


Monitoring and reporting on Australia's mental health system

National Report Card 2025


Australian Government
National Mental Health Commission





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Acknowledgements

Acknowledgement of Country

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.

We pay our respects to their clans, and to the elders, past and present, and acknowledge their continuing connection to land, sea and community.

Recognition of Lived Experience

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

The Commission's Report Card presents a population-level view of mental health in Australia, drawing on large-scale data and trends. We acknowledge that behind every statistic is a person and their lived experience.

We are privileged to report on high-quality data and evidence and thank everyone who has participated in surveys, shared their experiences through data collection, and contributed to advancing knowledge and practice in this field.

Contributors

The Commission greatly acknowledges the assistance and expertise of the Australian Institute of Health and Welfare and the Australian Bureau of Statistics. The Commission also acknowledges those who helped shape this work through their engagement in the Report Card Working Group.

A note on language

The Commission acknowledges that language relating to mental health and suicide is not neutral and evolves over time. It can influence how people experience, interpret and respond to these issues, carry different meanings for different people and communities, and may at times be contested. 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.

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

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CEO's Foreword

I am pleased to present the National Mental Health Commission's National Report Card 2025 on mental health and wellbeing. The National Report Card is Australia's key mechanism for monitoring mental health system performance. It brings together evidence on mental health outcomes, the factors that shape wellbeing, and the services that support people experiencing mental health challenges.

In our last National Report Card 2024 we saw a society experiencing a declining sense of control and continued high levels of psychological distress. Signs of financial stress were elevated, discrimination remained common, and experiences of loneliness were all too high. We also noted that the available data provided only a limited view of the extent to which care was improving outcomes for people.

This year's Report Card highlights both progress and opportunity. Promisingly, we are seeing more investment in the mental health system announced in 2025, and more people accessing support. However, the impact of this investment is unevenly distributed across society. There are signs that our service system isn't facilitating access early enough for those experiencing mental health challenges and a workforce projected to continue to fall short of need. People experiencing mental health challenges continue to report lower life satisfaction and higher levels of loneliness, discrimination and financial stress than the broader population.

These findings reinforce that mental health is shaped by more than healthcare alone. Financial strain, housing stress, climate change, technological shifts and the strength of our communities all influence mental health and wellbeing.

Our service system must be reformed to better meet the diverse needs of those it serves. The National Agreement on Mental Health and Suicide Prevention is due to expire on 1 July 2027. This presents a critical opportunity for governments to come together to set a fresh vision for our mental health system. Achieving these reforms requires us to work in partnership with people with a lived experience of mental health challenges, and those who care for them.

This Report Card also highlights the critical need to improve our national evidence base. Significant gaps remain in data on outcomes, service experiences, continuity of care and the contribution of non-government services. Better information will support better decisions, more targeted investment and a clearer understanding of what improves people's lives.

I thank the Australian Institute of Health and Welfare, the Australian Bureau of Statistics, Mental Health Australia, the National Mental Health Consumer Alliance, the Indigenous Australian Lived Experience Centre, Mental Health Carers Australia, members of the Report Card Working Group, and the many organisations and individuals who contributed their expertise to this report.

The Commission remains committed to continually improving our reporting framework to ensure it reflects emerging issues and advances in data availability. I encourage you to explore the findings of the *National Report Card 2025* and consider the opportunities they present to build a mentally healthier Australia.

David McGrath
Chief Executive Officer of the
National Mental Health Commission

Key Insights

Each year, the National Mental Health Commission delivers a Report Card, which is Australia's key monitoring and reporting mechanism to assess the performance of our mental health system.

Since 2023, our Report Card has utilised a clear, evidence-informed reporting framework to monitor and report on mental health outcomes, social determinants and system performance.

We continue to evolve our framework over time to ensure it asks the questions that matter and draws on latest available data and evidence.

Here we explore this year's key insights across our 3 domains, highlighting insights based on updated data since our last Report Card. More detail against each of our indicators is explored throughout this report.

Domain 1 Mental Health

Need remains high but is not fully visible in the data.

Psychological distress is common across the Australian population (aged over 15 years).

14.9%
Experienced **high** psychological distress

9.2%
Experienced **very high** psychological distress

People with a mental health condition were more likely to experience very high psychological distress.

30.7%
With a mental health condition

Compared with

5.9%
Without a mental health condition

Life satisfaction remains significantly lower for people with a mental health condition.

5.8/10 With a mental health condition

7.4/10 Without a mental health condition

This gap has not improved since 2020.

Domain 2 Social Determinants

Overall, people with mental health challenges face greater social pressures and poorer wellbeing outcomes.

People with a mental health condition are almost twice as likely to experience discrimination.

Than people who don't have a mental health condition.

31%

of specialist homelessness services clients **had a current mental health issue.**

Up from 25% in 2014/15

Financial stress remains higher for people with a mental health condition.

1 IN 3
With a mental health condition

Compared with

1 IN 5
Without a mental health condition

This gap has not improved on previous years.

Domain 3 Mental Health System

The service system is doing more, but uneven access, system fragmentation, workforce pressures and data gaps limit impact and opportunity to improve.

More Australians are accessing subsidised mental health services.

% of Australians who have received one or more Medicare/ DVA subsidised mental health-related services.

8.4%
2013-14

10.6%
2023-24

Service access is over three times higher in major cities than remote areas.

Medicare mental health-related services received per 1,000 people.

507
Major cities

473
National average

156
Remote/very remote

Cost is becoming a greater barrier to accessing mental health care.

% indicating cost as a reason for not seeing a mental health professional

12%
2020-21

20%
2024-25

Future reform needs to combine prevention, service system improvement, workforce growth and more comprehensive national data.

Domain 1 Mental Health

Need remains high but is not fully visible in the data

Experiences of psychological distress are common, but this doesn't tell us everything about community need

- We know that in 2025 **psychological distress is common** (14.9% of people aged 15 experienced high psychological distress, and 9.2% experienced very high psychological distress)[1]
- We know that people with a mental health condition were:
  - **Five times as likely to experience very high psychological distress**[i] (30.7% compared with 5.9% of people who do not have a mental health condition).
  - And twice as likely to experience high psychological distress (29.4% compared with 12.6% of people who do not have a mental health condition).[2]

However, looking at psychological distress alone cannot tell us about the full extent of need in the community. National mental health prevalence data has not been updated since 2020-2022.

People who experience mental health conditions continued to report lower satisfaction with life overall

- In 2025, people who have a mental health condition had an overall **life satisfaction** rating of **5.8**, compared with people who do not have a mental health condition (7.4).[ii] This gap has not narrowed since 2020.
- This gap is even **more pronounced in young people** aged 15-24 years with a mental health condition, compared to young people of the same age without a mental health condition.[3]

i In this context, psychological distress is measured by the self-report Kessler Psychological Distress Scale - 10 (K10), which is a 10-item questionnaire that asks how a person has been feeling over the past four weeks.
ii ABS, 2025 General Social Survey, which measures overall life satisfaction for people aged 15 years and over on a scale from 0 to 10 - where 0 means 'not at all satisfied' and 10 means 'completely satisfied'.

Domain 2 Social Determinants

Overall, people with mental health conditions face greater social pressures and poorer wellbeing outcomes

People with mental health conditions are disproportionately experiencing loneliness and discrimination

- Overall, the estimated proportion of people aged 15 and over experiencing loneliness has remained relatively steady between 2011 (15.3%) and 2024 (15.4%).[4]
- In 2024, **people with a long-term mental health condition were almost 3 times as likely to report loneliness** as those without a long-term health condition (35.0% compared with 12.2%).[5]
- In 2025, **people with a mental health condition were almost twice as likely to experience** discrimination or be treated unfairly, compared with those without a mental health condition (31.2% and 16.3%, respectively).[6]

Demand for homelessness support is increasing

- Persistent homelessness is increasing in Australia, **with the largest growth in absolute numbers among those with a current mental health issue, alongside Aboriginal and Torres Strait Islander clients.**
- Between 2018–19 and 2024–25, the number of Specialist Homelessness Services clients experiencing persistent homelessness rose by **39%**, from around 29,500 to 41,100 clients.[7]
- In 2024-25, **31% of all Specialist Homelessness Services clients (around 88,800 clients) had a current mental health issue, up from 25%** in 2014-15 (around 62,900 clients).[8]

Financial stress is increasing, especially for people experiencing mental health conditions

- In 2025, more than 1 in 5 (21.2%) people in Australia aged 15 years and over could not raise $2,000 within a week, a proportion which has steadily increased over time (13.1% in 2014 and 18.8% in 2020).[iii]
- Between 2011 and 2024, people living in areas classified as the most disadvantaged were the most likely to experience financial stress.[iv]

We continue to see a heightened gap in financial stress for people experiencing mental health conditions.

- In 2025, almost 1 in 3 (31.6%) people who had a mental health condition could not raise $2,000 within a week, compared with almost 1 in 5 (19.6%) people who did not have a mental health condition. **This gap has not improved** compared to previous years.[9]

iii This data refers to a survey question in the ABS 2025 General Social Survey, which reports on the proportion of people aged 15 years and over living in households in Australia that are unable to raise $2,000 within a week for something important.
iv AIHW analysis of survey data from *the Household, Income and Labour Dynamics in Australia Survey (HILDA)*. The data presented here are classified according to the SEIFA Index of Relative Socio-economic Advantage and Disadvantage (IRSAD).

Domain 3 Mental Health System

The service system is doing more, but uneven access, system fragmentation, workforce pressures and data gaps limit impact and opportunity to improve

There are indications that service use is increasing, alongside investment, but we need a clearer picture of whether this is meeting need

- For example, between 2013-14 and 2023-24 there was **an increase** in the proportion of Australians who received one or more Medicare/Department of Veterans' Affairs subsidised mental health-related services (from 8.4% to 10.6% of the population).[10]
- Over the same period, we have seen increased government spending on mental health-related services from $10.7 billion to $14.5 billion, representing **an increase of 35% in real terms**. Over this period, per capita spending increased from $460 to $537.[11]

Despite growth in services, access still depends on where you live and your circumstances

In 2024-25:

- **People living in Major cities still used Medicare mental health-related services at a higher rate** (507 mental health services per 1,000 people living in Major cities), compared to the rate for the overall population (473 mental health services per 1,000 of Australians).[12]
- This contrasts sharply to **people living in Remote/Very remote areas, who used these services at a much lower rate (156 mental health services per 1,000 people living in Remote/Very remote areas).**[13]
- During 2024-25, **people living in the most disadvantaged areas used fewer Medicare mental health-related services** (300 services per 1,000 people living in areas classified as SEIFA Quintile 1), compared to people living in areas of least disadvantage **who used services at more than twice this rate** (710 services per 1,000 people living in areas classified as SEIFA Quintile 5).

At the same time, people living in the most disadvantaged areas had **higher rates** of mental health-related **emergency department (ED) presentations** (155 per 10,000 people), compared to people living in the least disadvantaged areas who had the lowest rates (72 per 10,000 people).[14] This can be a sign that early access to community or hospital-based services is lacking, and warrants further exploration.

Mental health-related emergency department presentations are not decreasing overall, and people are waiting longer to be seen

- Nationally, mental health-related ED presentation rates decreased from 121 presentations per 10,000 people in 2020-21 to 109 in 2021-22 and remained stable in 2022-23, before increasing again to 116 presentations per 10,000 people in 2024-25.
- The proportion of mental health-related ED presentations **being seen on time has decreased from 71% during 2014-15 to 60% during 2023-24**.[15]

Cost remains a persistent barrier to care

- The proportion of people aged 15 years and older indicating cost as a reason for not seeing a mental health professional[v] **increased from 12% during 2020-2021 to 20% during 2024-2025.**[16]
- In 2024-25, people aged 25-34 and people living in areas of most disadvantage were more likely to report cost as a reason for not seeing a mental health professional when needed.[17]

v Includes GPs, psychiatrists, psychologists, mental health nurses, social workers, counsellors and occupational therapists.

