion of people reporting high and very high psychological distress, as measured by the *ANUPoll* survey, remained reasonably steady between October 2020 and January 2024. However, findings from the *Household, Income and Labour Dynamics in Australia (HILDA) Survey* show a slight decline in the proportion of people reporting a high sense of control over events in their life between 2019 (75.8%) and 2023 (71.3%).

Domain 2: Social determinants

Signs of financial stress are elevated.

Findings from the *Scanlon Mapping Social Cohesion Survey* show the percentage of people who are 'just getting along' has increased by 11 percentage points between 2021 and 2024. Data from the *ANUPoll* survey similarly shows that the proportion of people finding it difficult or very difficult to cope on their present income steadily increased between November 2020 (17.1%) and January 2024 (34.6%).

We are not seeing improvement in loneliness or experiences of discrimination.

Findings from the *HILDA Survey* show the estimated proportion of people aged 15 and over reporting loneliness remained relatively steady between 2011 (15.3%) and 2023 (15.3%), with a slight increase observed in 2021 (16.6%). Findings from the *Scanlon Mapping Social Cohesion Survey* show that in 2024, 1 in 6 (17%) of adults in Australia report experiencing discrimination because of their skin colour, ethnic origin or religion in the past 12 months. This proportion has remained relatively steady between 2018 and 2024.

Homelessness rates among females are increasing, and people with a current mental health issue represent a significant portion of those receiving specialist homelessness services.

Between 2016 and 2021, the rate of homelessness for females increased from 41 to 42 per 10,000, while for males it decreased from 58 to 55 per 10,000.

In 2023-24, 32% of all specialist homelessness services clients (around 88,300 clients) had a current mental health issue, up from 25% in 2014-15 (around 62,900 clients). Among clients with a current mental health issue, the most common reasons for seeking assistance were housing crisis (e.g., eviction) (20.4% or 17,983 clients), family and domestic violence (19.1% or 16,785 clients) and inadequate or inappropriate dwelling conditions (12.9% or 11,314 clients).

People with a mental health condition are more likely to be without a permanent place to live and experience financial stress, loneliness and discrimination.

In 2020-2022, 17.7% of people in Australia aged 16-85 years with a 12-month mental disorder had been without a permanent place to live in their lifetime, compared to 7.6% of people without a 12-month mental disorder.

In 2023, 32.2% of people with a long-term mental health condition reported financial stress, compared to 14.5% of people with another long-term condition (excluding mental health) and 10.2% of people with no long-term health conditions.

In 2023, 35.1% of people with a long-term mental health condition reported loneliness, compared to 19.0% of people with another long-term health condition (excluding mental health) and 12.3% of people with no long-term health conditions.

In 2020, 20.8% of people with a mental health condition experienced discrimination in the past 12 months, compared to 12.3% of people without a mental health condition.

Domain 3: System inputs and activities

There are substantial delays in people seeking treatment for mental health, particularly for anxiety disorders.

Data collected from the *National Study of Mental Health and Wellbeing* 2020-22 shows that, among people who seek treatment for their mental disorder, people with anxiety disorders experienced the longest delay in seeking treatment from onset of the disorder (Median = 11 years). People with mood disorders also experienced significant delays (Median = 3 years).

The number of people in Australia delaying mental health care due to cost is increasing.

In 2023-24, 20.4% of respondents to the *ABS Patient Experience Survey* said they had delayed or did not see a health professional for their mental health due to cost. This proportion is higher than 2021-22 (16.7%) and 2020-21 (12.0%).

More people with a mental disorder are accessing treatment compared to earlier years, however treatment rates are still well below current targets.

Data from the *National Study of Mental Health and Wellbeing* shows that in 2020-2022, 45.1% of people with a 12-month mental disorder saw a health professional for their mental health in the past year (up from 34.9% in 2007). While the 2020-2022 treatment rate is higher, it is still significantly below targets proposed through the *National Mental Health Services Planning Framework* (67% overall).

We are not seeing improvement in the number of people having a positive experience of public mental health care or the number of people showing improvement in clinical mental health outcomes.

Self-reported positive experiences of service in admitted (hospital) specialised mental health care in Australia, as measured by the *Your Experience of Service (YES) Survey*, have been largely stable between 2015-16 (NSW: 67%, Vic: 53%, Qld: 46%) and 2022-23 (NSW: 69%, Vic: 51%, Qld: 51%). Findings from the *National Outcomes and Casemix Collection (NOCC) Database* show the majority (72.1%) of hospital psychiatric care episodes were assessed by a care provider as showing a significant improvement in their clinical mental health outcomes at discharge in 2022-23. This proportion has been relatively stable over time (2013-14: 72.9%). In 2022-23, over 1 in 5 hospital-based psychiatric

episodes showed no significant change in clinical mental health outcomes (22.7%) and 1 in 20 (5.2%) showed significant deterioration after receiving care.

Rates of specialised community mental health care following discharge from a specialised mental health care hospital are stable nationally, but have declined for those in remote/very remote areas.

Nationally, the proportion of people who had contact with a specialised community mental health care service within a week of leaving hospital increased over the last decade (from 67.4% in 2013-14 to 76.2% in 2022- 23). However, between 2019-20 and 2022-23, rates have remained relatively steady (ranging from 75.1% and 76.2%). For people living in 'very remote' areas there was a drop in rates from 72.2% in 2021-22 to 64.5% in 2022-23. This was also evident for people living in 'remote' areas (81.0% in 2021-22 to 74.9% in 2022-23).

Use of seclusion and restraint in hospital mental health units continues to decline.

In 2023-24, the national seclusion rate in public hospital acute mental health units was 5.4 events per 1,000 bed days (down from 5.9 in 2022-23 and 7.9 in 2014-15). We also saw a notable reduction in the national seclusion rate between 2022-23 (12.0 events per 1,000 bed days) and 2023-24 (5.7 events per 1,000 bed days) for services which focus on children and adolescents. In 2023-24, the national physical restraint rate in public hospital mental health care was 8.5 events per 1,000 bed days (down from 9.7 events per 1,000 bed days in 2022-23). National data on chemical restraint is currently unavailable.

Looking forward

While there has been considerable expansion of mental health data over the last few decades, there remains several areas where key data is lacking to inform a full assessment of how the system is performing. In particular, limited data exists on the experiences and outcomes of people who receive support through the system, and their families, carers and kin. We need to better understand the extent to which the size and distribution of the mental health workforce is sufficient in supporting the needs of people with mental health challenges and whether the level and mix of skills is appropriate in matching intensity. There is also a significant gap in national reporting on non-government mental health services.

In collaboration with our partners, we will continue to build our understanding of the data landscape and opportunities to expand our framework. Over the coming months, we will be partnering with Mental Health Australia to explore opportunities to increase representation of non-government services in future iterations of the Report Card to provide a more comprehensive view of system performance. The Commission will also be engaging with governments, lived experience representatives (including the National Mental Health Consumer Alliance and Mental Health Carers Australia) and the sector to identify the elements of system performance that are most critical for national monitoring and reporting.

We are excited to work with our partners towards a more robust and complete picture of system performance that will influence action and affect change.

How to read this report

This report is accompanied by the *National Report Card 2024 Technical Report* (Technical Report) which provides more detail on the scope, rationale, findings and data source for each of the core indicators. The analysis presented in this report is best interpreted in conjunction with the Technical Report. Where this report refers to data and analyses presented in the Technical Report, we have flagged the relevant core indicator (**CI**) that should be referred to in the Technical Report for further information.

Download the Technical Report from our website: www.mentalhealthcommission.gov.au/monitoring-and-reporting/national-reports

Introduction

It is important that the mental health system continuously improves to ensure it is addressing the needs of Australians today and into the future.

Independent and impartial performance monitoring is an essential part of improving Australia's mental health system. By monitoring and reporting on relevant, reliable and timely data we can promote accountability, surface useful insights about system performance, highlight variation, identify areas for improvement, and make information available to support improvement.

As the National Mental Health Commission (the Commission) does not itself design, deliver or fund any form of service delivery, it is uniquely placed to undertake this monitoring at a national level. Since 2012, the Commission has been responsible for producing an Annual National Report Card on the performance of the mental health system. These reports draw on national data collections to gauge what is working well and what needs to improve in the system. They also inform efforts to improve the system and outcomes for people with mental health challenges.

The Commission's National Report Card 2023 (RC2023) reflected a refreshed approach to its annual reporting. It represented a first step towards establishing a more consistent reporting framework to enable consistent and objective monitoring and reporting on the performance of the Australian mental health system over time. This framework has been continued for the National Report Card 2024 (RC2024).

The National Report Card framework focuses on an initial set of core indicators based on reliable data collected at a national level. These include indicators of the mental health and wellbeing of people in Australia, the broader social factors that impact on people's mental health, and the performance of the mental health system itself. It provides a foundation to build on over time to inform a robust analysis of system performance through engagement with relevant government bodies, the sector, people with lived experience and relevant data custodians.

As the second report that applies this reporting framework, this report details how the core indicators are tracking and builds on the knowledge from RC2023. It focuses on the 2024 calendar year and includes data updates for 3 of the 13 core indicators where new data was available.

Due to many indicators not having new data available, the report also presents additional supplementary data that are closely related to the remaining 10 core indicators and are collected on a frequent basis to provide a contemporary and holistic national view. These data include findings from the latest *Household, Income and Labour Dynamics in Australia Survey,* the *Scanlon Mapping Social Cohesion Survey* and the *ANUPoll* survey. RC2024 draws on all these key pieces of information to provide an overarching analysis of opportunities for system improvement.

The analysis presented in this report is best interpreted in conjunction with the accompanying Technical Report, which includes a detailed description of the scope and rationale for each of the core indicators.

The Commission will continue to monitor and build on the reporting framework over time to promote accountability, identify areas for improvement and support change.

Box 1. National Report Card 2024 reporting period

RC2024 draws together relevant events and available core indicators to reflect on the 2024 calendar year. Given typical delays between data collection and publication, this report draws on the most recent data available across our core indicators as at **13 June 2025**, using data collected up until, and inclusive of, the 2024 calendar year. This extended cut-off allows the use of more recent data to inform our assessment of system performance.

Despite the 6-month delay between National Report Card's reference period (Jan – Dec 2024) and publication (July 2025), much of the data in this report was collected prior to 2024 and varies in the time periods covered. This is because:

- 2024 data for various core indicators will not be processed or published until after our cut-off date of 13 June 2025. This data will be published in the next Report Card.
- the collection schedules of the sources for these indicators varies considerably. For example, some data sources are annually collected with many years of data available, while others are national surveys collected relatively infrequently with few years of data available.

The use of supplementary data in addition to the core indicators has allowed assessment of more recent data collected up to, and throughout the 2024 calendar year. While the report draws on most recent data available at **13 June 2025,** the specific reference periods for each data source should be considered when interpreting the findings throughout this report.

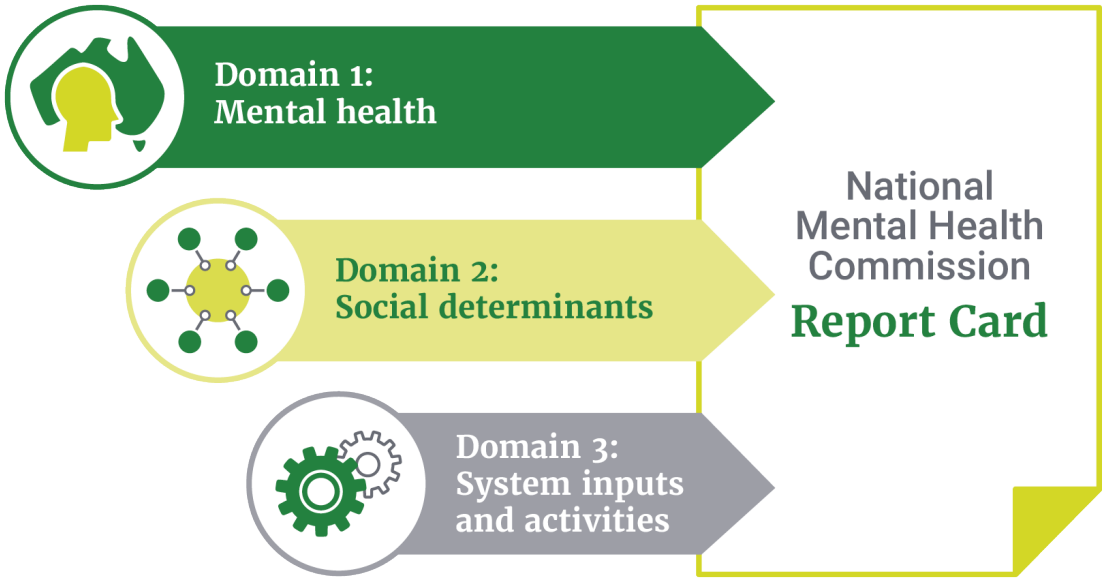
About our reporting framework

RC2024 applies a reporting framework that is designed to provide consistent and objective monitoring and reporting on the performance of the Australian mental health system over time.

Our approach, detailed in the National Report Card 2023 (RC2023), combines data and information relevant to overall system performance to present a unique view of the system at a national level. The framework organises this information under 3 broad domains (see Figure 2):

- **Domain 1: Mental health** – the status of key mental health and wellbeing outcomes for people with lived experience of mental health challenges.
- **Domain 2: Social determinants** – the broader social factors that have an impact on the mental health of people in Australia, as well as the whole of life outcomes for people with lived experience.
- **Domain 3: System inputs and activities** – the performance of system activities that impact the mental health outcomes of people in Australia.