The mental health workforce is growing*, but still projected to fall short of need

Between 2015 and 2024 we saw:

- Growth in the full-time equivalent (FTE) rate per 100,000 people for mental health occupational therapists (43% increase from 7 to 10), psychologists (28% increase from 88 to 113), mental health nurses (20% from 84 to 101), and psychiatrists (15% increase from 13 to 15).[18]
- However, future gaps in supply are projected for psychiatrists and psychologists.

**Most of our national data represents care delivered in publicly funded settings and does not represent the full quantum or breadth of the workforce. The contributions of the peer workforce and their impact is growing, with work underway to increase knowledge and data about this sector.*

Key data gaps continue to limit our understanding and opportunities for system improvement

The current scope and scale of mental health-related activity reporting provide a broad overview of how people in Australia interact and engage with the mental health system. However, evidence-informed investments such as targeting funding to areas of greatest need are difficult with stark gaps in data and evidence. Key data gaps include:

- A lack of regular, longitudinal and nationally representative prevalence data to support a contemporary understanding of need and how it is changing over time.
- **Outcome measurements** across a broader range of care settings. This is required to better understand the extent to which mental health services are improving outcomes for people. Existing nationally representative outcome measures largely only include publicly funded services.
- Lack of national data that measures service navigation, care continuity and movement between services is preventing **a holistic understanding of how well the system supports people**.
- **Carer, family and kin experiences** and outcomes are integral insights into how well services are working. However, the broader impacts of mental health challenges on families, carers and kin are not consistently measured. This limits our ability to fully quantify need and to effectively plan and deliver supports. When care is not accessible or is delayed, families and carers may take on additional caring and system-navigation responsibilities, which can in turn impact their own wellbeing.

Looking Forward

Report Card 2025 shows a complex picture. Mental health need remains high, and people with mental health conditions continue to experience poorer wellbeing and greater exposure to social and economic pressures. At the same time, service use and investment have increased. Access remains uneven, cost continues to be a barrier to care, the workforce is not sufficient to meet projected need, and critical data gaps continue to limit our understanding of whether services are improving outcomes.

So where to from here?

Future reform needs to combine prevention, service system improvement, workforce growth and more comprehensive national data.

Meaningful reform requires **a clear long-term vision for Australia's mental health system**, guided by what the data and lived experience tells us about need, access and outcomes.

The findings in this Report Card point to two reform priorities. Australia needs to **strengthen prevention by addressing the social and economic conditions that shape mental health** and wellbeing; while also **improving the mental health service system so people can access the right support** earlier, affordably and regardless of where they live or their circumstances.

This means continuing to **strengthen social inclusion, reduce stigma and discrimination,** and **ensure critical social services** — including housing, employment, education and community support — **are equipped to respond to people with mental health needs**, especially those experiencing multiple and intersecting forms of disadvantage.

There are clear opportunities to **improve mental health service planning,** so services better meet need, embed earlier support, and provide timely access to low or no cost care for those who need it. Continued effort is also required to build **an effective mental health workforce across all roles**, in line with the National Mental Health Workforce Strategy 2022–2032.

Better data is also critical. Current gaps make it harder to understand need, access and outcomes across the mental health system, limiting our ability to plan services, target investment and assess whether reforms are making a difference. Priorities include:

- **Regular, longitudinal and nationally representative prevalence data** to support a contemporary understanding of need and how it is changing over time.
- **Better data on** the distinct experiences and outcomes of consumers and families, carers and kin, including how people navigate and are supported to move through the mental health system.
- Outcome measures across a broader range of care settings, particularly services delivered by non-government organisations, which remain underrepresented in national data collections.
- **A stronger understanding of unmet need,** moving beyond measures of service activity and utilisation to better understand who is not accessing care and whether services are improving outcomes for people.

The Commission will continue to refine the Reporting Framework over time, so it can responsively capture the issues that shape mental health in Australia. This can support a clearer understanding of where reform is making a difference.

Continue reading our Report Card to explore these findings in greater detail and learn how we are building on our reporting approach.

Introduction

Independent and impartial performance monitoring and reporting, supported by high quality and comprehensive data systems, is essential to improving Australia's mental health system. It promotes transparency in how the system is meeting the needs of Australians and identifies where improvement is required. In doing so, it helps ensure approaches to preventing and responding to mental health challenges remain effective and responsive to current and future needs. As the National Mental Health Commission (the Commission) does not design, deliver or fund services, it is uniquely placed to undertake this role at a national level.

Through our monitoring and reporting function, we provide an independent, system-level assessment of progress, performance and reform across Australia's mental health system. By bringing together data, evidence and stakeholder and lived experience perspectives, we assess whether government actions are contributing to meaningful reform and better outcomes for people and communities. Monitoring and reporting serves both an accountability and reform-enabling function, helping to track progress, identify gaps, support course correction, and prepare for emerging risks and opportunities.

Since 2012, the Commission has produced the Annual National Report Card on the performance of the mental health system. Drawing on national data collections, these reports identify what is working well, where improvement is needed, and inform efforts to strengthen outcomes for people with mental health challenges.

The National Report Card 2023 (RC2023) introduced a refreshed approach to annual reporting and established a more consistent framework for objective monitoring of system performance over time. This framework has been continued through the National Report Card 2024 (RC2024) and National Report Card 2025 (RC2025).

Our Report Card Framework considers three domains:

- the mental health and wellbeing of Australians;
- the broader social factors that influence mental health; and
- the performance of the mental health system.

This approach reflects the interconnected nature of the factors shaping mental health outcomes.

Across these domains, we consider the latest available data and information on key mental health and wellbeing measures (such as prevalence of mental health conditions and psychological distress) to inform an understanding of mental health in Australia. We examine social determinants that influence mental health and wellbeing outcomes, such as housing, education, employment and developmental vulnerability in childhood. We assess differences in experience between people with mental health conditions and the broader population to identify areas where they may be disproportionately affected by factors such as financial stress or discrimination. We also assess the mental health service system, examining its accessibility, effectiveness, sustainability, and the extent to which people experience safe and integrated care.

Collectively, this work helps identify where action is needed across policy sectors to support prevention efforts and improve care for people experiencing mental health challenges.

Progress since last Report Card

The Commission has been working with stakeholders to continue to improve the National Report Card each year so that it reports in a clear and compelling way. Our Reporting Framework is built on a core set of initial indicators supported by reliable national data and provides a foundation for ongoing development.

This year, we have worked to advance our Reporting Framework through evolving Domain 3 - the Mental Health System which previously had no defined indicators. This Report Card introduces key themes and measures to explore this complex area. We achieved this through:

- Establishing our Report Card Working Group to improve our understanding of the complex mental health system performance, useful datasets and future measures, so we can monitor the progress of the mental health system effectively over time; and
- Partnering with Mental Health Australia to explore opportunities to include data from non-government organisations delivering mental health services in the community.

This builds on the work of previous report cards. Our 2023 and 2024 editions assessed 13 initial indicators across our first and second domains.

We will continue to strengthen our approach through engagement with governments, the sector, people with lived experience and data custodians to support robust assessment of system performance over time.

Reading Report Card 2025

The Report Card's Reporting Framework aims to deliver a comprehensive and holistic view of mental health, informed by a range of evidence sources, while also acknowledging that infrequent updates between key data sources and data gaps limit our understanding in areas.

Environmental Scan 2025

The National Report Card Environmental Scan reflects on the 2025 calendar year period (1 January-31 December 2025) to identify major trends and events which may have affected the mental health of people in Australia. This provides a contextual grounding against which to consider the findings through our domains. A scan summary is presented in this Report Card. The full report can be found at: https://www.mentalhealthcommission.gov.au/publications/national-report-card-2025-environmental-scan

Domains 1, 2 and 3

Domains 1, 2 and 3 present a whole-of-life view of mental health, informed by analysis of data:

- collected up to and including December 2025; and
- data released and published up to and including June 2026.

A key part of the approach to the Commission's Report Card is looking at how outcomes for people experiencing mental health challenges differ to outcomes experienced across the broader population, as represented in the data.

We use an equity-focused lens through which to consider the data. For example, we do this by asking *"is it the same for everyone?"* throughout our analysis, and where possible from the data provide a break down on specific population groups. Population groups are defined by a variety of factors such as geography, culture, age, and socioeconomic status. Under-representation of some population groups in national data, such as people from culturally and linguistically diverse backgrounds, and people who identify as LGBTIQA+, can limit the understanding of mental health outcomes for these groups. Having high-quality, representative data would help identify specific mental health needs, monitor outcomes, and support improvements in policy, service planning, and access to care.

Throughout the domains, we actively call out and acknowledge where data gaps are limiting our understanding. While the Commission is not a data custodian, we do play a role in creating transparency around what is known about the system, and what is not well understood.

Developing the National Report Card

This section describes our monitoring and reporting approach, what changes we are implementing and our future directions for iterative improvements over time. This is complemented by our forthcoming Report Card Technical Report.

How well is the mental health system meeting the needs of people in Australia? - Our Reporting Framework

	Guiding Questions	Indicator	Data
Domain 1 Mental Health	**How mentally healthy are people in Australia?** **Is it the same for everyone?**	4 indicators focussing on the overall state of the population, combining prevalence of mental disorders and psychological distress, with life satisfaction and feeling in control.	
Domain 2 Social Determinants	**Are the factors that influence mental health improving?** **What are the experiences of people with mental health challenges compared to the community?**	9 indicators capturing broader social factors that shape mental health, such as early childhood development, housing security, financial stress and employment. Domains 1 and 2 will be revised with stakeholders	
Domain 3 (NEW) Mental Health System	**How do consumers, carers, family and kin experience the system, in terms of:**	**34 indicators examining the mental health system from multiple angles, including:**	
	Accessibility	12 indicators representing barriers and enablers to support, such as wait times (barrier) and mental health literacy (enabler).	
	Continuity of care	6 indicators on how well the system supports consumers, carers, family and kin to move through care.	
	Safety and quality	6 indicators on how consumers, carers, family and kin are treated and have their rights respected within the mental health system.	
	Sustainability and efficiency	5 indicators on system resourcing, inclusive governance and lived experience participation.	
	Effectiveness	5 indicators on how the mental health system is working, through experiential, clinical and ED data.	

A note on data

This visual diagram shows indicators with available data and indicators with identified data gaps.

Each coloured circle represents a data source currently used to report on the indicator (further detailed in Appendix 1). Indicators with identified data gaps are coloured in white.

Domain 3 now incorporates indicators to understand the mental health system. These indicators were identified because they are important components to understand about the mental health system. Some indicators in Domain 3 highlight gaps in data coverage which limit our understanding.

The diagram reflects a system that is fragmented with complex funding and service delivery arrangements that can make measurement difficult. This contributes to the tension between what the mental health system delivers compared to what we can practically measure. There are identified data gaps for 24 of the 34 indicators captured in Domain 3.

2025 Retrospective Calendar Year Environmental Scan

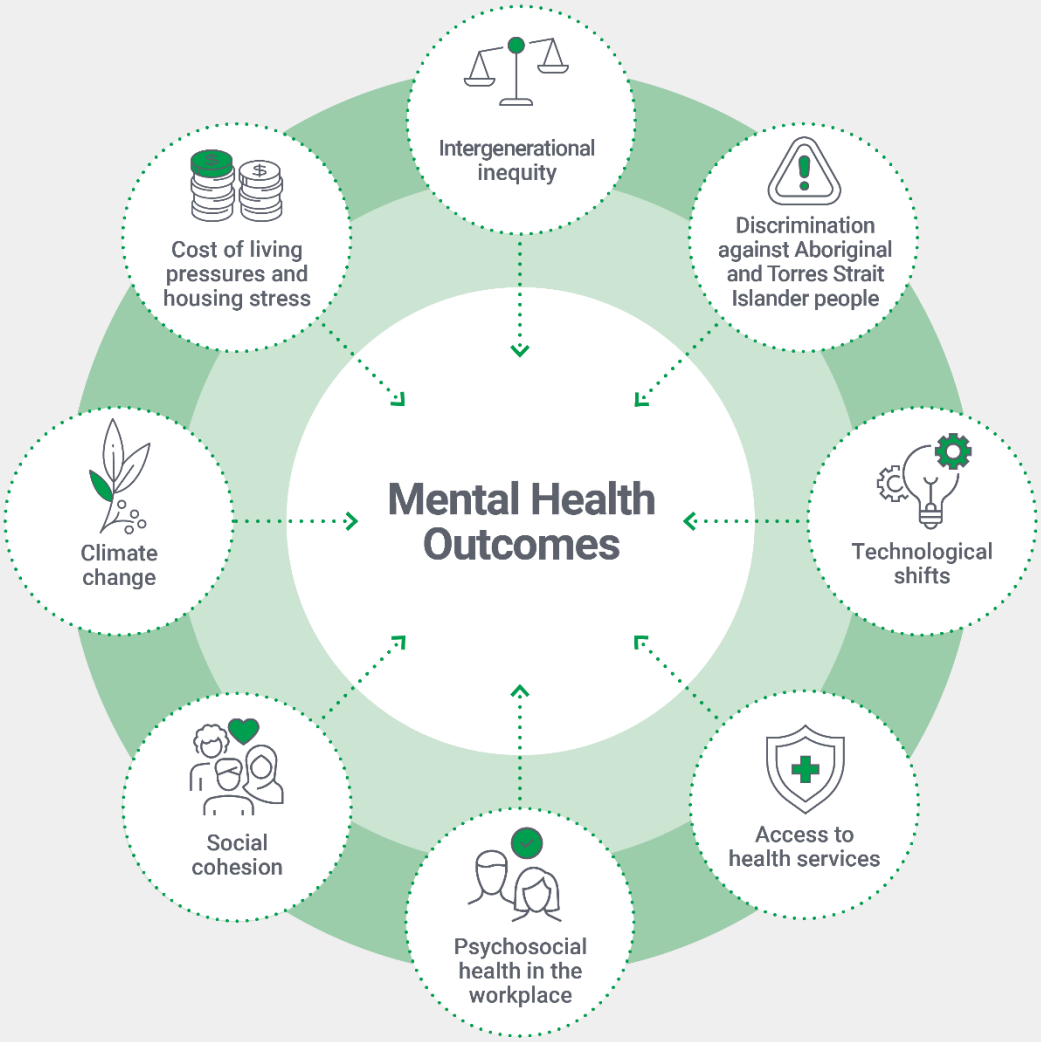
The Commission conducted a retrospective environmental scan of major events and trends that occurred between 1 January 2025 and 31 December 2025 to understand the external factors that had the potential to impact the mental health of people in Australia and to contextualise the data shown in this Report Card.

Each event/trend that emerged was assessed based on the estimated reach and size of the expected impact on the mental health of people in Australia, the strength of the evidence supporting a potential link between the event/trend and mental health outcomes, and the general relevance of the event/trend to the mental health of people in Australia.

Several interconnected themes emerged based on this evaluation that are summarised below and discussed in further detail in the separate National Report Card: Environmental Scan 2025, published on 12 August 2026.

These themes provide insight into the contextual environment of the 2025 calendar year and are intended to frame the changes in mental health outcomes described in the 2025 Report Card without suggesting they had a causal impact. The environmental scan involved a desktop review of reports, publications, media releases, peer-reviewed literature and other relevant outputs from organisations and institutions across sectors that influence mental health.

Cumulative and interconnected determinants that extend well beyond the health system...



Young people and Aboriginal and Torres Strait Islander people were disproportionately impacted by these themes.

Improving mental health and wellbeing in Australia will require more than simply expanding mental health services.

Cost of living and housing stress remained major pressures throughout 2025. Rising living costs, rental stress and housing affordability contributed to financial hardship and insecurity, and even influenced how often people access health care, including mental health care.[19]

[20 21 22 23] These pressures are no longer emerging issues but a persistent societal norm that poses increased risk to the longer-term mental health impacts for affected people in Australia.

Intergenerational inequity was evident in 2025, with young people disproportionately affected by cost-of-living pressures, housing insecurity, loneliness, workplace burnout and reduced optimism about the future. [24 25 26 27 28 29] Trans and gender diverse children and adolescents faced some uncertainty with the concurrent reviews into guidelines for gender-affirming care underway in 2025. [30 31 32 33 34 35] Demand for youth mental health supports increased, outpacing service availability and driving higher demand of web and phone supports. [36 37 38]

Climate change continued to impact communities in Australia with frequent natural disasters, including heatwaves, bushfires and floods. [39 40 41] There was growing recognition of climate-related mental health impacts in 2025, including eco-anxiety, disaster-related distress and a disproportionate impact on Aboriginal and Torres Strait Islander peoples. [42 43 44 45 46 47 48 49]

Discrimination against Aboriginal and Torres Strait Islander people intensified, with increased reports of racism (both direct and indirect) and record demand of services like 13YARN. [50 51 52 53] Experiences of discrimination and psychological distress were potentially compounded by ongoing over-representation of Aboriginal and Torres Strait Islander people in the justice system. [54 55 56 57]

Broader experiences of discrimination and prejudices in the context of global conflicts challenged **social cohesion** in Australia in 2025. [58 59] Perceptions of division increased, exacerbated by anti-immigrant sentiments and the Bondi Beach terror attack. [60 61] Misinformation and disinformation, particularly online, increasingly threatened to distort public perceptions and trust in institutions. [62 63] Despite these new and ongoing challenges, indicators of social cohesion remained stable in 2025 which was attributed to individuals' strong interpersonal connections and active participation in community. [64]

Technological shifts were a feature of 2025, particularly the growing use of AI and digital mental health tools (DMHTs) for mental health support, [65 66 67] and changes in the understanding and nature of harms posed by social media use. [68 69] These developments were significant enough to promote government action, including, but not limited to a review of the development and use of DMHTs, [70 71 72] the announcement of a new AI Safety Institute, [73] and eSafety regulations including the social media restrictions for young people.[74 75]

Psychosocial health in the workplace emerged as a significant concern, with mental health-related workers compensation claims continuing a record rise. [76 77] Hybrid work environments continued as a trend,[78] and there was an increasing shift towards using AI in workplaces. [79 80] Governments made some changes to address these shifting workplace trends, including improving how psychosocial risks are managed and increasing the thresholds for how psychological injury claims are defined and compensated. [81 82 83]

Access to health services remained constrained by increasing demand for public mental health care, long waits in emergency departments, GP workforce pressures, and psychiatrist shortages. The peer workforce was increasingly recognised as a valuable means of mental health supports, [84 85 86] and policy responses were announced to provide more free mental health services and support the mental health workforce.[87 88 89 90 91 92] The National Suicide Prevention Strategy 2025-2035 was released, [93 94] and the Productivity Commission finalised their review into the National Mental Health and Suicide Prevention Agreement, calling for a new overarching policy architecture to deliver effective and positive changes to the mental health system in the years to come. [95]

The Report Card Environmental Scan only captures a sample of events and trends from 2025, but those captured help contextualise the findings explored elsewhere in this Report Card. The Commission will continue to track events and trends over time to identify potential impacts on the mental health of people in Australia and the systems that support them.

Domain 1 Mental Health

This domain looks at dimensions of mental health and wellbeing, guided by the question, how mentally healthy are people in Australia?

Where available data allows, we also consider if the experience is the same for everyone.

To understand this question, the Commission draws on four indicators:

Key Insights - Need remains high but is not fully visible in the data

Experiences of psychological distress are common, but this doesn't tell us everything about community need

- We know that **psychological distress in 2025 is common** (14.9% of people aged 15 experienced high psychological distress, and 9.2% experienced very high psychological distress).[vi]
- We know that people with a mental health condition were:
  - **Five times as likely to experience very high psychological distress**[vii] (30.7% compared with 5.9% of people who do not have a mental health condition).
  - And twice as likely to experience high psychological distress (29.4% compared with 12.6% of people who do not have a mental health condition).[96]
  - However, looking at psychological distress alone cannot tell us about the full extent of need in the community.
  - National mental health prevalence data has not been updated since 2020-2022.

People who experience mental health conditions continued to report lower satisfaction with life overall

- In 2025, people who have a mental health condition had an overall life satisfaction rating of 5.8, which is lower when compared with people who do not have a mental health condition (7.4).[viii]
- This gap has not narrowed since 2020.
- This gap is even **more pronounced in young people** aged 15-24 years with a mental health condition, compared to young people of the same age without a mental health condition.[97]

[vi] ABS, 2025 General Social Survey, a nationally representative population survey based on data collected over a 2-month period from 1st May to 28th June 2025.
[vii] In this context, psychological distress is measured by the self-report Kessler Psychological Distress Scale - 10 (K10), which is a 10-item questionnaire that asks how a person has been feeling over the past four weeks.
[viii] ABS, 2025 General Social Survey, which measures overall life satisfaction for people aged 15 years and over on a scale from 0 to 10 - where 0 means 'not at all satisfied' and 10 means 'completely satisfied.

How mentally healthy are people in Australia?

Prevalence of mental disorders and psychological distress

The Commission monitors prevalence of mental health conditions to better understand population mental health needs over time and support evidence-informed policy, prevention and service planning.

- Prevalence of mental health conditions and psychological distress are shaped by a range of interacting social, economic, environmental and systemic factors. Looking at changes over time should be interpreted within this broader context. While a reduction in prevalence estimates could be an indicator of a well-functioning system and prevention approach, it is important to note that prevalence estimates can sometimes reflect improved recognition of mental health challenges, reduced stigma, better help-seeking and expanded diagnostic access.

While there is no new prevalence data to inform this Report, refer to **Box 1 - Gaps in timely prevalence data to inform mental health policy and planning,** we know mental health continued to be the most common reason for GP visits in Australia in 2025.[98] Consistent with these findings, the 2025 National Consumer Sentiment Survey (NCSS) reported that mental health conditions were the most commonly reported chronic condition (24.8%). In 2024, the 5 disease groups causing the most burden were cancer, mental health conditions and substance use disorders, musculoskeletal conditions, cardiovascular diseases and neurological conditions.[99]

Whole of population

As discussed in Report Card 2024, the latest data from the National Study of Mental Health and Wellbeing found 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.
  - This proportion equates to an estimated 4.3 million people and is slightly higher than the prevalence of mental disorders in 2007 (19.5%).
- Between 2007 and 2020-2022, anxiety disorders showed the largest increase in prevalence (from 13.8% to 17.2%).

The National Health Survey[ix] also provides additional information about the mental health of people in Australia. Latest available data from the National Health Survey in 2022 showed:

- An 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, from 13.6% in 2011-12, 17.5% in 2014-15, 20.1% in 2017-18 and 26.1% in 2022; and
- Mental and behavioural conditions are the most commonly reported chronic condition.

ix In the National Health Survey, 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. Whereas in the National Study of Mental Health and Wellbeing, the survey instrument assesses whether the person meets diagnostic criteria for a range of affective disorders, anxiety disorders and substance use disorders.

Is this the same for everyone?

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

There are also differences in the percentage of people reporting mental and behavioural conditions shaped by where people live and their circumstances. The latest available data from the 2022 National Health Survey shows the percentage of people reporting mental and behavioural conditions was higher for:

- people living in the most socio-economically disadvantaged areas (Quintile 1) (29.9%) relative to those in the least disadvantaged areas of Australia (Quintile 5) (20.1%).[x]
- people living in Inner regional Australia (29.1%) and Outer regional and Remote Australia (30.8%) relative to people in Major cities (24.8%).

Box 1 - Gaps in timely prevalence data to inform mental health policy and planning

Prevalence data can uniquely contribute to the policy evidence base because it informs understanding about changing population prevalence, and tells us about people who may need mental health care but have not used services or support.[100] In this way, prevalence data can inform understanding about estimates of need beyond data on mental health service use, which is limited to people who are receiving services.