Figure 2. Report Card reporting framework



Core Indicators

RC2024 continues the approach laid out in RC2023, which identified an initial set of 13 core indicators for Domains 1 and 2, based on objective criteria (see Box 2) and informed by a review of existing and proposed mental health indicator frameworks. While each indicator will not necessarily meet every criterion, the criteria help guide the development and continual improvement of the indicator set.

The indicators are designed to collectively provide a picture of the mental health and wellbeing of people in Australia and how Australia's mental health system is performing.

Box 2. Criteria for selection of core indicators

- **Nationally available** – derived from robust nationally available data sources with relevant disaggregation to allow analysis of selected population groups
- **Regularly collected** – ideally with an existing time-series
- **Reliable** – sourced from well-supported data collections with robust methodologies
- **Sustainable** – readily accessible and replicable in subsequent years
- **Relevant** – to the Commission's purpose and unique value-add in monitoring and reporting
- **Foundational** – provides a solid platform for stakeholder feedback and further development in future Report Cards

The core indicator sets for Domains 1 and 2 of the framework are identified in Table 1. Further information about the scope, rationale and findings for these indicators is outlined within the RC2024 Technical Report.

In RC2023, a respective primary data source was identified for each core indicator. These data sources were selected as they represent robust and reliable measures of mental health and social determinants. While the Commission intends to track these primary data sources over time, many of these data sources are not updated annually as they represent very large nationally representative surveys.

RC2024 Approach

Table 1 outlines which primary data sources have new data available to be reported on in RC2024. The data included in this report is the most recent data available for each indicator as at 13 June 2025.

It is important to note that for a significant proportion of indicators no new data is available from the primary source. Only 3 of the core indicators (**CI 4**, **CI 5** and **CI 12**) have updated data available and this data has been incorporated into this report. For the remaining 10 core indicators, the expected timeframe for updates varies, as shown in Table 1. Given the majority of indicators do not have updated data available for the primary data source, there is a need to draw on alternative data sources to continue to present a contemporary view of system performance.

For indicators with no updates to data sources specified in RC2023, this Report Card draws together:

- additional data from **principal data sources** specified in RC2023, such as greater use and more in-depth analysis of data from the *General Social Survey* and *Household, Income and Labour Dynamics in Australia Survey*
- new data from **supplementary data sources** that assess the same or similar dimensions as the core indicator(s) and are valid, reliable, timely and relevant.

We have assessed these supplementary data sources with key stakeholders to ensure that they are:

- **High-quality** – data are valid, reliable and sourced via robust methodologies
- **Relevant** – data collected is directly relevant to a core indicator, is sourced from the Australian population (or a sub-population of interest) and has been collected recently (i.e., within the last couple of years)
- **Consistent** – data are collected at multiple time-points which allows comparisons over time.

Technical information on the supplementary data sources is provided at **Appendix A**.

In future years, where the primary data source has been updated, Report Cards will capture the primary source data to enable a long-term assessment of how key measures are changing over time. Where no new data is available from the primary data source, supplementary sources will continue to be used. This approach helps to ensure we continue to provide a holistic and up-to-date picture of the mental health and wellbeing of people in Australia. In addition to drawing together these new data, the RC2024 builds on the previous iteration by presenting a more detailed view for particular community groups, including for those people in rural and low socio-economic areas.

Table 1. Expected future updates for primary data sources

Core indicator (CI)	RC2023 primary data source	Frequency of collection	Next update expected	RC2024 supplementary data source[1]
Domain 1:	**Mental Health**			
CI 1: Prevalence of mental disorders	*National Study of Mental Health and Wellbeing*	Infrequent	No future release scheduled	*National Health Survey* and *National Aboriginal and Torres Strait Islander Health Survey*
CI 2: Psychological distress	*National Health Survey*	About every 3 years	2028	*ANUPoll*
CI 3: Overall life satisfaction	*General Social Survey*[2]	About every 4 years	2026	*HILDA Survey* and *ANUPoll*
CI 4: Feeling in control	*Household Income and Labour Dynamics in Australia Survey*	Annually	New data included in RC2024	
Domain 2:	**Social Determinants**			
CI 5: Proportion of children developmentally vulnerable	*Australian Early Development Census*	About every 3 years	New data included in RC2024	
CI 6: Housing security (homelessness)	*National Study of Mental Health and Wellbeing*	Infrequent	No future release scheduled	*Census* and *Specialist Homelessness Services Collection*
CI 7: Financial stress	*General Social Survey*[1]	About every 4 years	2026	*HILDA Survey, Scanlon Mapping Social Cohesion Survey* and *ANUPoll*
CI 8: Employment rate	*National Health Survey*	About every 3 years	2028	*Labour Force*
CI 9: Engagement in employment or study for young people	*National Health Survey*	About every 3 years	2028	*Education and Work*
CI 10: Prevalence of physical health conditions	*National Study of Mental Health and Wellbeing*	Infrequent	No future release scheduled	*National Health Survey*
CI 11: Alcohol consumption	*National Drug Strategy Household Survey*	About every 3 years	2026	*ANUPoll*
CI 12: Feeling lonely	*Household Income and Labour Dynamics in Australia Survey*	Annually	New data included in RC2024	
CI 13: Experiences of discrimination	*General Social Survey*	About every 4 years	2026	*Scanlon Mapping Social Cohesion Survey*

1. Further information on supplementary data sources is provided at Appendix A.
2. The ABS will be delivering a General Social Survey (GSS) that will be run on an annual basis from 2026. The next GSS is scheduled to run in the middle of 2025 and will collect data from approximately 10,000 households

Box 3. Comparing primary and supplementary data sources

RC2024 includes new data from supplementary data sources that assess the same or similar dimensions as the primary source identified in Table 1.

When interpreting the findings in this report, it is important to recognise that some variation in findings and estimates between the primary source and supplementary source is expected. One reason for this expected discrepancy is sampling error. When a survey is undertaken there is typically a discrepancy between the survey estimate and the 'true' population value, since the survey respondents do not include every member of a population. The size of this discrepancy (i.e., sampling error) commonly varies between different surveys and is affected by a range of factors, including sample size and sample design. For further information on sampling error, please refer to Errors in Statistical Data.

In addition to sampling error, we may also see variation between data sources due to differences across a range of factors like:

- the study design and mode of data collection (e.g., when the survey was administered, whether the survey was administered to households or individuals and whether it was conducted in-person or over the phone)
- the questionnaire format (e.g., variation in length, wording, order of questions and content of questions)
- how the measure of interest is defined to respondents
- response rates and the nonresponse follow-up protocol.

While all data sources in this report provide valid and nationally representative data, these considerations should be kept in mind when interpreting the findings in the report. Differences in estimates between primary and supplementary data sources should not always be interpreted as actual differences in the indicators of interest.

Surveys can differ in terms of their purpose and therefore their methodology, including the type of questions. For example, pulse surveys, such as the *ANUPoll* survey, are intended to deliver real-time insights on issues that matter to people in Australia from an economic and social perspective and detect more granular trends or changes over time. As such, they are conducted very frequently, include a limited number of questions and are generally focused on specific issues or areas of interest. In contrast, national surveys, such as the *National Study of Mental Health and Wellbeing* and the *National Health Survey*, are broad and comprehensive studies conducted periodically (e.g., every 3 years or more) to gain a holistic understanding of the prevalence of conditions, risk factors or other characteristics. These differences should be considered when interpreting the findings.

Further information of the supplementary sources, including methodology and technical information is included at **Appendix A**.

Domain 3

In line with RC2023, for Domain 3, this report draws on data published elsewhere, including the AIHW's Mental Health website, the Productivity Commission's Report on Government Services 2025 (RoGS) and ABS survey data. Based on these data, we examine:

- what resources are being invested in the system
- the extent to which the system is delivering effective, high quality, safe and responsive care to people with mental health challenges
- the extent to which the system provides continuity of care and delivers coordinated services
- how timely, affordable and accessible services are to those who need them.

Moving forward, the Commission will be working to identify core measures for this Domain, to ensure a complete picture of system performance. As an initial step, the Commission will be working with Mental Health Australia and its members

to identify opportunities to provide a richer and more holistic view of system performance through incorporation of data collected from non-government mental health services. The Commission will also be consulting further with governments, lived experience representatives including the National Mental Health Consumer Alliance and Mental Health Carers Australia, and the sector, and engaging with a range of stakeholders, to identify the components of system performance that are most crucial for monitoring and reporting at a national level.

Domain 1: Mental Health

This snapshot shows the prevalence of mental disorders is high, particularly for young people. Overall, life satisfaction and psychological distress remained relatively steady, however there has been a slight decline in sense of control.

How mentally healthy are people in Australia?

Prevalence of mental disorders and psychological distress

Mental disorder prevalence rates provide a high-level indication of the mental health of people in Australia. The *National Study of Mental Health and Wellbeing* demonstrated that in 2020-2022, just over 1 in 5 people (21.5%) in Australia aged 16-85 years experienced a mental disorder in the previous 12 months (**CI 1**[1]). This proportion equates to an estimated 4.3 million people and is slightly higher than the mental health prevalence rate in 2007 (19.5%).

In 2020-2022, anxiety disorders were by far the most prevalent disorder across Australia (17.2%), relative to affective disorders (7.5%) and substance use disorders (3.3%). Looking over time, anxiety disorders also showed the largest increase in prevalence between 2007 and 2020-2022 (from 13.8% to 17.2%). The prevalence of affective disorders rose slightly between 2007 and 2020-2022 (from 6.2% to 7.5%), while the proportion of people with a substance use disorder decreased over time (from 5.1% to 3.3%).

An additional source of information about the mental health of people in Australia is the *National Health Survey* (see Box 4), which provides information on a range of long-term health conditions, including mental and behavioural disorders. The *National Health Survey* is collected more frequently than the *National Study of Mental Health and Wellbeing*, allowing for a more detailed examination of how prevalence may be changing over time.

Overall, data from the *National Health Survey* shows a steady increase in the proportion of people in Australia who have been told by a doctor or nurse that they have a mental and behavioural condition, ranging from 13.6% in 2011-12, 17.5% in 2014-15, 20.1% in 2017-18 and 26.1% in 2022. In 2022, mental and behavioural conditions were the most common chronic condition[i].

Findings from the *National Health Survey* similarly show that the proportion of adults in Australia with high or very high levels of psychological distress (**CI 2**[2]) has significantly increased, from 10.8% in 2011-12, to 13.0% in 2017-18 and 14.6% in 2022. When interpreting these changes, it is important to keep in mind the period in which the data was collected. In particular, the data collected in 2022 was during a time when there were several measures in place to stop the spread of COVID-19 (e.g., remote learning, stay at home orders), as well as additional supports (e.g., JobSeeker and Crisis payments).

Long-term monitoring over time is critical in understanding whether changes are transient or enduring. More recent data collected from the *ANUPoll*[3] survey suggests the overall proportion of people with high and very high psychological distress[ii] has remained relatively steady (at around 11%) between 2022 and 2024, ranging from a minimum of 9.6% in August 2022 and a maximum of 12.5% in August 2023.

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[i] Chronic conditions are a subset of long-term health conditions that are common, pose significant health problems, or have been a focus of ongoing public health surveillance. Selected chronic conditions include 10 chronic condition groups: arthritis, asthma, back problems, cancer, chronic obstructive pulmonary disease, diabetes, heart, stroke and vascular disease, kidney disease, mental health conditions and osteoporosis.

[ii] The *ANUPoll* survey measures psychological distress with the Kessler 6 (K6) scale, which is a shortened version of the Kessler 10 (K10) scale. The scores from each item are summed to produce a total score ranging from 6 to 30. A total score of 19 or more indicates high/very high psychological distress.

Box 4. The National Health Survey and the National Study of Mental Health and Wellbeing

The below table summarises key differences between the *National Study of Mental Health and Wellbeing* (NSMHW) and the *National Health Survey* (NHS). When interpreting the findings in this report it is important to note that the NSMHW is the recommended source for prevalence data for mental disorders as it uses diagnostic criteria rather than relying on respondents self-reporting[4]. The NHS provides more frequent data to enable analysis of trends over time. Due to key methodological differences, prevalence data collected from both sources are not comparable.

National Study of Mental Health and Wellbeing (NSMHW)	National Health Survey (NHS)
Purpose	
• Measure the prevalence and severity of mental disorders in Australia, the demographics of people experiencing mental disorders and access to mental health services.	• Provide detailed data about the health status of the population, including long-term health conditions (including mental or behavioural conditions), health risk factors and psychological distress.
Sample design and response rates	
• People aged 16-85 years from randomly selected households. • Total number of respondents (2020-2022) across both cohorts: 15,893 • Response rate (2020-2022): 52.0%	• People aged 0+ years from randomly selected households. A parent/guardian answers questions on a child's behalf if they are aged between 0-14 years. • Total number of respondents (2022): 13,095 • Response rate (2022): 56.7%
How mental health is measured	
• Includes modules from the World Health Organization's World Mental Health Composite International Diagnostic Interview (CIDI 3.0). • The survey instrument assesses whether the person meets diagnostic criteria for a range of affective disorders, anxiety disorders and substance use disorders.	• Respondents are asked whether they have been diagnosed with the condition ('ever told by a doctor or nurse'). • A person is identified as having a mental or behavioural condition if they report the condition was current at the time of interview and had lasted, or was expected to last, 6 months or more.
Key advantages	
• Nationally representative survey. • Uses diagnostic criteria to assess mental health prevalence (more reliable). • Data are comparable internationally.	• Nationally representative survey. • As it is collected every 3 years, it enables more frequent data to assess trends over time.
Key limitations	
• Provides prevalence data on affective, anxiety and substance use disorders only, and not other mental disorders such as psychosis. • Administered infrequently and therefore does not enable analysis of trends over short time periods.	• Relies on the respondent self-reporting health conditions, or in some cases reporting health conditions of other people in the household in the case of proxy interviews, which may impact reliability.