The National Study of Mental Health and Wellbeing (NSMHW) is part of the Intergenerational Health and Mental Health Study, a group of seven health-related surveys conducted between 2020 and 2024.The NSMHW measures the prevalence and severity of mental disorders in Australia, the demographics of people experiencing mental disorders and access to mental health services; however, was last undertaken in 2020-2022.

Timely and nationally consistent prevalence data are critical to identifying emerging trends, inequities between population groups and opportunities for early intervention and system improvement. The Commission supports the Productivity Commission's recommendation for more frequently updated national prevalence data on mental health to better monitor trends, as outlined in its Review of the Mental Health and Suicide Prevention Agreement

When will we know more about prevalence for children and young people?

Timely and nationally consistent prevalence data are critical to identifying emerging trends, inequities and opportunities for early intervention and system improvement, especially for understanding prevalence trends among young people.

In 2025, the Commission welcomed the announcement of the forthcoming National Child and Adolescent Mental Health and Wellbeing Study (expected 2027), last updated in 2013-14. Fieldwork commenced in November 2025 and is expected to run for up to 12 months. Critically, this study will be updating the national prevalence rates of mental health disorders for Australian children and adolescents (aged 4-17), including examining changes since 2013-14. Future Report Cards will include this data when it becomes available.

[x] 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).

Psychological distress

Monitoring levels of psychological distress helps identify how people are experiencing and responding to social, economic and environmental pressures including experiences that may not meet diagnostic criteria for mental illness but still affect wellbeing and daily functioning.

Population-level distress is shaped by a range of contemporary drivers (including cost-of-living-pressures, housing insecurity, financial stress, social isolation, discrimination, climate-related concerns and digital environments) and can signal both emerging mental health risks and broader societal pressures. Tracking distress can also provide insight into emerging trends, inequities and unmet support needs across the community, supporting prevention and early intervention.

Whole of population

As reported in Report Card 2024 and based on latest available data from the National Health Survey (2022):

- The proportion of adults in Australia with high or very high levels of psychological distress significantly increased, from **10.8% in 2011-12**, to 13.0% in 2017-18 and **14.6% in 2022**.

However, it is important to note that the data collected in 2022 was during implementation of public health measures focused on reducing the spread of COVID-19. In response to these measures, we saw changes such as increased remote learning and working, as well as short-term financial support. These changes may have impacted behaviours and responses to this survey data at this time.

Although National Health Survey data has not been collected since 2022, more recent national data on psychological distress can provide updated insights at the whole-of-population level. Based on findings from the **2025 General Social Survey**:

- In 2025, 9.2% of Australians aged 15 years and over experienced very high psychological distress.
- Experiencing very high psychological distress was more common among women than men (10.0% compared with 7.3%, respectively). Conversely, men were more likely to experience low psychological distress than women (54.7% compared with 49.5%, respectively).

Outcomes for people with lived experience

In 2025, **people who have a mental health condition were around 5 times as likely to experience very high psychological distress** compared with people who do not have a mental health condition (30.7% compared with 5.9%, respectively).

Men and women who have a mental health condition experienced levels of psychological distress at a similar rate. However, when compared to people who do not have a mental condition:

- **Men who have a mental health condition were almost 6 times more likely to experience very high psychological distress** compared with men who do not have a mental health condition (28.6% compared with 4.9%, respectively).
- **Women who have a mental health condition were almost 5 times more likely to experience very high psychological distress** compared with women who do not have a mental health condition (29.3% compared with 6.2%, respectively).

Box 2 - Understanding and preventing suicide

Suicide and self-harm are significant issues that require a whole-of-government response. The National Suicide Prevention Strategy 2025-2035 recognises that suicidal distress is a complex human response that arises from an interaction of factors. 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).101 So, while monitoring changes in suicide rates and attempts is important, in isolation they are not a reliable indicator of how the mental health system is performing. In recognition of this 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 suicide prevention and reducing suicidal distress.

The National Suicide Prevention Outcomes Framework (Outcomes Framework)

The National Suicide Prevention Office (NSPO) is developing the Outcomes Framework which aligns with the *National Suicide Prevention Strategy 2025-2035*, to improve our understanding of whether suicide prevention efforts are safe and effective. The Outcomes Framework expands the goals for suicide prevention to include reduced suicide attempts and suicidal distress, as well as increased wellbeing to protect against suicide. It identifies outcomes that reflect what matters to people about suicide prevention and what is needed to improve the effectiveness of suicide prevention efforts. It utilises both quantitative data and qualitative data to measure change, applying mixed- and multi- analysis to inform a more holistic picture.

Further information about the Outcomes Framework is available here: The National Suicide Prevention Outcomes Framework | National Suicide Prevention Office | National Mental Health Commission. NSPO's first report of their Outcomes Map is expected to be released in 2027.

The Commission continues to work with the NSPO to ensure our respective monitoring and reporting approaches complement each other, enabling a fuller picture to inform and drive improved outcomes for mental health and suicide prevention.

Overall life satisfaction

Levels of life satisfaction are closely connected to mental health and wellbeing and reflects how people experience their overall quality of life, which in turn can be shaped by factors such as social connection, financial security, physical health, safety, participation and sense of purpose.

Protective factors (including strong relationships, stable housing, inclusive communities, cultural connection and access to supportive services) play an important role in supporting wellbeing and buffering against distress. Monitoring life satisfaction at a population level provides a holistic view of whether broader social and economic conditions are supporting wellbeing across the community.

Whole of population

Based on latest data from the 2025 General Social Survey:

- In 2025, the overall life satisfaction rating for people aged 15 and over in Australia was 7.1 out of 10 (with 10 being the highest).
- This rating of perceived level of life satisfaction overall, which does not consider specific concerns or conditions a person may have, **has remained similar to 2020 (7.2) but is still lower than that recorded in 2014 (7.6).**

Recently collected data from the HILDA Survey (between 2011 and 2024) shows a similar pattern, with the mean life satisfaction among the total population aged 15 and remaining steady (around 7.9).

Is this the same for everyone?

No. While whole-of-population data indicates mean overall life satisfaction has remained steady in recent years, there are differences across age groups, gender, circumstances and where people live. Based on latest data from the 2025 General Social Survey, we know that:

- Life satisfaction scores ranged from 6.8 for people aged 15-24, to 7.2 for people aged 55-64 years.
- Life satisfaction scores were highest for people aged 65 years and over (7.7) when compared to all other age groups.
- Women had a slightly higher overall life satisfaction rating than men (7.3 compared with 7.1, respectively).
- People living in the most disadvantaged areas (Quintile 1) had the lowest life satisfaction rating (6.8), whilst people living in the least disadvantaged areas reported the highest life satisfaction rating (7.5).
- Mean overall life satisfaction was 7.1 for people living in Major cities, Inner regional areas, and Outer regional and Remote areas.

A similar pattern is seen in data from the HILDA Survey (between 2011 and 2024), which reported the highest mean life satisfaction for those aged 65 years and over (ranging between 8.2 and 8.3), and the lowest for those aged 35-64 (ranging between 7.7 and 7.8).

Similarly, people living in Major cities consistently had slightly lower mean life satisfaction (ranging between 7.8 and 7.9), while those living in Inner regional areas (ranging between 8.0 and 8.1) and Outer regional and Remote areas (ranging between 7.9 and 8.2) had a slightly higher mean life satisfaction.

Outcomes for people with lived experience

According to the 2025 General Social Survey:

- In 2025, people who have a mental health condition had an overall mean life satisfaction rating of 5.8. **This was significantly lower than people who do not have a mental health condition (7.4).**
- People aged 15-24 years who have a mental health condition had an overall life satisfaction score of 5.5. This score is significantly lower compared with the life satisfaction score of 7.4, reported by people of the same age who do not have a mental health condition.
- People aged 65 years and over who have a mental health condition had an overall life satisfaction score of 6.0. Similarly, this is still a significantly lower score compared with people of the same age who do not have a mental health condition (7.8).

Similar to the pattern of findings from the General Social Survey, data from the 2024 HILDA Survey found that:

- Between 2011 and 2024, people with a long-term mental health condition[xi] consistently reported lower mean life satisfaction than people who did not have a long-term health condition[xii] (6.8 compared with 8.1 in 2024).

xi In the HILDA Survey, people with a long-term mental health condition refers to those respondents who indicated they had a nervous or emotional condition which requires treatment or/and any mental illness which requires help or supervision.
xii In the HILDA survey, the term 'long-term health condition' is used to describe where a respondent records any long-term health condition, impairment or disability that restricts them in their everyday activities, and which has lasted or is likely to last for six months or more

Feeling in Control

A person's sense of control over their life can significantly influence wellbeing, coping capacity and mental health outcomes. Sense of control is shaped not only by individual circumstances, but also by broader social, economic and structural conditions that affect people's ability to make choices, access opportunities and participate fully in society. A person's sense of control can be shaped by factors such as financial security, housing stability, discrimination, employment conditions, safety, access to services and participation in decision-making.

Whole of population

Based on latest available data from the HILDA Survey, in 2023:

- The proportion of people reporting a high sense of control over events in their life remained stable between 2011 and 2019 but decreased from 75.8% in 2019 to 71.3% in 2023.

Is this the same for everyone?

No. When taking a closer look at the HILDA Survey data over time, we can see:

- In 2011, 2015, and 2019, **the proportion of people reporting a high sense of control decreased with age: people aged** 15–34 had the highest proportions, while those aged 65 years and over reported a lower sense of control.
- However, **these differences have narrowed over time**, with proportions becoming more similar across age groups (converging around 71.3% in 2023). Females were slightly less likely to report a high sense of control compared with males (70.3% compared with 72.3%, respectively).

There were differences according to factors such as where people lived, warranting further monitoring and attention.

- In 2023, people living in the most advantaged areas (Quintile 5) were substantially more likely to report a high sense of control than people living in the most disadvantaged areas (Quintile 1) (76.4% compared with 62.2%).
- In 2023, people living in Outer regional and Remote areas were slightly less likely to report a high sense of control (69.8%) than people living in Inner regional areas (71.2%) and Major cities (71.5%).

Outcomes for people with lived experience

Latest available data from the HILDA Survey showed a gap between sense of control reported by people with a long-term mental health condition compared to people without.

In 2023, almost 2 in 5 people with a long-term mental health condition (39.9%) reported a high sense of control. This proportion is much lower compared to:

- People with other long-term health conditions (62.6%); and
- People without any long-term health conditions (77.0%).

Box 3 - Aboriginal and Torres Strait Islander people and mental health and wellbeing

Social and emotional wellbeing (SEWB) is the foundation of physical and mental health for Aboriginal and Torres Strait Islander peoples. It encompasses interconnected domains including mind and emotions, body, family and kinship, community, culture, Country, and spirituality and ancestors.[102] Racism is a key structural determinant of social and emotional wellbeing, affecting psychological distress, identity, belonging, trust in services and access to culturally safe care.

Addressing racism is central to improving mental health and social and emotional wellbeing outcomes, and should be considered alongside other social, cultural and historical determinants of wellbeing. The *Gayaa Dhuwi (Proud Spirit) Declaration* calls for Aboriginal and Torres Strait Islander concepts of wellbeing, mental health and healing to be recognised throughout the Australian mental health system.[103] *Gayaa Dhuwi* (*Proud Spirit*) Australia, is the national peak body for social and emotional wellbeing, mental health and suicide prevention.

Broad population measures, including those used in the Report Card, often fail to capture key social and cultural determinants of mental health, particularly SEWB. To address this, *Gayaa Dhuwi* (*Proud Spirit)* Australia identifies the development of appropriate social and emotional wellbeing measures as a priority action in the *Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan*.[104] Another significant data gap identified by Aboriginal and Torres Strait Islander organisations is the definition and measurement of racism.

What we understand from currently available data

The Commission acknowledges that the outcomes experienced by Aboriginal and Torres Strait Islander peoples are shaped by historical, social and structural factors. As highlighted by the Australian Human Rights Commission, Aboriginal and Torres Strait Islander peoples experience higher levels of unfair treatment and hardship than non-Indigenous Australians.[105] While measures such as psychological distress are important, they represent only one aspect of social and emotional wellbeing. The data below should be interpreted alongside the wider context of culture, kinship, community, Country, self-determination, racism, colonisation, intergenerational trauma and the strengths that support healing and wellbeing for Aboriginal and Torres Strait Islander peoples.

Experiences of psychological distress for Aboriginal and Torres Strait Islander peoples are captured through the National Aboriginal and Torres Strait Islander Health Survey 2022-23. This survey was undertaken by the Australian Bureau of Statistics from August 2022 to March 2024. Based on findings released in November 2024, this survey found:

- In 2022-23, 3 in 10 Aboriginal and Torres Strait Islander people aged 18 years and over (30.2%) experienced high or very high levels of psychological distress in the last 4 weeks. This is similar to the proportion recorded in 2018–19 (31.1%).
- Of this group, 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 strengths and 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, (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 (74%) than those who did experience this (60%).

The Productivity Commission's review of the National Mental Health and Suicide Prevention Agreement emphasised the need to recognise factors affecting the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It recommended a dedicated schedule in the next National Agreement and, consistent with calls from *Gayaa Dhuwi (Proud Spirit)* Australia, the inclusion of outcome measures co-designed with Aboriginal and Torres Strait Islander peoples.[106] The Commission supports calls for the development of appropriate measures for social and emotional wellbeing and improved data on racism. Efforts to address these gaps should align with Indigenous Data Sovereignty Principles, including the rights of Aboriginal and Torres Strait Islander peoples to access, govern, control, interpret and determine how data about their peoples and communities is collected, used and reported.

Where can I find more data and research on Aboriginal and Torres Strait Islander peoples' social and emotional wellbeing and mental health?

Several existing data collections and studies measure aspects of the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples, including:

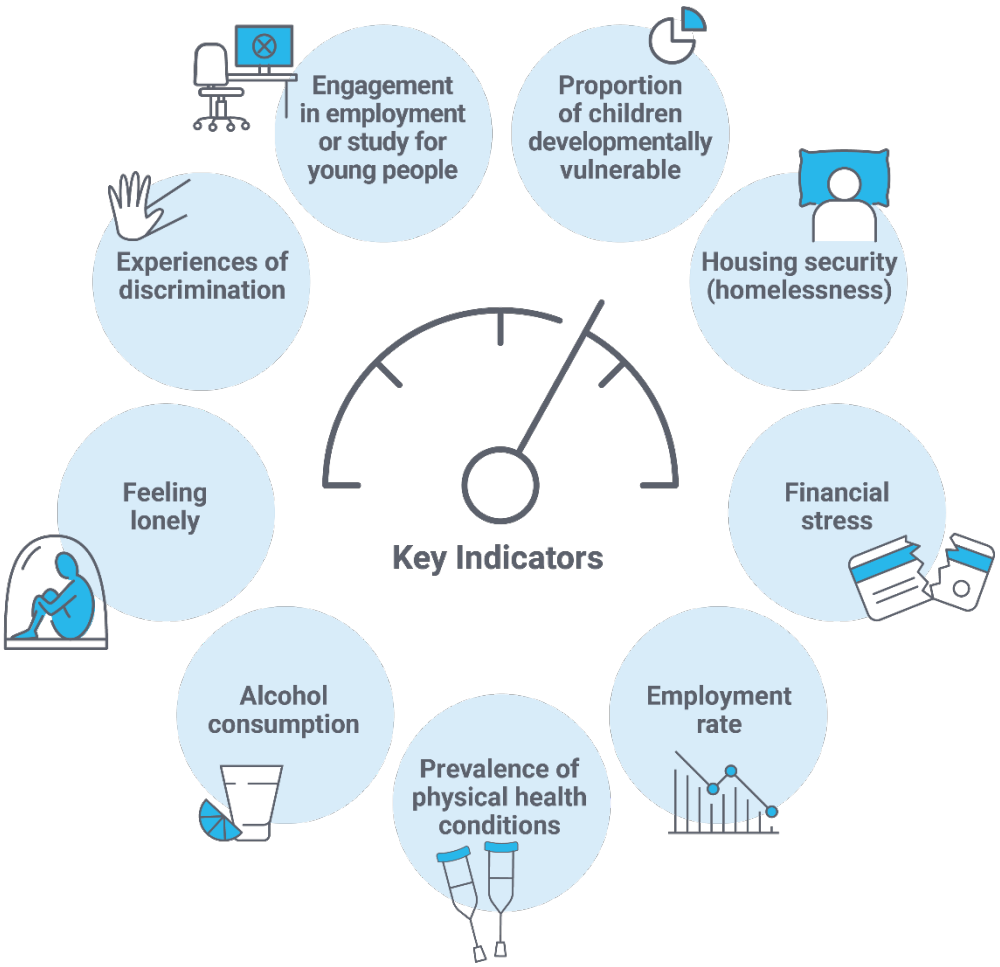
- The **Mayi Kuwayu Study** - conducted every 3 years, this survey examines culture, wellbeing and health, with a focus on understanding the cultural determinants of health and their impacts on mental and physical health. The survey is designed, led and controlled by Aboriginal and Torres Strait Islander peoples. Further information can be found at: https://mkstudy.com.au/
- In June 2025, the **Yardhura Walani National Centre for Aboriginal and Torres Strait Islander Wellbeing Research published analysis of data from the Mayi Kuwayu study** - including several measures of social and emotional wellbeing, collected before and after the Voice to Parliament Referendum which occurred from January 2022 to April 2025. Findings from the final report, Monitoring Aboriginal and Torres Strait Islander mental health and wellbeing around the Voice to Parliament Referendum, underscored the need for continued efforts to address racism and discrimination in Australia.
- **Footprints in Time -** this longitudinal study examines the developmental pathways of Aboriginal and Torres Strait Islander children, focusing on factors that help children "grow up strong". Findings from the first **10 years of Footprints in Time** are available at: A Decade of Data: Findings from the first 10 years of Footprints in Time, 2020 | Department of Social Services
- **Aboriginal and Torres Strait Islander social and emotional wellbeing measures** - a collaborative project between the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Measurement Consortium and the Australian Institute of Health and Welfare (AIHW) First Nations Health and Welfare Group which has researched over 30 SEWB measures. These are grouped into three categories: culturally derived, culturally informed and culturally adapted.
- **The Aboriginal and Torres Strait Islander Health Performance Framework-** brings together information on health outcomes, determinants of health and health system performance. This includes Measure 1.18, which presents data, research findings and policy implications relating to social and emotional wellbeing to inform governments, health services and the research sector.

Domain 2 Social Determinants

This domain looks at the social determinants that can shape mental health and wellbeing, guided by the question, are the factors that influence mental health improving?

Where available data allows, we also consider what are the experiences of people with mental health challenges compared to the community.

To understand these questions, the Commission draws on nine indicators:



Social Determinants: Domain 2 Key Insights

People with mental health conditions are disproportionately experiencing loneliness and discrimination

- Overall, the estimated proportion of people aged 15 and over experiencing loneliness has remained relatively steady between 2011 (15.3%) and 2024 (15.4%).[107]
- In 2024, **people who had a long-term mental health condition were almost 3 times as likely to report loneliness** than those without a long-term mental health condition (35.0% compared with 12.2%).[108]
- In 2025, **people with a mental health condition were almost twice as likely to experience discrimination or be treated unfairly**, compared with those without a mental health condition (31.2% and 16.3%, respectively).[109]

Demand for homelessness support is increasing

- Persistent homelessness is increasing in Australia, **with the largest growth in absolute numbers among those with a current mental health issue, alongside Aboriginal and Torres Strait Islander clients.**
- Between 2018–19 and 2024–25, the number of Specialist Homelessness Services clients experiencing persistent homelessness rose by **39%**, from around 29,500 to 41,100 clients.[110]
- In 2024-25, **31% of all Specialist Homelessness Services clients (around 88,800 clients) had a current mental health issue, an increase from 25%** in 2014-15 (around 62,900 clients).[111]

Financial stress is increasing, especially for people experiencing mental health conditions

- In 2025, more than 1 in 5 (21.2%) people aged 15 years and over could not raise $2,000 within a week, a proportion which has steadily increased over time (18.8% in 2020 and 13.1% in 2014).[xiii]
- Between 2011 and 2024, people living in areas classified as the most disadvantaged were the most likely to experience financial stress.[xiv]
- **We continue to see a heightened gap in financial stress for people experiencing mental health conditions.**
- In 2025, almost 1 in 3 (31.6%) people who have a mental health condition could not raise $2,000 within a week, compared with almost 1 in 5 (19.6%) people who do not have a mental health condition. **This gap has not improved** compared to previous years.

xiii This data refers to a survey question in the ABS 2025 General Social Survey, which reports on the proportion of people aged 15 years and over in Australia living in households that are unable to raise $2,000 within a week for something important.
xiv AIHW analysis of survey data from the *Household, Income and Labour Dynamics in Australia Survey (HILDA)*. The data presented here are classified according to the SEIFA Index of Relative Socio-economic Advantage and Disadvantage (IRSAD).

Are the factors that influence mental health improving?

Proportion of children who are developmentally vulnerable

Early childhood is a critical development period that shapes lifelong mental health, wellbeing, learning and social participation. It is influenced by family, community, cultural, educational and socioeconomic circumstances. Monitoring developmental vulnerability helps identify where children, families and communities may benefit from additional support, early intervention and equitable access to health, education and social services.

Mental health struggles often begin during childhood and an estimated 50% of adult mental illness begins during the mid teenage years.[112] A more recent meta-analysis found that the peak age of onset was 14.5 years across all mental disorders,[113] underlying the need for early intervention and prevention. More than one in five Australian children starting school are 'developmentally vulnerable', meaning they do not have the skills (learning, socio-emotional and/or physical) to thrive at school.

As noted in Report Card 2024, the proportion of children in Australia who were 'developmentally vulnerable' on one or more domains of the Australian Early Development Census (AEDC) increased between 2021 (22.0%) and 2024 (23.5%). Over this period, the percentage of children who were developmentally vulnerable increased across all 5 AEDC domains of physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge.

The relationships between early childhood development, social-emotional wellbeing and mental health outcomes in later years are complex. Data linkage can provide an opportunity to more closely understand these relationships.[114] In December 2025, the results of the First Five Years Project were published. For the first time, administrative data on childcare participation and quality was linked to a measure of childhood development, along with a broad range of family, social, economic and health data. This project used a range of statistical techniques to better understand developmental vulnerability in children, and risk and protective factors, including mental health. The results of the project showed that a range of child, family and social characteristics were associated with developmental vulnerability. More outcomes from this work can be found here.

Box 4 - Including wellbeing in early childhood health checks (ECHC)

The Commission recognises the importance of early childhood as a critical developmental period that shapes lifelong mental health and wellbeing. In September 2025, the Commission published the National Guidelines for including mental health and wellbeing in early childhood health checks. Key themes arising throughout the Commission's consultations for the National Guidelines include:

- the importance of integrated care and support, the value of a strengths-based and trauma-informed approach when working with children and families,
- the need for sustainable funding to support the delivery of ECHCs, and
- the critical role of an appropriately resourced and trained workforce.

Further insights from the development of the National Guidelines highlight the importance of using strengths-based, non-stigmatising language when describing children's development. Stakeholders emphasised the need to avoid labels that may inadvertently pathologise children, and instead focus on how children can be supported to thrive.

Housing security (homelessness)

Safe, stable and appropriate housing is a foundational determinant of mental health and wellbeing. Experiences of housing insecurity and homelessness can increase psychological distress, disrupt social connection and create barriers to accessing healthcare, education, employment and community supports. Mental health challenges can also increase vulnerability to housing instability.