For detailed information on comparing these data sources, refer to Comparing ABS Long-term Health Conditions Data sources.

Life satisfaction and sense of control

Communities where people feel satisfied with their life and have higher levels of wellbeing are associated with lower levels of mental distress[5]. Understanding the trajectory of these protective factors is therefore critical in understanding how the system is performing in supporting the mental health needs of people in Australia, as well as identifying opportunities to promote good mental health. In recognition of this, the Report Card series includes measures of positive mental health and wellbeing, including life satisfaction (**CI 3**[6]) and feeling in control (**CI 4**[7]).

Life satisfaction is a summary measure of subjective wellbeing, reflecting how satisfied people are feeling with their lives in general. As reported in RC2023, in 2020, the overall life satisfaction rating for people in Australia—as measured from 0 ('not at all satisfied') to 10 ('completely satisfied') in the *General Social Survey*—was 7.2 (**CI 3**). This rating is slightly lower than what has been reported in previous years (2014: 7.6, 2019: 7.5), and for all years, life satisfaction was

significantly lower for people with a mental health condition compared to those without a mental health condition. From 2026 onwards, this indicator will be updated annually with data from the *General Social Survey.*

More recently collected data suggests life satisfaction has remained relatively steady in recent years, however younger people and those with a mental health condition report lower levels relative to older people and those without a mental health condition. In particular:

- Findings from the *HILDA Survey* show overall life satisfaction remained steady at around 7.9 between 2020 and 2023, with little difference observed between females and males. People aged 65 and over consistently reported higher life satisfaction, while those aged 35 to 64 reported lower levels. Similar to the pattern of findings from the *General Social Survey,* in 2023, people with a long-term mental health condition reported the lowest level of life satisfaction (6.8), while those without a long-term health condition had the highest levels of life satisfaction (8.1).
- *ANUPoll* survey data shows life satisfaction has been relatively steady over the period of 2020 to 2024 (at around 6.7). In line with findings from the *HILDA Survey*, there was little difference observed between females and males, but older people (aged 65 years and over) consistently reported higher life satisfaction compared to those aged 18-64 years.

People vary in the extent to which they believe life events are caused by their own actions, as opposed to outside factors beyond their control. A belief that events in life are within one's own control—i.e., a high sense of control (**CI 4**)—is generally associated with better mental health and wellbeing outcomes[8]. Overall, the proportion of people reporting a high sense of control was relatively stable between 2011 and 2019, however decreased between 2019 (75.8%) and 2023 (71.3%). Among people with a long-term mental health condition, just 39.6% reported a high sense of control in 2023 (compared to 76.9% for people with no long-term health condition).

Box 5. Suicide and self-harm

Suicide and self-harm are significant issues that require a whole-of-governments response. In 2023, 3,264[iii] people died by suicide in Australia, making suicide the 16th leading cause of death in Australia overall and the leading cause of death among people aged 15-44 years. Approximately three-quarters of deaths by suicide were among men (2,454 males and 810 females). This is a long-term persistent trend. Since 1907, the male age-standardised suicide rate has been consistently higher than the female rate.

Suicide rates have remained high but consistent over the past decade at a population level. Nationally, the age standardised rate of suicide (deaths per 100,000) was 11.8 in 2023. This rate has remained relatively consistent over the last decade. However, among First Nations peoples, rates have increased over this period[9].

Data on intentional self-harm includes incidents of deliberate self-injury or hurting of oneself, with or without the intent of dying, including both suicide attempts and non-suicidal self-injury[10]. While most people who self-harm do not go on to die by suicide, prior self-harm is a strong risk factor for suicide.

Females are overrepresented in terms of self-harm presentations, with signs this may be trending upwards amongst younger females. In 2022-23, the rate of hospitalisation for intentional self-harm was substantially higher for females than males (124.1 compared with 65.5 per 100,000). Over the last 4 years, an increase in rates has been observed for females aged 0-14 years (40.7 in 2019-20, 71.0 in 2020-21, 71.5 in 2021-22 and 66.1 in 2022-23). The increase in intentional self-harm from 2019-20 to 2020-21 was also seen among females aged 15-19 years (and to a lesser extent females aged 20-24 years), however in 2022-23 the rate dropped to lower than it was

[iii] Figure based on revised Causes of Death data as of 15 May 2025. See Causes of Death, Australia, 2023 | Australian Bureau of Statistics

in 2019-20 for both groups. In contrast, for females aged 0-14 years, the rate remained somewhat elevated in 2022-23. For further information, refer to Suicide & self-harm monitoring - AIHW.

The *National Suicide Prevention Strategy 2025-2035* recognises that suicidal distress is a complex human response that arises from an interaction of a host of factors, as opposed to a single isolated cause. These factors include social determinants (such as employment and housing), contextual factors (such as trauma and stressful life events), clinical factors (such as mental illness), personality factors, genetic factors and demographic factors (such as age and gender)[11]. While monitoring changes in suicide rates and attempts is important, it does not provide meaningful insight into how factors such as social determinants are influencing those rates and whether progress is being made in reducing their impact on suicidal distress and suicide.

In recognition of this, and noting that other entities (including the National Suicide Prevention Office (NSPO) and the Australian Institute of Health and Welfare) consider, monitor and report on aspects of the suicide prevention system specifically, we do not include suicide-related measures as core indicators in the Report Card. We do, however, recognise that an effective mental health system is a critical element in preventing suicides, and reducing the emergence of suicidal distress in the first place.

The NSPO is currently developing a National Suicide Prevention Outcomes Framework (Outcomes Framework) that will align with the direction set out in the *National Suicide Prevention Strategy 2025-2035*. It will include an Outcomes Map, Data Improvement Plan and Monitoring and Reporting Plan. The Outcomes Framework will define key outcomes relating to suicide prevention and measure whether progress against these is being made. The outcomes will be person focused, providing greater insight into the pathways to suicide and the impact of prevention efforts. It will contribute to reducing suicidal distress, attempts and lives lost to suicide by enabling meaningful and transparent reporting of progress in suicide prevention.

The Commission is working with the NSPO to ensure our respective monitoring and reporting approaches complement each other to provide a fuller picture that informs and drives system improvement efforts. For further information on the development of the National Suicide Prevention Outcomes Framework, refer to: https://www.mentalhealthcommission.gov.au/development-national-suicide-prevention-outcomes-framework

Is it the same for everyone?

Age and sex

No. The *National Study of Mental Health and Wellbeing* demonstrated that in 2020-2022, young adults aged 16–24 years and females[iv] were significantly more likely to experience a mental disorder in the previous 12 months, and prevalence rates for these cohorts increased significantly between 2007 and 2020-2022.

A similar pattern emerges when looking at recent data on psychological distress measured by the *ANUPoll* survey. For the period between 2020 and 2024, the proportion of people with high and very high psychological distress generally decreased as age increased. Younger adults aged 18-29 years reported the highest levels of psychological distress, averaging around 20%, while older adults aged 65 and over reported the lowest levels, averaging around 3%. Notably, in October 2021 and April 2023, particularly high proportions of young women aged 18-29 reported high and very high psychological distress, 30% and 26%, respectively (compared to 17% and 12% of young men in the same age group).

[iv] Note comparisons between groups are based on sex assigned at birth, as opposed to gender (man, woman, non-binary) or gender experience (cis experience or trans experience). A disproportionate number of non-binary people (80.4%) and trans and gender diverse people (33.1%) experienced a 12-month mental health disorder in 2020-2022. Similarly, people who described their sexual orientation as Gay or Lesbian, Bisexual or who used a different term (including Asexual, Pansexual and Queer) had higher rates (58.7%) compared to people who described their sexual orientation as heterosexual (19.9%). For further information, refer to www.abs.gov.au/articles/mental-health-findings-lgbtq-australians

The increased rates of mental health challenges among younger people are consistent with longitudinal studies examining mental disorder prevalence and psychological distress across cohorts of adolescents[12]. Multiple factors may be contributing to the rising number of young people experiencing mental disorders and psychological distress, such as increased financial insecurity, increasing concerns about climate change and the social determinants of health, changes in how young people connect with others resulting in feeling more disconnected from others, shifts in lifestyle factors (e.g., sleep, substance use, screen time and nutrition) and the disproportionate social and economic impact of the COVID-19 pandemic on the lives of young people[13,14]. However, the precise contributions of these factors and how they intersect is unknown and requires further research.

Socio-economic disadvantage and remoteness

Breaking down the data into groups according to levels of socio-economic disadvantage and remoteness can provide richer insights into outcomes and experiences for different population groups across Australia. In 2022, based on the *National Health Survey,* the percentage of people reporting mental and behavioural conditions was:

- significantly higher for people living in the most socio-economically disadvantaged areas (Quintile 1[v]) (29.9%) relative to those in the most advantaged areas (Quintile 5) (20.1%)
- significantly higher for people living in inner regional Australia[vi] (29.1%) and outer regional and remote Australia (30.8%) relative to people in major cities (24.8%).

These findings are consistent with research showing that living in remote areas and socio-economic disadvantage can present unique challenges that can impact mental health outcomes significantly. It also highlights the need for targeted policies and programs for these populations. Barriers to accessing support include distance to, or accessibility of, mental health services and supports, along with availability of infrastructure.

When looking at psychological distress, in 2022, among people with a mental or behavioural condition:

- over half (50.4%) of people living in the most disadvantaged areas (Quintile 1) reported high/very levels of psychological distress, compared to less than one-third (28.4%) of those in the most advantaged areas (Quintile 5). This pattern of findings is consistent with previous years (2017-18 and 2014-15). These findings are significantly higher when compared to those without a mental or behavioural condition, where proportions ranged between 3.4 and 8.7%.
- the proportion of people reporting high/very high levels of psychological distress did not significantly differ according to remoteness (Major cities: 37.4%, Inner Regional: 42.9%, Outer Regional and Remote areas: 43.3%).

For life satisfaction and feeling in control, findings from the *HILDA Survey* similarly show that people living in the most disadvantaged areas generally reported slightly lower life satisfaction and were more likely to report a low sense of control. Interestingly, in 2023, people living in Major Cities reported slightly lower levels of life satisfaction, while those living in Remote areas reported slightly higher levels. Since 2011, the proportion of people reporting a high sense of control was consistently higher for people living in Remote areas compared to those living in Major Cities, Inner Regional and Outer Regional Australia. These findings may reflect some of the protective factors of living in regional and remote areas, such as the potential for more connectedness with community members and social cohesion, as well as increased informal support from community members[15], despite other unique challenges due to geographic isolation.

First Nations people

Social and emotional wellbeing (SEWB) is the foundation for physical and mental health for Aboriginal and Torres Strait Islander (First Nations) peoples. It is a holistic concept that is formed from a network of relationships between individuals,

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[v] The ABS uses SEIFA (Socio-Economic Indexes for Areas) to measure and rank areas in Australia based on relative socio-economic advantage and disadvantage. SEIFA data is presented using quintiles, dividing the areas into 5 groups based on their scores, with Quintile 1 representing the lowest 20% (i.e., the most disadvantaged) and Quintile 5 the highest 20% (i.e., the most advantaged).
[vi] Remoteness Areas (i.e., Major Cities of Australia, Inner Regional Australia, Outer Regional Australia, Remote Australia) are defined by the Australian Statistical Geography Standard (ASGS). For further information refer to: Remoteness Areas | Australian Bureau of Statistics

family, kin and community, and recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect an individual's holistic health, including mental health[16]. It includes several interconnected domains including: mind and emotions, body, family and kinship, community, culture, country, and spirituality and ancestors. Evidence shows that strengthening the connections that exist between the domains of SEWB has a positive impact on the overall health of First Nations people[17]. The *Gayaa Dhuwi (Proud Spirit) Declaration*[18] adopts the key principles of social and emotional wellbeing and emphasises the importance of using values based SEWB and mental health outcome measures in combination with clinical outcome measures. Under the *Gayaa Dhuwi (Proud Spirit) Implementation Framework and Plan*[19], a key priority action is the development and promotion of the uptake of SEWB measurement tools.

The ABS has run several Aboriginal and Torres Strait Islander-specific health surveys, including the *Australian Aboriginal and Torres Strait Islander Health Survey: First Results, 2012-13*, the *National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) 2018-19* and the most recent *NATSIHS 2022-23*. The *NATSIHS 2022-23*[20], published November 2024, collected information from First Nations people of all ages in non-remote and remote areas of Australia on a range of topics including the cultural determinants of social and emotional wellbeing[vii], long-term health conditions, mental wellbeing and health risk factors. While the language of the survey does not directly align with the concepts of social and emotional wellbeing, it is used in this report in lieu of other recently published national data which encompasses values based SEWB measures.