- In 2024-25, 31% of all Specialist Homelessness Services (SHS) clients (around 88,800 clients) had a current mental health issue, up from 25% in 2014-15 (around 62,900 clients).[115]
- Among clients with a current mental health issue, the most common reasons for seeking assistance were housing crisis (e.g., eviction) (20.8% or 18,406 clients), family and domestic violence (19.3% or 17,066 clients) and inadequate or inappropriate dwelling conditions (13.5% or 11,989 clients).[116]

Clients experiencing persistent homelessness

In 2024–25, around 1 in 7 (14% or 41,100 clients) Specialist Homelessness Services clients were experiencing persistent homelessness. Of note, **around half of this group (50% or 20,500 clients) had a current mental health issue**, which is important to continue to monitor over time.

Long-term or repeated episodes of homelessness are associated with a wide range of disadvantages, including childhood trauma, chronic mental and physical health conditions, social isolation and experiences of rough sleeping.[117] Persistent homelessness is increasing in Australia, with the largest growth in absolute numbers among First Nations clients and those with a current mental health issue. Between 2018–19 and 2024–25, the number of SHS clients experiencing persistent homelessness rose by 39%, from around 29,500 to 41,100. Over the same period, the number of clients with a current mental health issue experiencing persistent homelessness increased from approximately 15,700 to 20,500.

Financial stress

Financial hardship or insecurity can affect mental health and wellbeing through impacts on stress levels, relationships, reduced help-seeking and reliance on negative coping strategies. Financial stress can increase uncertainty about financial stability (including the ability to meet everyday expenses, maintain housing, manage debt, or plan for the future). This can reduce feelings of security and control, and limit people's capacity to meet basic needs and participate fully in community life. Population-level monitoring of financial stress can help identify emerging pressures and inequities that may increase vulnerability to psychological distress and mental health challenges.

Most recent data suggest financial stress is yet to show signs of easing for people in Australia. In 2025, according to the Scanlon Mapping Social Cohesion Survey, 2 in 5 adults (40%) said they were either 'just getting along', 'struggling to pay bills' or 'poor'. This proportion is similar to findings from 2023 and 2024 (both 41%). Data from the General Social Survey indicated that in 2025:

- **21.2% of people in Australia aged 15 years and over could not raise $2,000 within a week, a substantial increase from 2020** (18.8%) and 2014 (13.1%).
- People aged 15-34 and 35-54 years were more likely to be unable to raise $2,000 within a week (25.2% and 24.4%, respectively), compared with people aged 55 years and over (14.9%).

A similar pattern is observed in the HILDA Survey, between 2011 and 2024, people aged 15-64 were more likely to experience financial stress compared with people aged 65 years and over.

What are the experiences of people with mental health challenges compared to the community?

- According to the General Social Survey, in 2025, almost 1 in 3 people (31.6%) who have a mental health condition could not raise $2,000 within a week. This is a significantly higher proportion compared with people who do not have a mental health condition (19.6%).
- These findings are similar to 2020 (29.9% compared with 17.1%, respectively) and 2014 (25.3% compared with 10.3%, respectively), indicating that financial stress has become a more common experience over time.

Employment rate

Meaningful, secure, inclusive and psychologically safe employment can support mental health and wellbeing through financial security, social connection, routine, purpose and participation in community life. However, employment alone does not guarantee positive outcomes; job quality, including safety, security, fair conditions and whether people feel valued and supported all play a critical role.

Poor quality, precarious or unsafe work can also negatively affect mental health and wellbeing through increased financial insecurity, job instability and a lack of support in the workplace. These forms of work are also associated with higher levels of stress, reduced sense of control and exposure to psychosocial hazards, which can contribute to worsening mental health.

What are the experiences of people with mental health challenges compared to the community?

As highlighted in previous Report Cards, there is a gap between the employment rate experienced by the general population and those experiencing mental health challenges, although this gap has been decreasing. Based on data from the National Health Survey 2022:

- Among people in Australia aged 16-64 years with a mental or behavioural condition, the employment rate was 71.6% (compared with 82.8% for people without a mental or behavioural condition).
- This gap was also observed in 2014-15 and 2017-18; **however, it has reduced over time**.

- In 2022, almost 3 in 4 of people (74%) 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%).

Engagement in employment or study for young people

Participation in education, training and employment can support young people's mental health and wellbeing by fostering social connection, skill development, financial security, confidence, sense of purpose and hope for the future. Monitoring engagement can help identify barriers experienced by young people during key life transitions and inform early intervention and support strategies.

Similar to the observed gap in employment rate, there is a similar but smaller gap in engagement in work or study among young adults, based on the available data from the National Health Survey:

- In 2022, among people aged 16-24 years, 89.2% of people with a mental or behavioural condition were employed or studying, compared to 96.4% of people without a mental or behavioural condition.

It is important to note that these measures only provide limited insight into work and study participation outcomes for people with mental health challenges, based on data that is not regularly updated. Given that people living with mental health challenges may also experience structural barriers to employment and education, including stigma, discrimination, insecure work conditions and limited access to appropriate supports, continued monitoring of these areas is crucial. The Commission plans to strengthen understanding of mental health, work and education outcomes as part of its iteration of the Report Card Reporting Framework.

Prevalence of physical health conditions

Physical and mental health are closely interconnected and can influence each other in complex and bidirectional ways. People living with mental health challenges often experience inequities in physical health outcomes due to interacting factors such as social disadvantage, stigma, fragmented systems of care and barriers to accessing timely, holistic and person-centred services. Strengthening integrated, coordinated care, reducing stigma and investing in prevention and early intervention are critical to improving overall health and wellbeing outcomes.

What are the experiences of people with mental health challenges compared to the community?

- Based on data from the 2020-2022 National Study of Mental Health and Wellbeing, there were 4.3 million people (21.5% of the population at that time) aged 16-85 years with a 12-month mental disorder. Of these, 1.7 million people (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.

Going forward, the Commission aims to build on current understanding of the relationship between physical and mental health care in the Report Card, beyond population-based measures that are updated infrequently. Improved data in this space can improve understanding of physical and mental health to inform person-centred, holistic and coordinated care models.

Alcohol consumption

Monitoring alcohol consumption at a population level helps identify patterns that may affect mental health, wellbeing and broader health outcomes across the community. Alcohol use is shaped by a range of factors including social norms, stress, trauma, financial pressures, availability and broader environmental conditions. Harmful consumption can both contribute to and be influenced by mental health challenges. Monitoring patterns in population-level alcohol consumption helps build a clearer picture of broader health and wellbeing impacts.

As reported in Report Card 2024, based on latest available data from the National Drug Strategy Household Survey (NDSHS) 2022-23, about 30.7% of people in Australia aged 14 years and older exceeded the Australian Alcohol Guidelines.[xv] This is a downwards trend compared to earlier years (from 33.2% in 2016 to 32.0% in 2019 and 30.7% in 2022-23).

What are the experiences of people with mental health challenges compared to the community?

- In 2022-23, about 36.9% of people diagnosed or treated for a mental illness aged 18 years and over exceeded the Australian Alcohol Guidelines. This was slightly higher than the proportion of people without a mental illness (31.6%). This gap has widened from 2% in 2010 to 5.3% in 2022-23.
- The 2022-23 NDSHS found that people aged 18 years and over experiencing high/very high levels of psychological distress were more likely to drink alcohol at risky levels (39.1%), compared with people aged 18 years and over experiencing low levels of psychological distress (30.3%).

In this year's Report Card, we supplement monitoring population-level alcohol consumption with latest available data about how people in the community are seeking support from publicly funded treatment services.

Based on latest available data from the Alcohol and Other Drugs Treatment Services in Australia: Early Insights 2024-25 report:

- In 2024-25, alcohol made up 41% of all treatment episodes for which people received support from publicly funded treatment services. This makes alcohol the most common substance for which people sought treatment in the period.
- When looking over time from 2015-16 to 2024-25, alcohol continued to be the most common substance nationally that led people to receive treatment.[118]

While population monitoring indicates a steady downward trend in the proportion of people who consumed alcohol at risky levels, monitoring the extent to which alcohol is the focus of publicly funded treatment services provides us with further insights about alcohol consumption in the community and the need for services. Furthermore, while numbers of treatment episodes provide insight into the services that people received, they don't tell us about the extent to which people need treatment services but did not access or experienced a barrier to access.

xv "Risky alcohol consumption" is defined by the Australian Alcohol Guidelines as consumption of more than 10 standard drinks per week, and/or more than 4 standard drinks in a single day.

Feeling lonely

Loneliness and social isolation are influenced by a range of factors including poor health, marginalisation, low income or education, living alone, limited work or community infrastructure and major life changes. Social connection and belonging are important protective factors for mental health and wellbeing, yet loneliness can occur even when social contact exists, particularly when relationships lack safety, inclusion or meaning.

Monitoring loneliness at a population level helps identify how social, economic, cultural, digital and environmental conditions may affect people's ability to maintain relationships, participate in community life and feel connected to others, and highlights opportunities to strengthen inclusion and wellbeing.

For the total population, the estimated proportion of people aged 15 and over experiencing loneliness remained relatively steady between 2011 (15.3%) and 2024 (15.4%). There was an increase in 2021 (16.6%) before declining to 15.4% over subsequent years.

However, loneliness is experienced differently across population groups:

- Across almost all years between 2011 and 2024, the proportion of women experiencing loneliness has been slightly higher than that for men.
- For most years between 2011 and 2024, people aged 15–34 were the least likely to report loneliness. An exception to this was during the emergency phase of the COVID-19 pandemic when the proportion of people aged 15-34 reporting loneliness increased from 13.7% in 2019 to above 16% between 2021 and 2022. During these years, the proportions of people aged 65 and over reporting loneliness were lower than those aged 15–34. From 2021 to 2024, people aged 35-64 were most likely to report loneliness.
- In 2024, people living in areas classed as the most disadvantaged according to the SEIFA Index of Relative Socio-economic Advantage and Disadvantage (IRSAD) were more than twice as likely to report loneliness as those living in areas classed as the most advantaged (23.2% in Quintile 1 compared with 10.6% in Quintile 5). Between 2011 and 2024, the data show that the more disadvantaged a Quintile, the higher the proportion of people who reported experiencing loneliness. Whilst Quintiles 2 to 5 showed little to no overall change in the proportion reporting loneliness between 2011 and 2024, Quintile 1 (most disadvantaged) saw an increase from 19.6% to 23.2%.
- In 2024, Outer Regional and Remote areas had the highest proportion of people reporting loneliness (17.4%), followed by Inner regional areas (16.9%) and Major cities (14.8%).

What are the experiences of people with mental health challenges compared to the community?

- In 2024, people who had a long-term mental health condition were almost 3 times as likely to report loneliness as those without a long-term health condition (35.0% compared with 12.2%).
- Those diagnosed with other long-term health conditions, disabilities, or impairments were also more likely to report loneliness (20.1%) compared with people without any long-term health condition.
- These patterns were consistent from 2011 to 2024, with statistically significant differences observed between all groups. In 2021, during the emergency phase of the COVID-19 pandemic, there was a spike in the proportion of people with a long-term mental health condition who reported loneliness. The proportion rose from 32.9% in 2020 to 40.8% in 2021, before returning to around 34% in 2022.

Experiences of discrimination

Stigma and discrimination are significant drivers of mental health inequities. They can arise through individual attitudes, interpersonal behaviours and structural barriers, affecting wellbeing and limiting help-seeking, safety, trust in systems, and participation in employment, education, housing and community life.

Experiences of discrimination may be cumulative and intersectional, reflecting overlapping forms of disadvantage. Monitoring discrimination helps identify inequities, track change over time, identify emerging issues, measure impact and support efforts to promote social inclusion, social cohesion, and strengthen trust in services. This is needed to improve systems, policies and community attitudes.

Data from the most recent General Social Survey found that in 2025:

- 18.3% of people in Australia aged 15 years and over experienced some form of discrimination in the previous 12 months. While this is an increase from 2020 (13.3%), it is similar to 2019 (17.4%).
- Of people who had experienced discrimination, more than half (51.9%) of people experienced some form of discrimination at work, school or university.
- 45.5% of people reported their most recent incident of discrimination was because of their ethnic/ cultural background or appearance, followed by gender (30.8%), and age (26.6%).