Box 6. First Nations people's mental health and wellbeing

Use and interpretation of Aboriginal and Torres Strait Islander people's data and information should be made in partnership with First Nations people to ensure reporting of data accurately reflects stories, knowledges and experiences, and captures intrinsic cultural differences, values and priorities.

In 2022-23 the SEWB Policy Partnership was initiated under the *National Agreement on Closing the Gap* to bring together First Nations and government representatives to improve social and emotional wellbeing and mental health and reduce suicide rates. As an initiative of the SEWB Policy Partnership, the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* was introduced to guide and inform First Nations people's mental health and wellbeing reforms. In 2025, the SEWB Policy Partnership endorsed the final draft of the refreshed *National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2025-2035* and agreed for this to progress to the Joint Council on Closing the Gap following jurisdictional endorsement.

There are a range of data collections and studies underway focused on measuring the SEWB and mental health of Aboriginal and Torres Strait Islander people. These include:

- The Mayi Kuwayu Study: a national survey of First Nations people, aged 16 years and above, which captures culture, wellbeing and health every 3 years and aims to understand the cultural determinants of health and their impacts on mental and physical health.
- Footprints in Time: The Longitudinal Study of Indigenous Children (LSIC): a long-term study of First Nations children that started in 2008. It aims to provide quality quantitative and qualitative data on how a child's early years affect their development over the life course. LSIC is guided by a majority Indigenous Steering Committee and involves annual waves of data collection. Findings from the first 10 years of Footprints in Time are available

[vii] These include but are not limited to: connection to country, family, kinship and community, Aboriginal and Torres Strait Islander beliefs and knowledge, cultural expression and continuity, Aboriginal and Torres Strait Islander language and self-determination and leadership.

at A Decade of Data: Findings from the first 10 years of Footprints in Time, 2020 | Department of Social Services.

There remain several data gaps that limit current understanding of SEWB among First Nations peoples. For example, a key data gap identified by First Nations organisations is defining and measuring racism. While some attempts have been made to measure racism in Australia in the past, these have typically focused on overt racial discrimination. Definitions of racism need to be led by First Nations people and measurement needs to be facilitated and enabled by non-Indigenous people and institutions.

There has been recent progress in addressing current data gaps to provide a fuller picture of SEWB among First Nations peoples. The *National Agreement on Closing the Gap*—particularly Priority Reform Three (Transforming Government Organisations) and Priority Reform Four (Shared Access to Data and Information at a Regional Level)—aims to improve First Nations-led data. Additionally, the Data Policy Partnership, agreed to by the Joint Council on Closing the Gap in July 2024, will be established in the latter half of 2025. This partnership will accelerate progress on Priority Reform Four, with representation from ten Aboriginal and Torres Strait Islander parties.

For further information on up-to-date data, emerging research and evaluation projects about First Nations people's wellbeing, mental health and suicide prevention, see the Indigenous Mental Health and Suicide Prevention Clearinghouse at Indigenous Mental Health & Suicide Prevention Clearinghouse - AIHW Indigenous MHSPC.

In 2022-23, around 3 in 10 (30.2%) First Nations people aged 18 years and over experienced high or very high levels of psychological distress in the last 4 weeks. People aged 18-24 years (34.3%) and females (35.7%) were most likely to report high or very high levels of psychological distress.

Of note, several cultural determinants of social and emotional wellbeing were associated with lower levels of psychological distress. For example:

- people who felt 'satisfied' or 'very satisfied' with their own level of knowledge of culture were more likely to experience low or moderate levels of psychological distress in the last 4 weeks (71%) relative to those who were not very satisfied or not at all satisfied (61%).
- people who were *not* removed from their natural family (or did not have relatives removed from their natural family) were more likely to experience low or moderate levels of psychological distress in the last 4 weeks (74%) than those who did experience this (60%).

The proportion of First Nations people with high and very high levels of psychological distress did not decrease between 2012–13 (30.1%), 2018–19 (31.1%) and 2022-23 (30.2%).

Between 2018-19 and 2022-23 there was an increase in the proportion of First Nations people aged 2 years and over who had mental and behavioural conditions (from 24.2% to 29.2%). Similar to the findings for psychological distress, several cultural determinants of social and emotional wellbeing were associated with a lower prevalence of mental and behavioural conditions, including being satisfied or very satisfied with one's knowledge of culture.

It is important to note that data alone is insufficient in providing the full picture of Aboriginal and Torres Strait Islander social and emotional wellbeing and does not completely grasp the diverse lived experiences of Aboriginal and Torres Strait Islander people and culturally appropriate indicators of social and emotional wellbeing. The data must be understood in the broader cultural and historical context. While the survey methodology of the NATSIHS produces both valid and useful data, First Nations knowledge generation through unique inquiry and validation techniques is essential in providing valuable contextual information to help progress from measuring problems into defining solutions. For further information on work underway to improve First Nations-led data, refer to Box 6.

Domain 2: Social determinants

This section presents results from our environmental scan analysis and summarises data related to the social determinants of mental health. Overall, 2024 was another challenging year for many Australians, with many of the social factors impacting mental health not showing improvement or declining in recent years.

2024 in review

We undertook an environmental scan of major events or trends that have the potential to influence the mental health of people in Australia between 1 January 2024 and 31 December 2024. As shown in Figure 3, we used a PESTEL methodology (i.e., political, economic, social, technological, environmental, and legal) to identify:

- key events occurring in 2024 that have the potential to impact the mental health of people in Australia or the system
- trends or changes across data measures that are potentially relevant to mental health or wellbeing outcomes
- government activity and responses at the national level which have the potential to influence future changes to the mental health system.

These events, trends and activities were selected according to the relative reach and size of the expected impact on the mental health of people in Australia, the strength of the available evidence supporting a link between the event/trend/activity and its association with mental health, and its general relevance to the mental health of people in Australia.

This environmental scan helps to contextualise data presented within this Report Card. The findings are not intended to reflect events or changes that have a causal impact on mental health or the mental health system. Instead, they are merely intended to frame the data in this Report Card, providing context and a backdrop of events and changes that are potentially relevant to the mental health or wellbeing of Australians now and into the future.

The year 2024 was characterised by the ongoing cost of living pressures[21], heightened tensions over continuing geopolitical conflicts[22] and a slump in Australia's living standards with a fall in real disposable income[23], rising mortgage stress[24] and household prices[25].

Similar to 2023, financial struggles have been prevalent again in 2024, with the cost of living still high, house prices continuing to rise[26] and real incomes declining. Recent data suggests 49% of adults in Australia thought the economy was the most important problem facing the country, while 15% of people rated housing shortages and affordability as most important[27]. These proportions are similar to those reported in 2023. Notably, Australian households experienced the largest fall in disposable incomes across the OECD between 2022 and 2024[28]. There are also growing concerns about wealth inequality, with recent data showing Australia's middle class is shrinking[29].

Over the course of the year we saw polarised debates and protests continue over the conflict in the Middle East. The conflict in the Middle East may be contributing to more negative attitudes towards people of Jewish and Muslim faiths, with data showing that negative attitudes towards these groups increased between July 2023 and July 2024[30]. We also saw a decline in the proportion of people in Australia feeling safe in the last year which may in part be driven by high profile instances of family and community violence[31,3233]and global instability. This coincided with a substantial 11% increase in sexual assaults recorded by police between 2022 and 2023[34]. The 2023 victimisation rate (136 victims per 100,000 persons) is the highest rate recorded since data was first collected in 1993. Despite the challenging and tumultuous events of the year 2024, data suggests that connection and cohesions within neighbourhoods has been

stable between 2021 to 2024, with the majority of adults continuing to have active engagement within their communities. These connections continue to be a protective factor for personal wellbeing[35].

Politically, Government health spending appears to be returning to pre-pandemic levels[36]. We also saw a range of policy activity in response to new evidence which will have implications for the future mental health system. For example, following many years of grassroots advocacy to enhance consumer, carer and family voices in reforming Australia's mental health system, the Government funded the National Mental Health Consumer Alliance and Mental Health Carers Australia as the sector's two new independent peak bodies to represent people with lived experience of mental health challenges. We also saw the release of:

- The *Royal Commission into Defence and Veteran Suicide Final Report*, which was delivered to Government in September 2024, including 122 recommendations to Government for meaningful and lasting reform. The Government's response, released in December 2024, accepted the majority of these recommendations including establishing a new statutory entity to oversee enduring and systemic reform to drive better outcomes for current and ex-serving Australian Defence Force personnel.
- The Government's response to the *Independent Evaluation of the Better Access Evaluation*. Seven of the 16 recommendations were supported, while 2 were supported in-principle and the remaining 6 were noted. The supported recommendations include the introduction of multidisciplinary models of service delivery to complement Better Access and addressing workforce distribution issues (particularly the lack of providers in rural and remote areas) in the context of the *National Mental Health Workforce Strategy*. Due to the risk of further exacerbating current inequalities in access, the Government did not support the recommendation to introduce additional treatment sessions as part of a tiered model under Better Access.
- The *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme – Final Report*. The report presented estimates of unmet need for psychosocial supports outside the NDIS for the 2022-23 financial year. It estimated that there were approximately 230,500 people with severe mental illness and 263,100 people with moderate mental illness aged 12 to 64 years who required psychosocial support but were not receiving psychosocial support through the NDIS or other government-funded programs.

As part of the 2024-25 Federal Budget, the Government announced $361.0 million over 4 years ($888.1 million over 8 years) into mental health and suicide prevention as part of a stronger Medicare. This included:

- a new national early intervention service providing free, safe and high-quality therapy and resources
- an enhanced national network of 61 Medicare Mental Health Centres (formerly Head to Health) to provide free, walk-in access to mental health services and support
- extending the headspace Early Career Program and co-designing new fit for purpose models of care for young Australians
- funding Primary Health Networks to deliver mental health multidisciplinary services in primary care settings for people with severe and complex mental health care needs.

Near the end of the year, we also saw the introduction of legislation to enforce a minimum age of 16 for access to social media and other relevant digital platforms, in response to concerns around the potential harmful impacts of these online environments and addictive social media behaviour. The new laws represent a world first and will come into effect by the end of 2025, allowing sufficient time for social media platforms to make the required changes to their systems.

The environmental scan only captures a small sample of activities that happened in 2024. But the events and trends it does capture help contextualise the findings explored elsewhere in this Report Card. The Commission will continue to track events and trends over time through the PESTEL methodology to identify potential impacts on the mental health of people in Australia.

Figure 3. Environmental shifts from 1 January 2024 to 31 December 2024

The below infographic summarises key environmental events, trends and government activity at the national level which occurred in 2024. This environmental scan provides a broad but not comprehensive view of relevant factors to help contextualise data presented within this Report Card. The findings are not intended to reflect events or changes that will have a causal impact on mental health or the mental health system. Instead, they are intended to contextualise the data in this Report Card, providing a backdrop of events and changes that are potentially relevant to the mental health or wellbeing of Australians now and into the future.

Political

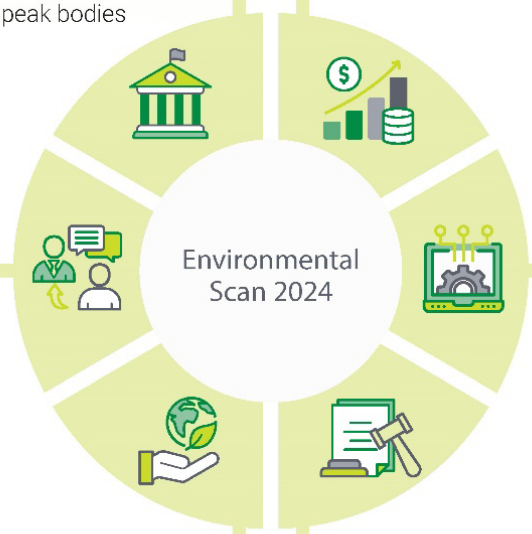
- Final Report of the Royal Commission into Defence and Veteran Suicide and Government response
- Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme - Final Report and Government response
- Government response to Better Access evaluation
- Announcement of the establishment of two independent lived experience peak bodies

Economic

- Continuing cost-of-living pressures
- Health expenditure returning to pre-pandemic levels
- Budget 2024–25 Mental health measures

Social

- Increased diagnoses of Autism, ADHD and Dementia
- Continuing geopolitical conflicts and protests
- Safety a major domestic issue, following high profile instances of family and community violence, particularly against women
- New data suggests Australia's middle-class is shrinking



Technological

- Australia passes the Online Safety Amendment Act
- Increasing AI usage in Australia and new policies enacted
- Increasing investment in digital support services

Environmental

- Continued severe weather events – floods, droughts, cyclones and ongoing impact of bushfires
- Select Committee on Australia's Disaster Resilience deliver final report

Legal

- Right to disconnect bill passes and comes into effect
- Managing Psychosocial Hazards at Work code of practice introduced

Are the factors that influence mental health improving?

As highlighted in the environmental scan, people in Australia are continuing to face significant economic pressures, with inflation driving cost-of-living higher across the economy and rising interest rates increasing mortgage and rent costs.

Signs of financial stress are elevated. As reported last year in RC2023, when looking over a broad timeframe the proportion of households experiencing financial stress (**CI 7**[37]) has increased, with 18.7% unable to raise $2,000 within a week[viii] if needed in 2020, compared to 14.5% in 2006.

A similar—albeit smaller—increase was observed over this period for other measures of financial stress experienced by households. For example, in 2020, 22.9% of households either used assets or incurred or increased debts to pay for basic living expenses in the last 12 months, and 20.7% had at least one cash flow problem[ix] in the last 12 months. In 2006, these proportions were 19.4% and 18.5% respectively. This suggests that at the onset of the COVID-19 pandemic households were experiencing additional financial concerns.

More recent data suggests financial stress is yet to show signs of easing across the population, despite an increase in employment-to-population rates from 2014 to 2024[x]. For example:

- Data from the *HILDA Survey* shows a significant rise in the proportion of people experiencing financial stress[xi] from 10.6% in 2022 to 12.5% in 2023. Females consistently reported higher levels of financial stress compared with males over this period. In 2023, people aged 15–34 and 35-64 reported higher proportions of financial stress (14.2% and 14.1%, respectively), whereas those aged 65 and over reported notably lower levels, at just 6.2%.
- Findings from the *Scanlon Mapping Social Cohesion Survey* showed that in in 2024, 41% of adults said they were at best 'just getting along' financially, 11% described themselves as 'poor' or struggling to pay bills and over a quarter (28%) said they 'often' or 'sometimes' could not pay for meals, medicine or healthcare in the last 12 months, or could not pay their rent or mortgage on time. These levels are similar to those recorded in 2023, while the percentage of people who are 'just getting along' has increased by 11 percentage points since 2021.
- Data from the *ANUPoll* survey similarly show people in Australia have experienced increased financial stress between 2020 and 2024. The overall proportion of people finding it difficult or very difficult to cope on their present income steadily increased between November 2020 and January 2024. Two significant spikes were observed during this period: the first from 17% in November 2020 to 22% in January 2021, and the second from 25% in August 2022 to 32% in April 2023. Women consistently reported higher levels of financial stress over this period.

On Census night in 2021, more than 122,494 people were estimated[xii] to be experiencing homelessness in Australia, an increase of 6,067 people since 2016. When accounting for growth in the population, the overall rate of homelessness decreased over this period, from 50 people per 10,000 in 2016 to 48 in 2021. For males, the rate of homelessness decreased between 2016-2021 (from 58 to 55 per 10,000), while for females the rate increased (from 41 to 42 per 10,000).

[viii] Data for the ability to raise $2,000 is nominal (not adjusted for inflation). The purchasing power of $2,000 was less in 2020 compared to 2006, yet a higher proportion of people were unable to raise $2,000 in 2020. The observed increase over time for this measure may therefore under-represent the actual rise in financial stress across the population.

[ix] Cash flow problems are defined as experiencing being unable to pay bills, going without meals, borrowing money from family or friends, and others due to a shortage of money.

[x] The employment-to-population ratio provides a measure of employment relative to the size of the population. Further information, refer to Labour Force, Australia, April 2025 | Australian Bureau of Statistics

[xi] For HILDA, a person is classified as being in financial stress if they report 2 of the following happening due to a shortage of money since January (survey year):' 1) Could not pay electricity, gas or telephone bills on time, 2) Could not pay the mortgage or rent on time 3) Pawned or sold something, 4) Went without meals 5) Was unable to heat home 6) Asked for financial help from friends or family, 7) Asked for help from welfare/community organisations

[xii] Estimates are based on the ABS Statistical definition of Homelessness: when a person does not have suitable accommodation alternatives, they are considered as experiencing homelessness if their current living arrangement:1) is in a dwelling that is inadequate, 2) has no tenure, or if their initial tenure is short and not extendable, or 3) does not allow them to have control of, and access to space for social relations. For further information refer to Estimating Homelessness: Census methodology, 2021 | Australian Bureau of Statistics

Of the people experiencing homelessness in 2021, the majority (58%) were younger than 35 (23.6% were aged from 12 to 24 years), over half (55.9%) were male and 1 in 5 (20.4%) were First Nations people[38]. It is important to recognise the potential impact of the COVID-19 pandemic on the data collected in 2021, including restrictions to international travel and migration, border control measures, stay at home orders and temporary accommodation state and territory initiatives. For further information, see Estimating Homelessness: Census methodology, 2021 | Australian Bureau of Statistics

The following indicators have also not shown improvement over time:

- **Physical health**: the proportion of people in Australia's general population who have one or more selected chronic physical health conditions (**CI 10**) has been relatively stable over time (37.3% in 2007-08 and 37.4% in 2022).
- **Loneliness:** overall, just under 1 in 6 (15.3%) people in Australia aged 15 years and over reported feeling lonely in 2023 (**CI 12**). Looking over time, the estimated proportion of people aged 15 and over reporting loneliness remained relatively steady between 2011 (15.3%) and 2023 (15.3%), with a slight increase observed in 2021 (16.6%) before declining in subsequent years. When looking at age and sex, since 2015 there are no consistent trends in the differences between males and females, or different age groups.
- **Experiences of discrimination:** the most recent *General Social Survey* found that in 2020 13.3% of people aged 18 years and over experienced some form of discrimination (**CI 13**) in the past 12 months. More recent data from the *Scanlon Mapping Social Cohesion Survey* shows that in 2024, across the Australian population, 1 in 6 (17%) of adults in Australia report experiencing discrimination because of their skin colour, ethnic origin or religion in the past 12 months. This proportion has remained relatively steady between 2018 and 2024.

Interestingly, there has been a steady downwards trend in the proportion of people in Australia who exceeded the Australian Alcohol Guidelines[xiii] since 2010 (37.7%) (**CI 11**[39]), which has been slightly less pronounced in recent years (from 33.2% in 2016 to 32.0% in 2019 and 30.7% in 2022-23). Recent findings from the *ANUPoll* survey similarly show that the overall proportion of people reporting high alcohol consumption[xiv] slightly declined from 27% in August 2021 to 24% in August 2023. Overall, younger people reported lower levels of high alcohol consumption compared to older people. In 2023, only 8% of young people aged 18-29 reported high alcohol consumption, compared with 18% of people aged 30-49, 31% of people aged 50-64, and 40% of people aged 65 and over.

Looking earlier in the lifespan, the proportion of children in Australia who were 'developmentally vulnerable' (**CI 5**[40]) on one or more domains of the Australian Early Development Census (AEDC) increased between 2021 (22.0%) and 2024 (23.5%). The percentage of children developmentally vulnerable increased across all 5 AEDC domains over this period (i.e., physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge).

How are people with mental health challenges faring compared to the rest of the community?

When the system is performing well, we would expect to see an improvement in whole-of-life outcomes among people with mental health challenges, such as in their physical health, employment, housing and relationships. We would also expect to see a narrowing of the gap in outcomes between people with mental health challenges and the wider community on these measures.

[xiii] This includes those who consumed more than 10 standard drinks a week and/or more than 4 standard drinks on any day at least monthly in the last 12 months (on average).
[xiv] Alcohol consumption is measured based on responses to the question "In the last 12 months, how often did you have an alcoholic drink?" High alcohol consumption is defined as a person responding with either: "Every day", "5-6 days per week", or "3-4 days per week".

Financial distress

Research shows financial stress is a significant risk factor for poor mental health and can cause or worsen psychological distress, anxiety, depression or suicidal thoughts[41,42]. The most recent *General Social Survey* found that in 2020, 29.9% of people in Australia with a mental health condition could not raise $2,000 within a week, compared to 17.1% without a mental health condition. Looking over time, between 2014 to 2020, these proportions have increased significantly for both those with a mental health condition (2014: 25.3%, 2020: 29.9%) and those without a mental health condition (2014: 10.3%, 2020: 17.1%).

More recent data collected through the *HILDA Survey* shows that in 2023, people with a long-term mental health condition reported the highest levels of financial stress[xv], with almost 1 in 3 (32.2%) in financial stress. This proportion was significantly higher than people with other long-term health conditions (excluding mental health) (14.5%) and people with no long-term health conditions (10.2%). This pattern of findings has been relatively consistent between 2011 and 2023 and there is no evidence of financial stress reducing among people with a long-term mental health condition over time.

Physical health

Higher rates of co-occurring physical and mental conditions can result in reduced life expectancy, increased levels of ongoing disability, and reduced workforce participation. For the 4.3 million people (21.5% of the population) aged 16-85 years with a 12-month mental disorder in 2020-2022, 1.7 million (8.4% of the population) also had a physical condition. The proportion of people with a mental disorder who experienced a long-term physical condition (39.3%) was similar to people without a mental disorder (37.5%). Among those with a mental health disorder living in areas of most disadvantage (Quintile 1), close to half (48.5%) also had a physical health condition. In contrast, for those with a mental health disorder who were living in areas of least disadvantage (Quintile 5), around one-third (32.5%) of people also had a physical health condition.

Consuming alcohol at harmful levels is shown to increase the risk of experiencing some physical conditions and may contribute to existing mental health challenges. In 2022-23, 36.9% of people in Australia aged 18 years and over diagnosed or treated for a mental health condition exceeded the Australian Alcohol Guideline[xvi]. This was higher than the proportion of people without a mental illness (31.6%). This gap has not narrowed over time and the proportion of people drinking at risky levels has remained relatively stable among people with a mental health condition since 2013.

Employment and housing security

There are many mental health benefits associated with employment. Participation in personally rewarding work can enhance financial security, develop social and community relationships, and contribute to a sense of purpose and personal fulfilment. In 2022, among people in Australia aged 16-64 years with a mental or behavioural condition, the employment rate was 71.6% (compared to 82.8% for people without a mental or behavioural condition). This gap was also observed in 2014-15 and 2017-18, however, encouragingly, it has reduced over time. This is because the employment rate for people with a mental or behavioural condition is increasing at a greater rate than the employment rate for people without a condition.

The largest increase in employment rates was seen for people living in Major Cities: in 2022, 74.0% of people living in Major Cities with a mental health condition were employed, compared to 62.5% in 2014-15. The increase was smaller for people in Inner Regional areas (57.6% to 64.7%) and people in Outer Regional and Remote areas (61.4% to 67.2%).

[xv] For the HILDA survey, a person is classified as being in financial stress if they report 2 of the following happening due to a shortage of money since January (survey year):' 1) Could not pay electricity, gas or telephone bills on time, 2) Could not pay the mortgage or rent on time 3) Pawned or sold something, 4) Went without meals 5) Was unable to heat home 6) Asked for financial help from friends or family, 7) Asked for help from welfare/community organisations

[xvi] This includes those who consumed more than 10 standard drinks a week and/or more than 4 standard drinks on any day at least monthly in the last 12 months (on average).

As well as employment, a safe and suitable home is an important protective factor for health and wellbeing. Further, people who are without a permanent place to live and experience homelessness have poorer health outcomes and significant disadvantage across a wide range of social determinants[43]. In 2020-2022, among those with a 12-month mental disorder (4.3 million people), 17.7% (756,000) of people aged 16-85 years had been without a permanent place to live in their lifetime (**CI 6**[44]). This was significantly higher than the proportion of people without a 12-month mental disorder (7.6% or an estimated 1.2 million people).

The likelihood of a person with a mental disorder having a history of homelessness varied according to remoteness and socio-economic disadvantage. Among those with a 12-month mental disorder, in 2020-2022:

- 28.9% of people in Outer Regional and Remote Areas had ever been without a permanent place to live, compared to 16.4% for those living in Major Cities.
- 28.5% of people who were living in areas of most disadvantage (Quintile 1) had ever been without a permanent place to live, relative to 9.6% of those living in areas of most advantage (Quintile 5).

Over the past 9 years, there has been a 40% increase in the number of people with a current mental health issue receiving specialist homelessness services (SHS) support:

- In 2023-24 around 88,300 of SHS clients (32% of all clients) had a current mental health issue (up from 62,900 clients or 25% in 2014-15).
- In 2023-24, among SHS clients with a current mental health issue, the most common reasons for seeking assistance were housing crisis (e.g., eviction) (20.4% or 17,983 clients), family and domestic violence (19.1% or 16,785 clients) and inadequate or inappropriate dwelling conditions (12.9% or 11,314 clients).

Discrimination, connection and belonging

Discrimination can cause a person to believe negative stereotypes about themselves, increase feelings of isolation, reduce help-seeking and create barriers to social, economic and cultural participation[45]. In 2020, the proportion of people with a mental health condition who experienced discrimination in the previous 12 months (**CI 13**) was significantly higher (20.8%) than that of the rest of the Australian community (12.3%). Among people with a mental health condition who experienced discrimination, the most common reasons for the most recent incident of discrimination were the respondent's gender (40.6%), a disability or health issue (31.0%) and age (27.8%). More recent data on discrimination among people with a mental health condition will be available following the release of the next *General Social Survey* in 2026.

Meaningful social relationships and connections are very important in maintaining mental health and wellbeing. People who feel lonely are more likely to experience depression[46], social anxiety and poorer wellbeing[47]. In 2023, people reporting a long-term mental health condition recorded the highest proportions of loneliness, reaching 35.1% in 2023 (compared to 34.1% in 2022). Those diagnosed with other long-term health conditions, disabilities, or impairments also reported elevated levels of loneliness (19.0% in 2023), compared with 12.3% among people without any long-term condition. These patterns were consistent from 2011 to 2023. Critically, there is no evidence of heightened loneliness among people with a mental health condition reducing over time.

Domain 3: System inputs and activities

In this section we explore how the system is functioning in delivering care to people with mental health challenges and highlight where further data is needed to provide a fuller picture.