What are the experiences of people with mental health challenges compared to the community?

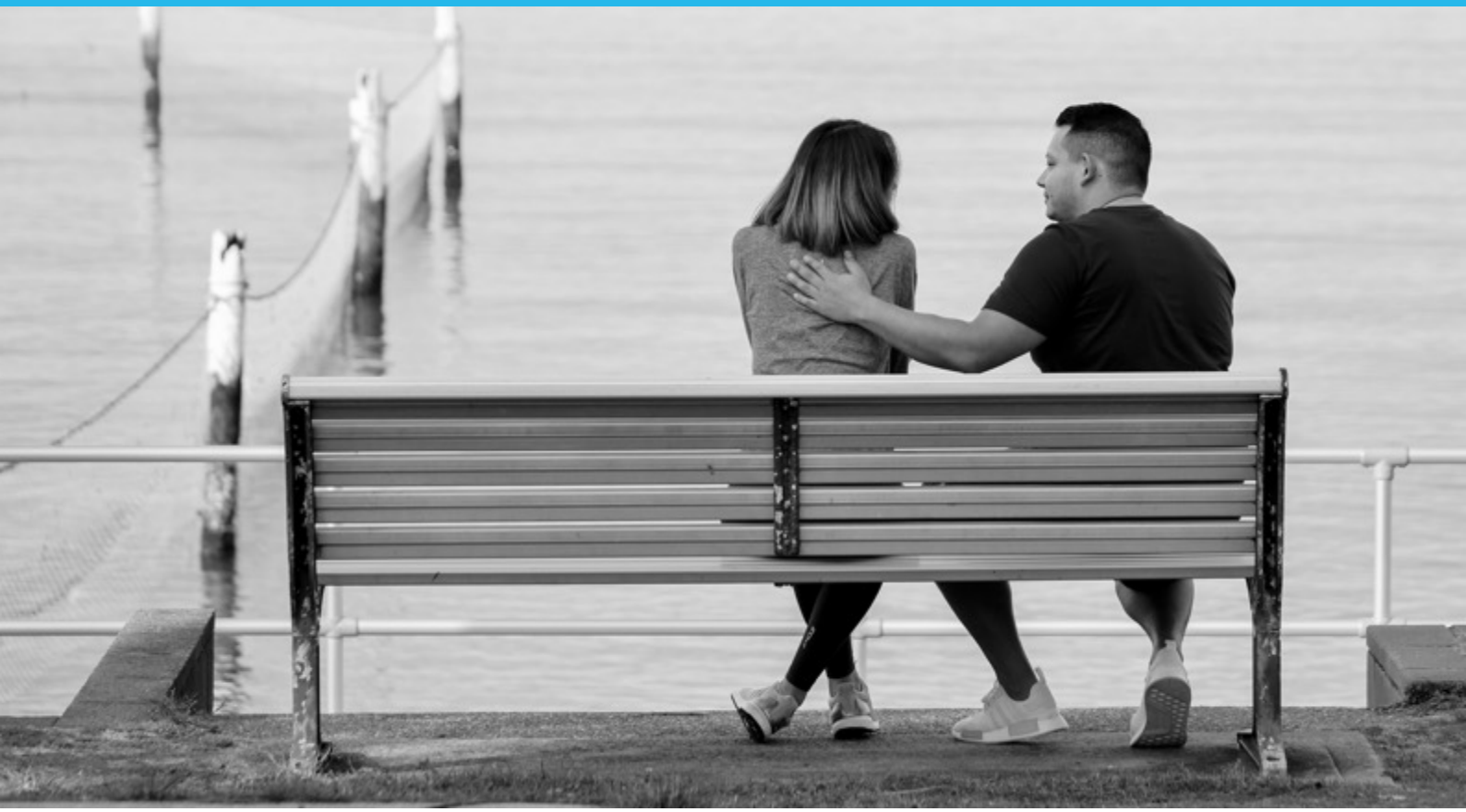
In 2025, according to the General Social Survey, people who have a mental health condition were almost twice as likely to experience some form of discrimination or be treated unfairly as people who do not have a mental health condition (31.2% compared with 16.3%, respectively).

In 2025, among people who have a mental health condition and had experienced some form of discrimination:

- More than 1 in 3 (34.5%) felt that their disability or health issue was the reasons for their most recent of discrimination (compared with 6.4% of people who do not have a mental health condition).
- The most common place people with a mental health condition experienced discrimination was at school, work or university (#50.8%)[xvi], followed by in public (49.2%), and dealing with justice, government or health care (40.7%).

As recent data indicates, there are no signs that experiences of discrimination are declining at a population level, nor for people with a mental health condition. Stigma towards mental health challenges can lead to discrimination; however, until recently there was a lack of national data to support our understanding of this issue.

xvi # To note, this proportion has a margin of error greater than 10% and should be used with caution.



Box 5 - 2026 National Stigma and Discrimination Report Card

The Commission considers reducing stigma and discrimination to be a shared priority for governments, service providers, employers, and the community. Consistent monitoring of stigma and discrimination, based on high quality evidence, matters.

To take action, the Commission has partnered with SANE Australia to develop the Commission's first National Stigma and Discrimination Report Card. The 2026 National Stigma and Discrimination Report Card includes nationally representative data about people's experiences with stigma and discrimination in the mental health system, as well as in everyday life. Key findings include:

- 70% of people with mental health challenges had experienced discrimination in at least one area of life.
- The greatest burden of discrimination for people with mental health challenges was seen in finding or keeping a job, in dating and forming intimate relationships, and when accessing housing.
- Overall, 81% of people reported positive experiences, including respectful, understanding and supportive responses to their mental health challenges.

The 2026 National Stigma and Discrimination Report Card project directly addresses key findings from the Productivity Commission's National Mental Health and Suicide Prevention Agreement review, which identified stigma as an ongoing national challenge and addresses a key data gap we called out in our National Report Card 2024. Going forward, a second National Stigma and Discrimination Report Card is scheduled to be published in 2028, from which we can monitor experiences over time.

For further information on the scale and impact of mental health stigma and discrimination in Australia, please see the 2026 National Stigma and Discrimination Report Card.

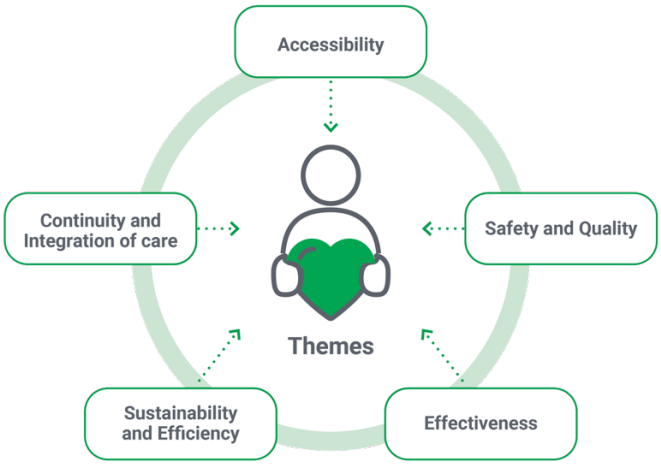
Domain 3 Mental health system

This domain looks at the mental health support system to inform an overview on how the system is performing as a connected whole. Given the complexity of this system, this domain explores 5 key themes, with guiding questions for each key theme.

This is the first time the Commission is introducing a revised approach to domain 3. In the following sections we apply guiding questions across 5 key themes and draw on indicators to explore aspects of the system performance. We also highlight gaps in data coverage which limit our understanding. This approach recognises that not all the issues that matter are currently well measured and holds space in our reporting approach to address these factors as data availability improves over time.

Some guiding questions include the experiences of consumers, carers, family and kin. This is not intended to conflate the experiences of consumers with those who support them, but to ensure these distinct experiences can be reported where data is available.

The Commission developed this revised approach with stakeholders, building on previous Report Cards and emerging evidence. Domain 3 will continue to evolve over time as new and improved evidence becomes available. Refer to **Developing the National Report Card** section to find out more about how we've worked to develop this domain in 2025.



The guiding questions for each, and the relevant indicators, are explored throughout this domain.

Key Insights - The service system is doing more, but uneven access, system fragmentation, workforce pressures and data gaps limit impact and opportunity to improve

There are indications that service use is increasing, alongside investment, but we need a clearer picture of whether this is meeting need

- For example, between 2013-14 and 2023-24 there was **an increase** in the proportion of Australians who received one or more Medicare/DVA subsidised mental health-related services (from 8.4% to 10.6% of the population).[119]
- Over the same period, we have seen increased government spending on mental health-related services from $10.7 billion to $14.5 billion, representing **an increase of 35% in real terms.** Over this period, per capita spending increased from $460 to $537.[120]

Despite growth in services, access still depends on where you live and your circumstances

In 2024-25:

- **People living in Major cities recorded the highest rates of Medicare mental health-related services use** (a rate of receiving 507 mental health services per 1,000 people living in Major cities), which is more than the overall population (473 mental health services per 1,000 Australians).[121]
- This contrasts sharply to **people living in Remote/Very remote areas, who used these services at a much lower rate (156 mental health services per 1,000 people living in Remote/Very remote areas).**[122]
- During 2024-25, **people living in the most disadvantaged areas used fewer Medicare mental health-related services** (300 services per 1,000 people residing in areas classified as SEIFA Quintile 1), compared to people living in areas of least disadvantage **who used services at more than twice the rate** (710 services per 1,000 people residing in areas classified as SEIFA Quintile 5).

At the same time, people living in the most disadvantaged areas had **higher rates** of mental health-related **Emergency Department presentations** (155 per 10,000 people), compared to people living in the least disadvantaged areas who had the lowest (72 per 10,000 people). This can be a sign that people have not had early enough access to support from community or hospital-based services.

Mental-health related emergency department presentations are not decreasing overall, and people are waiting longer to be seen

- Nationally, mental health-related ED presentation rates decreased from 121 presentations per 10,000 people in 2020-21 to 109 in 2021-22 and remained stable in 2022-23, before increasing again to 116 presentations per 10,000 people in 2024-25, which is the same recorded over ten years ago.
- The proportion of mental health-related ED presentations **being seen on time has decreased from 71% during 2014-15 to 60% during 2023-24**.

Cost remains a persistent barrier to care

- The proportion of people aged 15 years and older indicating cost as a reason for not seeing a mental health professional **increased from 12% during 2020-2021 to 20% during 2024-2025.**[123]
- In 2024-25, people aged 25-34 and people living in areas of most disadvantage were more likely to report cost as a reason for not seeing a mental health professional when needed.[19]

The mental health workforce is growing*, but still projected to fall short of need

Between 2015 and 2024 we saw:

- Growth in the full-time equivalent (FTE) rate (per 100,000 people) for mental health occupational therapists (43% increase from 7 to 10), psychologists (28% increase from 88 to 113), mental health nurses (20% increase from 84 to 101), and psychiatrists (15% increase from 13 to 15). However, future gaps in supply are projected for psychiatrists and psychologists.

Key data gaps continue to limit our understanding and opportunities for system improvement

The current scope and scale of mental health-related activity reporting provides a broad overview of how people in Australia interact and engage with the mental health system. However, evidence-informed investments such as targeting funding to areas of greatest need is difficult with stark gaps in data and evidence.

- Existing nationally representative outcome measures largely represent publicly funded services, highlighting the need for **outcome measurements** across a broader range of care settings, to better understand the extent to which mental health services are improving outcomes for people.
- Lack of national data that measures service navigation, care continuity and movement between services is preventing **a holistic understanding of how well the system supports people.**
- **Carer, family and kin experiences** and outcomes are integral insights into how well services are working; however, the broader impacts of mental health challenges on families, carers and kin are not consistently measured. This limits our ability to fully quantify need and to effectively plan and deliver supports. When care is not accessible or delayed, families and carers may take on additional caring and system-navigation responsibilities, which can in turn impact their own wellbeing.