In this section we draw on data published elsewhere, including the AIHW's Mental Health website, ABS survey data and the Report on Government Services 2025, which provides annual information on the equity, efficiency and effectiveness of key government services in Australia. It should be acknowledged that while much of the data in this section was recently published, a significant amount was collected prior to the 2024 calendar year. This discrepancy is because there is frequently a delay between when data is collected and when it is published. This delay is to allow for several processes that ensure high quality data that maximises consistency and comparability over time and between jurisdictions. These processes include translating and transforming data into the appropriate format, data validation undertaken by the AIHW, and necessary reviews and approvals by jurisdictions prior to publication. It is also important to note that much of the national data presented in this section focuses on the public sector only, yet many people receive supports and services provided by private specialists and non-governmental organisations. This is currently a significant gap in national reporting.

Box 7. Domain 3 indicators

While there is a wide array of potential system indicators, much of the available data is at a detailed service-level, focused on processes or activity (rather than system outcomes), not collected nationally, or already reported through other performance frameworks. We want to ensure that the Report Card draws on the right information and data to enable a whole-of-system view – across governments, across portfolios and across jurisdictions. We also want to make sure that our Report Card provides unique and valuable insights to inform system improvement.

In this Report Card we have provided an overview of the type of data available and findings against some example measures commonly used to understand system performance. In future Report Cards we will expand our understanding of the data landscape by working further with experts—such as governments, the sector and people with lived experience, including the National Mental Health Consumer Alliance and Mental Health Carers Australia—to ensure our Report Card focusses on the areas that matter and provides unique insights to inform system improvement. In particular, over the coming months, we will be partnering with Mental Health Australia and its members and stakeholders to explore opportunities to increase representation of non-government services in future iterations of the Report Card.

What resources are being invested in the system?

Expenditure

A high performing mental health system must be adequately funded and resourced to meet the needs of people in Australia now and into the future.

In 2022-23, around $13.2 billion was spent on mental health related services[xvii] in Australia (up from around $12.2 billion in 2021-22). This equates to $501 per person in the population (up from $491 in 2021-22). Of this amount, the majority

(an estimated $8.1 billion[xviii]) was spent on state and territory mental health services, including services provided in public hospitals and specialised public community mental health services. Currently, around 7% of total Government health expenditure is expenditure on mental health-related services. This proportion has remained very stable over the last 10 years, ranging from 7% and 8% between 2013-14 and 2022-23.

It is important to note that mental health-related costs for support packages delivered under the National Disability Insurance Scheme (NDIS) are currently excluded from this estimate of Australian Government expenditure on mental health related services. According to RoGS 2025, as at 30 June 2024, there were 63,837 active NDIS participants with a psychosocial disability (9.7% of all participants), receiving approximately $5.3 billion in payments.

Further, estimated expenditure excludes:

- mental health related programs (including promotion/prevention programs) delivered by non-health portfolios, such as housing, justice, employment and education
- individual out-of-pocket spending
- income support payments, such as the Disability Support Pension.

In 2023-24[xix], the Australian Government spent over $1.5 billion[xx] on Medicare-subsidised mental health-specific services[xxi]. Services provided by psychologists were the largest proportion of this spending ($715 million or 47%). In real terms, spending on Medicare-subsidised mental health specific services decreased from $64 per person in the population in 2018-19 to $57 per person in the population in 2023-24.

In 2023–24, Australian Government spending on mental health-related subsidised prescriptions under the Pharmaceutical Benefits Scheme (PBS) and RPBS was $691 million, or $26 per person in the population. Prescriptions for Antipsychotics (34%) and Antidepressants (34%) accounted for the majority of PBS mental health-related spending in 2023–24. In real terms, expenditure on mental health-related prescriptions remained relatively stable between 2019–20 and 2023–24 from $692 million to $691 million, with the highest expenditure of $734 million in 2020–21 and the lowest expenditure of $672 million in 2022–23. While expenditure has remained steady over this period, the number of medications dispensed has slightly increased over this period. For further information on expenditure on mental health services refer to Expenditure - Mental health - AIHW. It is important to note that these figures alone are unable to tell us whether funding is being directed towards the areas of highest need and/or enhancing access to or improving the quality of services or outcomes.

Workforce

In addition to expenditure, the mental health workforce is a critical resource with significant influence on the quality, accessibility, effectiveness and sustainability of the mental health system.

[xviii] This estimate includes Commonwealth, State and Territory, and Private Health Insurer/other insurer spending on mental health-related services. It does not take into account payments from the Commonwealth Government to states and territories (such as through the National Health Reform Agreement) for the running of public hospital services, including the community-based services managed by public hospitals.

[xix] The most recent year of data for total Mental health expenditure and State and Territory government mental health expenditure statistics is 2022–23, and the most recent year for MBS and PBS expenditure is 2023–24.

[xx] Total spending (Australian Government and consumer contribution) was $2.3 billion in 2023-24.

[xxi] Refers to mental health-specific services subsidised by the Australian Government through the Medicare Benefit Schedule (MBS). These services include mental health-specific services provided by psychiatrists, other medical specialists, general practitioners (GPs), psychologists and other allied health professionals and are defined in the MBS.

Number of mental health workers employed in Australia[xxii]

In 2022, for every 100,000 people in Australia, there were approximately 96 mental health nurses, 125 psychologists, 10 mental health occupational therapists and 11 accredited mental health social workers. In 2023, there were 16 psychiatrists per 100,000 population working in Australia.

In addition to these professions, there are a range of different professions and roles that may be considered under the broad category of generalist mental health workers, as they commonly play a role in managing mental health challenges and/or acting as a gateway to the professions outlined above. For example:

- General Practitioners: in 2023, there were around 32,200 GPs working in Australia.
- Nurses: in 2023, there were around 331,000 registered nurses employed in Australia[48].
- Aboriginal and Torres Strait Islander health practitioners: in 2022, there were around 660 Aboriginal and Torres Strait Islander health practitioners working in Australia.
- Counsellors and psychotherapists: The Australian Counselling Association reports that they have over 20,000 members[49]. However, the actual number is likely higher as counsellors and psychotherapists are not required to be members of this organisation.
- Support line volunteers: There are multiple support lines providing mental health-related assistance across Australia. One of the largest support lines is Lifeline, which has around 1,000 paid employees and 10,000 volunteers[50].

Currently, there is a lack of national data on the community-managed mental health and psychosocial support workforce. This includes minimal reliable data on the total number of lived experience workers in Australia due to the broad scope of lived experience workers' engagement with the mental health sector. However, data is available for specialised mental health facilities: in 2022–23, there were 126 full time equivalent (FTE) paid consumer workers and 48 FTE paid carer workers employed in these facilities. The number of consumer workers and carer workers doubled from 2017–18 to 2022–23. For more information, refer to Mental health workforce.

Meeting level of demand

While monitoring the above figures and trends is important in understanding workforce trends, critically, these findings are not able to tell us the extent to which the mental health workforce is meeting the level of demand and the current degree of unmet need across the population. This information is crucial in supporting service planning and guiding evidence-based decision-making.

The Commission is currently exploring with data owners what opportunities exist to better understand the mental health workforce, including how we can better track the extent to which the size, distribution and skill mix of the current mental health workforce is sufficient and appropriate in supporting the needs of Australians. As an example, the *Productivity Commission's Mental Health Inquiry Report* recommended gaps in mental health services should be estimated using the National Mental Health Service Planning Framework[xxiii] (NMHSPF) and published annually, including at a national level to both guide resource allocation decisions and hold governments to account. For further information on the NMHSPF, refer to National Mental Health Service Planning Framework - AIHW.

Of note, recent national workforce research and analysis using the NMHSPF suggests critical shortages across the mental health workforce. In 2019, there was a 32% shortfall in mental health workers when compared to the National Mental Health Service Planning Framework (NMHSPF) target[51]. If this shortage is not appropriately addressed, it is estimated to increase to 42% by 2030. When looking across mental health workforce categories, there was a moderate

[xxii] In addition to the number of workers employed, it is important to consider workforce capacity (or hours worked) across mental health professions. The National Health Workforce Data Set is a collection of data on registered health professionals in Australia and includes demographic and employment information including average weekly hours. Data are publicly available on the Health Workforce Data Tool, available at https://hwd.health.gov.au/resources/information/nhwds.html

[xxiii] The NMHSPF is a needs-based planning tool, managed by the AIHW, that quantifies the total mental health need in the Australian community and estimates the resources required to meet mental health service demand.

under-provision in FTE across nearly all mental health professions. The largest gaps in 2019 were observed for consumer and peer workers (5% and 14% of the NMHSPF target, respectively), psychologists (35% of the NMHSPF target), and Indigenous mental health workers (37% of the NMHSPF target). The findings from this work were limited by data gaps, including a paucity of data on non-Ahpra[xxiv] regulated professions and on the full workforce delivering psychosocial support services.

Workforce sustainability

In addition to understanding whether the mental health workforce meets current demand, estimating the capacity of the mental health workforce in meeting *projected* service demand is essential for planning and monitoring performance. The Productivity Commission's Report on Government Services 2025 examines workforce sustainability by looking at:

- whether there is a high or increasing percentage of new entrants in the workforce and/or a low or decreasing percentage of workers who are nearing retirement. This is measured by looking at the age distribution of the mental health workforce.
- mental health sector attrition rates (i.e., the rate at which employees depart an organisation, whether voluntary or involuntary).

In 2023, among medical practitioners (including psychiatrists), nurses, psychologists and other allied health practitioners, the proportion of FTE workers younger than 30 years old ranged between 3.7% to 27.5%, while the proportion of FTE workers aged 60 years or over varied between 4.7% and 22.2%. Allied mental health practitioners had the highest proportion of FTE workers aged less than 30 years (27.5%) and the lowest proportion of FTE workers aged 60 years or over (4.7%). In contrast, medical practitioners (including psychiatrists) had the lowest proportion of FTE workers younger than 30 years old[xxv] (3.7%) and the highest proportion of FTE workers aged 60 years or over (22.2%). These proportions have remained relatively stable over the last 5 years ranging from 2.7% to 3.7% for workers younger than 30 years old and 21.6% to 23.7% for workers 60 years or over. For more information, refer to the Report on Government Services 2025.

In 2023, among those working in a registered profession, nurses employed in the mental health sector[xxvi] had the highest attrition rate (29.7%), followed by other allied health practitioners (26.6%), medical practitioners (18.2%) and psychologists (5.4%).

It is important to note that both attrition rate and age distribution measures are not a substitute for a full workforce analysis that considers factors such as duration of professional training, estimated demand increase, trends in full-time work and skilled migration.

To what extent does the system deliver effective, high quality, safe and responsive care to people with mental health challenges?

Consumer and carer experience

An effective mental health system should provide access to services that are responsive to consumer and carer goals, and meet the specific needs of people with mental health challenges. Measuring the experiences of consumers and carers is therefore a key component of understanding the effectiveness of system performance.

The *Your Experience of Service (YES) Survey* currently collects information on experiences of care among people receiving public mental health care in Australia. The survey was developed in partnership with mental health consumers across Australia and measures experience of service across 6 domains (i.e., Making a Difference, Information and Support, Individuality, Participation, Respect, and Safety and Fairness). New South Wales, Victoria and Queensland are

[xxiv] Australian Health Practitioner Regulation Agency

[xxv] When interpreting these data, it is important to recognise that the average training time to receive necessary qualifications varies across professions, which may explain some differences in the proportions observed.

[xxvi] Includes professionals working in both the public and private sector.

the only jurisdictions that currently provide data to the AIHW for national reporting. There are differences across these jurisdictions in how the survey is administered and therefore comparisons between jurisdictions should be made with caution.

In 2022-23, for jurisdictions where data is currently collected, between 51% and 69% of consumers reported positive experiences of service[xxvii] in admitted (hospital) specialised mental health care[xxviii] (NSW: 69%, Vic: 51%, Qld: 51%). Of note, close to half (48%) of surveys were from respondents with an *Involuntary* status recorded[xxix]. Higher proportions of consumers reported a positive experience of service in admitted care if they were receiving care under *Voluntary* status (NSW: 75%, Vic: 62%, Qld: 61%) compared to *Involuntary* status (NSW: 63%, Vic: 46%, Qld: 48%).

For those accessing ambulatory (non-admitted) care—i.e., specialised mental health services to people not currently admitted to hospital or a residential service—in 2022-23 between 74% and 81% of consumers reported a positive experience (NSW: 81%, Vic: 74%, Qld: 80%). Approximately 28% of surveys were from respondents with an *Involuntary* status recorded. Similar to admitted care, people with a *Voluntary* status were more likely to report a positive experience (NSW: 84%, Vic: 81%, Qld: 84%) relative to those with an *Involuntary* status (NSW: 78%, Vic: 58%, Qld: 76%).

These proportions have been relatively stable over time. In 2022-23, across the jurisdictions where data is currently collected, between 6% and 13% of consumers rated their overall experience of care as poor[xxx] in admitted care and between 3% and 6% of consumers rated their overall experience of care as poor in ambulatory care.

The *Mental Health Carer Experience Survey* (CES) has been developed as a measure of carers' experiences that is suitable for national use in public sector mental health services. In 2018, the former Mental Health Information Strategy Standing Committee (MHISSC) endorsed the release of the CES for use by the sector. Currently, New South Wales[xxxi] and South Australia[xxxii] publicly report on CES data. The AIHW recently received ethics approval to establish a CES database and will shortly be approaching jurisdictions to invite them to supply CES data for national reporting.

Of note, a recent research project explored how the COVID-19 pandemic affected the experiences and wellbeing of caregivers who support people with mental health challenges in Australia. The study found that mental health service closures, changes and restrictions during the pandemic resulted in feelings of abandonment and increased psychological distress for carers. Carers also provided more hours and more complex support during the pandemic, many without the assistance of financial, practical, social or emotional resources. For further information, refer to https://nmhccf.org.au/our-work/discussion-papers/report-mental-health-family-carer-experiences-of-covid-19-in-australia

Consumer outcomes

If the system is delivering effective care, we should expect to see many consumers experiencing a significant improvement in mental health outcomes following care, and few or no consumers experiencing significant deterioration.

In 2022-23, 72.1% of hospital psychiatric care episodes were assessed by a care provider as showing a significant improvement in their clinical mental health outcomes at discharge, while close to a quarter (22.7%) showed no change

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[xxvii] The positive experience of service score is calculated based on respondent's answers to 22 survey questions. A threshold score of 80 and above (out of 100) is used to indicate a positive experience of service. For further information on interpreting consumer ratings refer to https://www.aihw.gov.au/mental-health/topic-areas/consumer-rated-experience

[xxviii] This includes specialised mental health services that provide overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital.

[xxix] An involuntary status is recorded if the person received care under the relevant state or territory mental health legislation compulsory treatment provisions.

[xxx] Ratings are in response to the survey question "Overall, how would you rate your experience of care with this service in the last 3 months?". Response options include: poor, fair, good, very good and excellent.

[xxxi] NSW Mental Health Carer Experience Survey Reports are available at https://www.health.nsw.gov.au/mentalhealth/Pages/carer-experience-survey.aspx

[xxxii] The latest SA Mental Health Carer Experience Survey Report is available at https://www.chiefpsychiatrist.sa.gov.au/news/mental-health-carers-experience-survey-ces-report-for-2021

and 5.2% showed significant deterioration. Among ambulatory care episodes, in 2022-23 just under half (48.5%) were assessed by a care provider as showing a significant improvement between baseline and follow-up, while 44.5% showed no change and 7.0% showed significant deterioration. These proportions have remained relatively stable between 2013-14 and 2022-23, varying between 71-74% in inpatient settings and between 48-52% in ambulatory settings over this period.

There are several limitations of this metric that must be considered when interpreting these findings. In particular, mental health outcomes are assessed by the service provider (as opposed to the consumer), and the approach considers care and outcomes from a clinical perspective and within discrete segments (hospital and community), rather than measuring overall outcomes across care settings or broader whole-of-life outcomes. Within these discrete segments of care, the realistic goal of treatment may be stabilisation and maintenance and prevention of deterioration, particularly for those individuals with severe mental illness. Further, this metric includes data for state and territory public specialised mental health services only, excluding services such as private hospitals, non-government organisations, Primary Health Networks, and other services.

As noted in RC2023, there are significant data gaps surrounding the needs, experiences and outcomes of people in Australia who see a mental health professional, particularly for people who access mental health services outside of the public health system.

Safety

Ensuring the safety of consumers using mental health services is fundamental to a rights-based approach to treatment, care and support.

To help achieve this, mental health services must meet a range of safety and quality standards. The majority of expenditure on publicly funded specialised mental health services is through organisations that comprehensively meet the required standards. As at 30 June 2023, 96.3% of expenditure on specialised public mental health services was on services that met the required standards (compared to 93.7% as at 30 June 2022)[xxxiii].

Restrictive practices in mental health care settings refer to any interventions that restrict an individual's rights or freedom to move. Such practices are typically used as a behavioural management strategy to protect both the consumer and those in the immediate environment. However, these practices can create trauma and impede recovery[52][53], and frequent adoption of these practices is considered an indicator of poor performance.

Seclusion and restraint are examples of restrictive practices. Seclusion refers to instances where a person receiving treatment is confined alone in a room and prevented from free exit, while restraint refers to instances where freedom of movement is restricted by physical (i.e., the use of hands-on immobilisation) or mechanical means (i.e., the application of devices, such as belts or straps).

In 2023-24, the national[xxxiv] rate of seclusion in public mental health care was 5.4 events per 1,000 bed days (down from 5.9 in 2022-23 and 7.9 in 2014-15). When looking at rates across target populations, there was a notable reduction in the national rate of seclusion between 2022-23 and 2023-24 for services which focus on children and adolescents, from 12.0 seclusion events per 1,000 bed days to 5.7 events per 1,000 bed days in 2023-24. However, it should be noted that rates for this cohort tend to vary quite a lot from year to year (the rate for 2021-22 was 6.7). Rates were relatively stable over this period for older people (0.1 in 2022-23 to 0.2 in 2023-24) and there was a slight reduction for those receiving services in correctional settings (8.8 in 2022-23 to 8.0 in 2023-24).

[xxxiii] Data was not available for the ACT for 2022 or 2023.
[xxxiv] Excludes data from the ACT

In 2023-24, the national rate of physical restraint[xxxv] in public hospital mental health care was 8.5 events per 1,000 bed days (down from 9.7 events per 1,000 bed days in 2022-23), while the rate[xxxvi] of mechanical restraint remained very low at 0.4 events per 1,000 bed days (compared to 0.7 in 2022-23). Measurement of the number of chemical restraint events is currently under development.

How timely, affordable and accessible are services to those who need them?

Cost and wait times

While many factors determine the accessibility of mental health care, both cost and wait times can provide an insight into how well the mental health system is operating in responding to people's needs in a timely way. Each year the ABS undertakes the *Patient Experience Survey* which collects data on access and barriers to healthcare services in the 12 months before a respondent's interview. In 2023-24, 20.4% of survey respondents indicated that they had delayed seeing any mental health professional due to cost. This continues a year-on-year upwards trend over the last 4 years of data collection (19.3% in 2022-23, 16.7% in 2021-22 and 12.0% in 2020-21). In 2023-24, approximately 1 in 4 respondents delayed mental health care due to cost for psychologists, psychiatrists and other mental health professionals (24.6%), while one in ten delayed care due to cost for GPs (10.3%).

People seeking mental health related care via an emergency department were less likely to be seen within clinically recommended wait times than those presenting for non-mental health reasons and were more likely to experience longer overall wait times. In 2023-24, 60% of people who presented to a hospital emergency department (ED) with a mental health related care need were seen within clinically recommended waiting times according to their triage category, compared to 67% of all ED presentations. Approximately 10% of mental-health related presentations had a waiting time longer than 2 hours and 23 minutes, while the median waiting time was 21 minutes. By comparison, 10% of all ED presentations had a waiting time longer than 1 hour and 57 minutes, while the median waiting time was 18 minutes. Data on waiting times for other mental health services, including specialised public mental health services and MBS subsidised services for mental health, is not currently available.

Importantly, other barriers aside from cost and wait time can inhibit access to appropriate care, such as the availability and cultural appropriateness of services, time pressures and distance to care, as well as past or anticipated experiences of stigma or discrimination. National data on these barriers is currently lacking. System complexity may also delay consumers finding and getting the right care, this is further explored in the section on continuity of care below.

A recent study[54] has looked at the patterns and predictors of delay in making initial treatment contact based on data from the *National Study of Mental Health and Wellbeing 2020-2022.* This investigation showed significant delays in accessing treatment across all mental and substance use disorders, with the largest delays among people with an anxiety disorder (Median = 11 years), followed by those with substance use orders (Median = 8 years) and affective (or mood) disorders (Median = 3 years). Females demonstrated a higher likelihood of seeking treatment and experiencing shorter delays for mood disorders and anxiety disorders, however the opposite was true for substance use disorders, with females less likely to seek treatment and experience longer delays, compared to males. The study also found that younger cohorts were more likely to seek treatment and experience shorter delays, which may partly reflect increased education and national mental health literacy. The findings of this study underscore the need to better understand the barriers to seeking timely care.

Treatment rates

Delivery of treatment from a mental health professional is a fundamental component of the mental health system and can play a vital role in easing symptoms, connecting people to other supports and helping people feel supported in their

[xxxv] Excludes data from the ACT
[xxxvi] Excludes data from WA and the ACT

recovery journey. Monitoring the rate at which people in Australia access such treatment is therefore a central focus in assessing system performance.

Findings from the *National Study of Mental Health and Wellbeing* show that the proportion of people with a mental disorder using services remains low but has shown improvement over time. In 2020-2022, 45.1% of people with a 12-month mental disorder accessed treatment in the past year (up from 34.9% in 2007). People with more severe 12-month mental disorders were more likely to access treatment, relative to those with milder symptoms[55]. While the 2020-2022 treatment rate is higher, it is still significantly below targets proposed through the *National Mental Health Service Planning Framework* (67% overall)[56].

Nationally, in 2023-24, 10% (101 per 1000 population) of people in Australia received Medicare subsidised mental health-specific services[xxxvii]. This is an increase of 14.8% since 2014-15 and equivalent to 467 services per 1,000 population. Females aged 18-24 years showed the largest increase in patient rates over this period, from 14% in 2014-15 to 20% in 2023-24. In 2023-24, patient rates were highest for General Practitioners (78 per 1000), followed by Other Psychologists (27 per 1000), Psychiatrists (21 per 1000), Clinical Psychologists (20 per 1000) and Other allied health providers (4 per 1000).

In 2023-24, around 47.3 million mental health-related prescriptions[xxxviii] were dispensed in Australia and 18% of Australians were dispensed a mental health-related prescription (up from 16% in 2014-15). In 2023-24, the majority (84%) of all mental health-related prescriptions dispensed were issued by General Practitioners and Antidepressants were the most commonly dispensed medication (34.2 million). Research suggests that the increase in antidepressant use may be partly driven by rising long term antidepressant use and prescribing[57,58].

In addition to these services, the AIHW monitors service activity of some crisis, support and information services provided by the community sector, such as Lifeline, Kids Helpline and Beyond Blue. Key recent insights from these data include:

- Just over 270,000 phone calls were made to Lifeline in the December quarter of 2024, which is 5% higher than the rate for the same period in 2023 and 7% lower than the rate observed in 2022.
- 60,849 contacts were answered by Kids Helpline nationally in the December quarter of 2024, compared to 71,192 contacts in the same quarter in 2023 (a decrease of 15%).
- 75,208 contacts were answered by Beyond Blue nationally in the December quarter of 2024 (compared to 64,098 in the same quarter in 2023).

For further information on service activity across the mental health system, refer to Service activity monitoring - Mental health - AIHW.

While the above data provides some insights into how many Australians are accessing mental health services—as well as how access rates are changing over time—it is important to note that these data alone cannot reliably tell us how the system is performing in addressing unmet need. This is a key question in assessing how the system is functioning. In a well performing system, the proportion of Australians who are not receiving treatment but have an active need for care (i.e., those with current mental health challenges with a need for treatment) is minimal. Currently, it is difficult to reliably answer this question based on available data because:

- Unlike service access data which is generally collected quite frequently (e.g., annually or quarterly), mental health prevalence data is collected relatively infrequently.

[xxxvii] These proportions relate only to services claimed under specified mental health care MBS item numbers. However, an unknown number of people receive GP mental health-related care that is billed as a general MBS item number. As such, the reported percentage likely under-estimates the actual proportion of people who receive mental health care.

[xxxviii] Mental health-related medications encompass the broad groups *Antipsychotics*, *Anxiolytics, Hypnotics and sedatives*, *Antidepressants,* and *Psychostimulants*, *agents used for Attention deficit hyperactivity disorder (ADHD) and nootropics*.

- As highlighted in Report Card 2023, there are significant data gaps for mental health service activity, particularly for General Practitioners, non-government organisations, digital mental health tools and services, ambulance services and public community and residential mental health services.

It also important to note that service access data cannot indicate whether people are accessing the right services to meet their needs or whether people can readily access care without barriers. This highlights the need for more robust national data on consumer's experience of services.

To what extent does the system provide continuity of care and deliver coordinated services?

Australia's mental health system is complex, consisting of a range of different service offerings across the stepped care continuum. People commonly move across and between different treatment settings, healthcare practitioners and levels of care or support over time. However, due to the complexity and fragmentation of the current system, service users can experience significantly interrupted and unconnected care which lacks continuity. Research suggests continuity of care is critical to positive consumer experiences, higher satisfaction and improved outcomes[59,60]. Increasing meaningful measures of continuity of care will be important in understanding overall system effectiveness.

High or increasing rates of community follow-up after hospitalisation for mental health can indicate the system is performing well in providing continuity of care. The national rate of community follow-up for people within the first 7 days of discharge from an acute inpatient psychiatric unit was 76.2% in 2022-23, an increase over the 10 years from 2013-14 (67.4%). However, it should be noted that rates have remained relatively consistent over the past 4 years (ranging from 75.1% and 76.2%) and for some target populations, rates declined between 2021-22 and 2022-23. In particular, for people living in 'Remote and very remote' areas there was a drop from 77.2% in 2021-22 to 70.2% in 2022-23. When considering this data, however, it should be acknowledged that only community mental health care delivered by state funded services is captured. It is therefore unclear to what extent community-follow up after hospitalisation is improving when considering all components of the system that provide community mental health care. In addition, data on post-discharge community mental health care cannot indicate why some people do not access community mental health care following their discharge from hospital.

Readmission to hospital within 28 days of discharge from inpatient treatment may indicate that treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person's treatment out of hospital. As such, a low or decreasing rate of readmissions may suggest that the system is performing well in providing coordinated services and enabling continuity of care[xxxix]. In 2022-23, the national rate of readmission to hospital acute psychiatric units within 28 days of discharge was 13.7%. This is slightly lower than the rate reported in 2021-22 (14.7%) and is the lowest rate reported over the past 10 years.

It should be acknowledged that the data we currently have available to measure continuity of care is focused on people who receive care from public hospitals. However, we know people access mental health care in a range of settings outside of public hospitals, including GPs and private practices. As such, overall, we know relatively little about the extent to which the system as a whole provides uninterrupted care across programs and providers.

[xxxix] Readmissions may be planned (i.e., related to routine care) or unplanned. This measure does not distinguish between planned and unplanned readmissions and therefore caution should be used when interpreting changes in rates over time.

So, how are things tracking overall?

Overall, many of our core indicators are not showing improvement or have shown some deterioration in recent years. We have also seen a steady rise in financial stress and the proportion of people in Australia delaying mental health care due to cost.

When considering Australia's broader environmental context—from ongoing cost of living pressures, heightened tensions over continuing geopolitical conflicts and rising mortgage stress and household prices—many of the trends observed in this report are not surprising. However, they do reinforce the urgent need for a broad and multi-faceted prevention approach, as well as a need to address current barriers to accessing care.

While much of the data presented in this report is not encouraging, there are some positive stories to take away from this report. In particular, in recent years we have seen:

- a narrowing of the gap in employment rates between those with a mental health condition and those without
- continuing progress in reducing the national seclusion rate, particularly for children and adolescents
- an increase in the proportion of people with a mental disorder accessing treatment.

Nevertheless, we know that a significant proportion of Australians with mental health challenges are not accessing (or are delaying) care they need and, among those who do access care, clinical outcomes have not shown significant improvement in recent years (particularly for those living in remote and very remote areas). We also continue to see significant gaps in outcomes between those with a mental health condition and those without across a range of factors, including homelessness, loneliness and experiences of discrimination. This is not acceptable.

Despite growth in mental health data development in recent years, there are still significant challenges in providing a full assessment of how the system is performing due to national data gaps. To effectively influence change and inform planning, we need to better understand:

- the needs, experiences and outcomes of people who receive support through all areas of the system (including non-government organisations and the private sector), and their families, carers and kin
- the level of unmet need across the Australian population, including whether the current mental health workforce is sufficient and appropriate in supporting the needs of people with mental health challenges
- how well the various components of the mental health and adjacent systems interact and fit with one another to deliver a cohesive system
- the impact and efficacy of the current level of expenditure invested into the system each year on the experiences and outcomes of people who receive support, as well as their carers and kin.

We are excited to work with our partners towards a more robust and complete picture of system performance that will influence action and affect change.

Future Directions

The Commission's Report Card framework is intended to provide a foundation to build on over time. Future Report Cards will continually evolve in line with the maturing data landscape, while retaining a level of consistency that enables comparison across time.

While the National Report Card 2024 goes some way in illuminating how Australia's mental health system is performing in meeting people's needs, there are several data gaps which limit our current understanding.

In particular, much of the available data continues to focus on system activity, with fewer measures available relating to the needs, experiences and outcomes of consumers, families, carers and kin. We need to find ways to better capture and reflect the outcomes that matter most to people, and what is required to bring us closer to a well-functioning mental health system. We also need to better understand the extent to which the size and distribution of the mental health workforce is sufficient in supporting the needs of people with mental health challenges. Growing understanding of how people move through the system to receive connected and continuous care will also be an important factor assessing system performance.

There is still a long way to go in building our framework, particularly for Domain 3. Over time, we want to ensure our reporting framework captures all the elements of an effective mental health system and provides a picture that resonates with people's experience of the system.

Moving forward, the Commission intends to work towards a more robust and comprehensive picture of system performance that will influence action and affect change. Our partners—including relevant government bodies, the sector, lived experience representatives (including the National Mental Health Consumer Alliance and Mental Health Carers Australia) and data custodians—will be fundamental in achieving this.

We will be engaging further with our stakeholders to understand what opportunities exist to facilitate a more robust analysis of system performance that:

- appropriately captures performance across all relevant service areas of the system, including the non-government and private sector, as well as psychosocial supports provided through the NDIS
- asks the right questions about how the system is performing and presents the right data to inform system improvements and influence change
- draws on robust quantitative and qualitative data from relevant stakeholders, including people with lived experience of mental health challenges and those that support them, to provide a comprehensive picture.

We are committed to engaging with relevant government bodies, the sector, people with lived experience and relevant data custodians to achieve these aims. In collaboration with our partners, we will continue to build our understanding of the data landscape and opportunities to expand our framework. In the second half of 2025 and early 2026, we will be partnering with Mental Health Australia and the sector to explore opportunities to increase representation of non-government services in future iterations of the Report Card to provide a more complete view of system performance (see Box 8). The Commission will be consulting further with governments, lived experience representatives and the sector and engaging with a wide range of stakeholders to identify the elements of system performance that are most critical for monitoring and reporting at a national level.

Box 8. Non-government mental health sector data

The non-government mental health sector incorporates a wide range of non-profit, community-based supports provided across the mental health continuum, from prevention and early intervention to treatments for severe and complex mental illness. In Australia, the non-government mental health sector is a critical part of the mental health system and there is ample evidence demonstrating the value of these supports in supporting people in distress. Despite the importance and prevalence of these services, there is a currently a significant gap in national reporting on these mental health services.

In the second half of 2025 and early 2026, the Commission will be partnering with Mental Health Australia and the sector to explore opportunities to increase representation of non-government services in future iterations of the Report Card. This will include targeted engagement with non-government service providers and Australian Government agencies who currently collate non-government mental health service data. The project will seek to understand what data is currently collected across the system and explore options to increase systemic data collection and reporting to support holistic representation of the non-government sector in future Report Cards.

Addressing data gaps takes significant time, investment and coordination. The work with Mental Health Australia is intended to be a useful starting point in identifying areas for future improvements to our framework and we look forward to reporting on the outcomes of this consultation in the next iteration of the Report Card.

We are ambitious for the future and committed to continuing work with our partners to ensure we are reporting on what matters most to people and our framework reflects an evolving mental health system.

Appendix A

Supplementary data sources

Table A1. Supplementary data source technical information

Title - Custodian	Collection frequency	Description	Methodology	Sample	Limitations
ANUPoll – ANU Centre for Social Research Methods	Quarterly	*ANUPoll* aims to assess various wellbeing related measures, as well as Australians' opinions on important and topical issues (e.g., perceptions on the Voice referendum), with an emphasis on international comparisons.	• Nationally representative • Cross-sectional • Not all data items are collected on an ongoing basis • Predominantly online survey data collection with some telephone interviews	In Jan 2024: • 4,057 individuals	• Volunteer bias from online survey and panel-based sampling • Some concepts are assessed using small sets of questions, limiting the quality of assessment • For further information on the methodology and limitations, please use the following link.
Household, Income and Labour Dynamics in Australia Survey (HILDA) – The Melbourne institute	Annually	The *HILDA Survey* collects information about economic and personal well-being, labour market dynamics, and family life of Australian residents.	• Nationally representative longitudinal study of Australian Households • Not all data items are collected annually • Mostly face-to-face interviews with some conducted over telephone	In 2022: • 9,003 households • 15,954 individuals	• The long-term mental health condition response group has small sample sizes, making it difficult to detect statistical differences • Survey attrition • Response rates • Questionnaire design • For further information on the methodology and limitations, please use the following link.
Scanlon Mapping Social Cohesion Survey – Scanlon Foundation Research Institute	Annually	The *Scanlon Mapping Social Cohesion Survey* collects information on Australian's attitudes, perceptions, and behaviours towards social cohesion, immigration, multiculturalism, wellbeing and other topical issues.	• Nationally representative • Cross-sectional • Predominantly online survey data collection with some telephone and face-to-face interviews	In 2024: • online panel-based sample • 7,965 individuals • 229 additional targeted individuals • 45 additional in-depth interview individuals	• Volunteer bias from online survey and panel-based sampling • There has previously been issues with representativeness of different nationalities • For further information on the methodology and limitations, please use the following link.

Title - Custodian	Collection frequency	Description	Methodology	Sample	Limitations
National Aboriginal and Torres Strait Islander Health Survey – Australian Bureau of Statistics	Every 6-7 years	The NATSIHS collects information on health, use of health services, health risk factors, and the social and emotional wellbeing of First Nations people.	• Nationally representative • Cross-sectional • Collected via face-to-face interviews	In 2022-23: • 7,839 households • 7,768 individuals	• Response rates • For further information on the methodology and limitations, please use the following link.
Labour Force – Australian Bureau of Statistics	Monthly	*Labour Force* includes information related to employment, underemployment, participation and hours worked.	• Nationally representative • Cross sectional • Mixed collection methods for face-to-face, telephone and online survey	In Dec 2024: • 24,000 dwellings • 50,000 individuals	• For further information on the methodology and limitations, please use the following link.
Education and Work – Australian Bureau of Statistics	Annually	*Education and work* is conducted as a supplement to the monthly *Labour Force* Survey. It includes information on engagement in work and/or study, current and recent study, qualifications, and transitions to work.	• Nationally representative • Cross-sectional • Mixed collection methods for face-to-face, telephone and online survey	In May 2024: • 24,000 dwellings • 50,000 individuals	• Data is only collected in May of every year and may not be representative of other months of the year • For further information on the methodology and limitations, please use the following link.
Census – Australian Bureau of Statistics	Every 5 years	The *Census* is the most comprehensive snapshot of Australia and tells us the economic, social and cultural make-up of the country.	• Nationally representative • Collected via paper forms and online survey	In 2021: • entire Australian population • response rate of 96.1% (private dwellings)	• Lower response rate in the Northern Territory • Undercount of First Nations populations • For further information on the methodology and limitations, please use the following link.

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AEDC	Australian Early Development Census
Ahpra	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
ASGS	Australian Statistical Geography Standard
CES	Mental Health Carer Experience Survey
CI	Core Indicator
CIDI 3.0	World Mental Health Composite International Diagnostic Interview, version 3.0
Commission	National Mental Health Commission
ED	Emergency Department
FTE	Full Time Equivalent
GP	General Practitioner
GSS	General Social Survey
HILDA	Household, Income and Labour Dynamics in Australia
LSIC	Longitudinal Study of Indigenous Children
MBS	Medical Benefits Schedule
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
NDIS	National Disability Insurance Scheme
NHS	National Health Survey
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework
NOCC	National Outcomes and Casemix Collection Database
NSMHW	National Study of Mental Health and Wellbeing
NSPO	National Suicide Prevention Office
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Schedule
PESTEL	Political, Economic, Social, Technological, Environmental and Legal
Qld	Queensland
RC2023	National Report Card 2023
RC2024	National Report Card 2024
RoGS	Report on Government Services
SEIFA	Socio-Economic Indexes for Areas
SEWB	Social and emotional wellbeing
Vic	Victoria
WA	Western Australia
YES survey	Your Experience of Service Survey

Glossary

Affective Disorder
Affective disorders involve mood disturbance or change in affect. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations.

Admitted mental health care
A specialised mental health service that provides overnight care in a psychiatric hospital or a specialised mental health unit in an acute hospital.

Ambulatory mental health care
Mental health care provided to hospital patients who are not admitted to hospital, such as patients of emergency departments and outpatient clinics. The term is also used to refer to care provided to patients of community-based (non-hospital) health care services.

Anxiety Disorder
Anxiety disorders generally involve feelings of tension, distress, or nervousness. A person may avoid, or endure with dread, situations which cause these types of feelings.

Community mental health care
Government-funded and government-operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics.

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

Loneliness
The loneliness measure is based on a 3-item scale ('People don't come to visit me as often as I would like', 'I often need help from other people but can't get it', 'I often feel very lonely').

Long-term health condition
In the *HILDA survey*, the term 'long-term health condition' is used to describe any long-term health condition, impairment or disability which a respondent reports restricts them in their everyday activities, and which has lasted or is likely to last for 6 months or more. People with a long-term mental health condition are respondents who indicated they had a nervous or emotional condition which requires treatment or/and any mental illness which requires help or supervision.

Mental disorder
A mental disorder is characterised by a 'clinically significant disturbance in an individual's cognition, emotional regulation, or behaviour[61]'. The term itself covers a range of disorders including anxiety, affective and substance use disorders.

National Mental Health Service Planning Framework
A framework to guide evidence-based decision-making about the mix and level of mental health services and workforce needed to meet local circumstances.

Non-government organisations
Private organisations (both not-for-profit and for-profit) that receive government and/or private funding. Usually these services are focused on providing well-being programs, support and assistance to people with mental health challenges.

Restraint
The process of holding down or stopping a person from moving freely, either through use of an item (i.e., mechanical restraint) or one's hands or body (i.e., physical restraint).

Seclusion
The confinement of a consumer/patient at any time of the day or night alone in a room or area from which free exit is prevented.

Specialised mental health services
Services with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. This includes admitted patient mental health care services, ambulatory mental health care services and residential mental health care services.

Substance use disorder
Substance use disorders involve the harmful use and/or dependence on alcohol and/or drugs. The misuse of drugs, defined as the use of illicit substances and the misuse of prescribed medicines, included opioids, cannabinoids, sedatives and stimulants.

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