What we know about the system

Australia's mental health system includes a broad range of services and programs. Services are funded and delivered across different levels of government. Non-government and third-party providers also play a significant role in service delivery. Measurement of these services and the outcomes they achieve for consumers is inconsistent. For example, in their Review of the National Mental Health and Suicide Prevention Agreement (the Agreement), the Productivity Commission highlighted limitations in data measuring many of the Agreement's outcomes.[124] Separately, recent research identified data availability limitations, concluding there was no centralised knowledge base of Australian public mental health data.[125] Existing data mainly reflected input and activity data with comparatively little data on prevention, early intervention and social determinants.[126]

Theme Accessibility

To understand this theme, we consider the following guiding questions:

Are consumers, carers, family and kin getting the right care and support when they need it?

The Commission draws on the following indicators:

- Mental health care is timely, affordable and geographically accessible for all communities
- Treatment rates
- Unmet need for mental health care **Identified data gap**
- Access to non-government mental health services **Identified data gap**
- Services received that did not meet needs **Identified data gap**

To what extent are consumers, carers, family and kin unable to access the mental health supports they need, trust and prefer?

The Commission draws on the following indicators:

- Cost related delays to accessing care
- Wait times following referral **Identified data gap**
- Capability and capacity of families, carers and kin to effectively support people experiencing mental health challenges **Identified data gap**

To what extent do consumers, carers, family and kin have awareness, understanding, and trust towards available mental health supports?

The Commission draws on the following indicators:

- Knowledge and awareness of how to navigate to relevant mental health care **Identified data gap**
- Mental health literacy **Identified data gap**
- Proportion of people who report receiving effective support to navigate between multiple mental health providers **Identified data gap**
- Experience of stigma in mental health services **Identified data gap**

Mental health supports must be available to people in the community when and where they need them. However, this is often not the case. Access can be affected by barriers such as cost, wait times, demand for services and geographic availability. Accessibility is also shaped by whether services and supports are aligned with consumers' preferences, needs and circumstances, and whether people feel able and willing to use them.

Mental health care is timely, affordable and geographically accessible for all communities

Monitoring whether mental health care is timely, affordable and geographically accessible can help identify barriers to access, opportunities to improve service planning and who might be missing out on services they need. Measurement of this indicator is informed by latest available data across publicly funded mental health care settings, digital and online mental health services. Increasing service use in isolation is not a direct measure of availability and accessibility of services. It may also reflect other factors, such as increasing demand across the system. However, when considered alongside other measures, service use can provide useful insights into access across the system. There are known gaps in service use data, including in non-government mental health services (called out **in Box 9**).

Overall, based on available data, mental health service use has increased or remained steady across most care settings.

Admitted hospital care service use

This setting involves a person staying in a hospital ward to receive more intensive mental health care and support. Admitted mental-health related care can involve same day treatment, as well as overnight treatment.

- Nationally, between 2014-15 and 2024-25 the rate of same day mental health-related hospitalisations (per 10,000 people) was relatively **steady** in public hospitals (changing from 22 to 21) and **increased** in private hospitals (from 62 to 70).

Residential mental health service use

This setting reflects care and support for people residing in government-funded residential mental health care services, except residential aged care facilities. Residential mental health service facilities include both government-operated services and government-funded, non-government operated services. These facilities employ mental health trained staff on-site, with some services involving 24-hour staffed services.

- Residential mental health care episodes increased slightly between 2014-15 and 2023-24, with the national rate rising from 2 to 3 per 10,000 people.

Emergency Department (ED) presentations

Mental health-related ED presentations are defined as presentations to public hospital EDs that have a principal diagnosis of a mental and behavioural disorder. It is important to note that the mental and behavioural disorders principal diagnosis codes may not fully capture all mental health-related presentations to EDs.

- Mental health-related presentations showed some signs of decreasing from 2020-21 (a rate of 121 presentations per 10,000 people) and remained stable in 2022-23, before increasing again to 116 presentations per 10,000 people in 2024-25.
- However, disparities in rates were observed according to factors like geography and socio-economic circumstances, with the highest rates recorded for people living in Remote/Very remote areas, and for people living in areas classified as most disadvantaged (Quintile 1) (refer to **Box 6 - Social and economic circumstances impact mental health care use** and **Box 7 - Where people live and mental health care use).**

Community Mental Health Care Services

This setting provides specialised community and hospital-based outpatient psychiatric services for people in the community, who are not admitted to hospital or a residential mental health care service. Data is collected from government-funded and operated community mental health care services across Australia. This excludes non-specialised mental health care services (e.g. accommodation support services), and services provided by non-government organisations.

- **Community mental health care contacts have decreased slightly** over the 10-year period, with the national rate falling from 373 to 365 per 1,000 people between 2014-15 and 2023-24.

Medicare Benefits Schedule (MBS)

Medicare mental health-related services are delivered on a fee for service basis, subsidised by the government through the MBS. Medicare mental health-related services are delivered by psychiatrists, general practitioners (GPs), psychologists and other allied health professionals. They are delivered across a range of settings – including hospitals, consulting rooms, home visits, and telehealth – as defined in the MBS.

- **Medicare mental health-related services have increased over the past decade**, with the national rate of services increasing from 443 in 2015-16 to 473 in 2024-25 (per 1,000 people).

Pharmaceutical Benefits Scheme (PBS) medications dispensed

The PBS and Repatriation Pharmaceutical Benefits Scheme includes both subsidised prescriptions and under co-payment prescriptions.

- **Mental health-related prescriptions on the PBS increased moderately** from 2015-16 to 2024-25, with the national rate rising from 1,488 to 1,806 per 1,000 people.

Digital and online mental health services

There are a range of digital and online mental health services which are designed to increase access by more flexibly offering services such as outside of business hours, and in ways that are less impacted by geography.

In the December quarter of 2025, national mental health crisis services, including Lifeline, Kids Helpline, Beyond Blue and 13YARN, reported:[127]

- 12,154 contacts were answered by 13YARN. The rate of answered contacts per 100,000 people was **89% higher** than the same period in 2024 (6,305 answered contacts) and 93% higher than the same period in 2023 (6,055 answered contacts).
- 197,248 contacts were answered by Lifeline. The rate of answered contacts per 100,000 people was 11% lower than the same period in 2024 (217,617 answered contacts) and **3% lower** than the same period in 2023 (195,473 answered contacts).
- 31,929 contacts (includes phone, webchat, email contacts as well as outbound calls) were answered by Kids Helpline. The rate of answered contacts per 100,000 people was **10% lower** than the same period in 2024 (35,042 answered contacts) but **16% higher** than the same period in 2023 (26,831 answered contacts).
- 56,238 contacts (includes phone, webchat and email contacts) were answered by Beyond Blue. The rate of answered contacts per 100,000 people was 2% lower than the same period in 2024 (56,713 contacts) but 6% higher than the same period in 2023 (51,201 answered contacts).

eheadspace is a digital mental health service providing confidential, free online and telephone support and counselling, for young people and family members. In 2024-25, eheadspace supported 17,690 young people and family members, providing 48,495 occasions of service. Of these requests to eheadspace, approximately 64% were made outside business hours, and around one third (31%) of the young people and families who accessed eheadspace were based outside of metropolitan areas in regional and remote locations.[128] Although headspace is not the only model of youth-focused mental health care in Australia, this data provides some insights into when digital services are used, and how digital services can flexibly respond to young people and their families.

In January 2026, the Australian Government's new digital mental health service, Medicare Mental Health Check In, was launched and is being rolled out in stages, starting with guided support delivered by trained professionals via phone or video.[129] In February 2025, the Australian Government announced additional short-term funding of $800,000 to Lifeline for MensLine Australia, from April 2025.[130] These services will continue to be monitored.

Beyond the mental health service settings explored above, some people may be eligible to access psychosocial support through the NDIS. Supports for psychosocial disability is explored below, including information on service access through the NDIS.

Box 6 - Supports for Psychosocial Disability

Psychosocial disability is the term used to describe disabilities that may arise from mental health challenges. Psychosocial disability can be influenced by the interaction between a person's mental health challenges with wider determinants, including social, economic and environmental factors. This reinforces the need to address barriers in broader support systems for people experiencing mental health challenges, including psychosocial disability.

People with mental health challenges can demonstrate needs for tailored, non-clinical supports to assist them with daily living activities and community participation. Psychosocial supports include, but are not limited to:

- life-skills, daily living and housing support;
- social, community and relationship support;
- vocational, educational and economic participation support;
- support coordination, navigation and brokerage;
- psychosocial recovery coaching/capacity building; and
- group-based and community-based programs.

Psychosocial supports are delivered in a range of settings, including through the National Disability Insurance Scheme (NDIS) and through non-government operated mental health services. Defining 'psychosocial' supports in data collection can be challenging, especially for providers delivering multiple services across different settings.[131]

Below we explore what we know from national data about specialist disability support services provided under the NDIS to participants with a psychosocial disability. This data is for participants with psychosocial disability recorded as their "primary disability", noting many other participants also experience psychosocial disability or mental health challenges. Supports provided through the National Disability Insurance Scheme (NDIS) for people with psychosocial disability are an important component of the continuum of supports for people with mental health challenges in Australia, and where possible, should be included in national mental health system reporting.[132]

This Report Card draws on AIHW's online *Psychosocial Disability Support Report* (updated February 2026), which uses data about participant access and experiences with the NDIS, collected and published by the National Disability Insurance Agency (NDIA). The measures below are selected because they are regularly updated to enable monitoring over time.

Access to the NDIS for people with psychosocial disability

At 30 June 2025 (for the 2024-25 financial year):

- 65,272 NDIS participants had a psychosocial disability as their primary disability, representing about 9% of all NDIS participants, and the **fourth largest primary disability group in the NDIS**.
- The **highest population rates of inclusion in the NDIS for participants with a primary psychosocial disability were for people aged 55-64 years** (550 per 100,000 people), followed by 45–54 years (533 per 100,000 people).
- The lowest population rates were among people who were aged 18 years or younger.

Experiences of NDIS participants with a primary psychosocial disability

At 30 June 2025 (for the 2024-25 financial year):

- At their most recent NDIS assessment, **81%** of NDIS participants aged 15 years and over with a primary psychosocial disability reported they felt the NDIS had helped them have more choices and control in their life.
- This **is higher than 69%** at their first reassessment after entry to the NDIS, and in line with broader experiences of NDIS participants (81%).
- At their most recent NDIS assessment, **11% of NDIS** participants aged 15–64 years with a primary psychosocial disability reported being in a paid job, compared with 10% at entry to the Scheme. This proportion is **still lower** compared to outcomes for NDIS participants more generally (23%). This **indicative gap in employment outcomes** can be seen in families and carers of participants with a psychosocial disability, in that 37% of psychosocial primary disability participants had families or carers in a paid job. This is **much lower than 53% reported by** families or carers of participants across the NDIS generally.

Gap in psychosocial supports outside of the NDIS

As highlighted in Report Card 2024, the Analysis of unmet need for psychosocial supports outside of the NDIS - Final Report presented estimates of unmet need for psychosocial supports outside the NDIS for the 2022-23 financial year. This report 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.[133]

In November 2025, the Grattan Institute published their analysis of the work undertaken by Health Policy Analysis. The Grattan Institute's analysis of the Unmet need for psychosocial supports outside of the NDIS concluded that most people experiencing psychosocial disability were receiving very little or no support through the mental health system or the NDIS. The Grattan Institute estimated about 130,000 adults were going without supports in this way.[134]

In May 2026, the Commission contributed its submission to the Senate inquiry into the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026.[135] The Commission's submission highlighted that without careful design and implementation, proposed reforms to the NDIS risked amplifying gaps in equitable access to quality psychosocial supports in Australia.[136]

While this year's Report Card provides access insights across a greater range of service settings than previously, available data still does not capture access across the full spectrum of services. This is particularly evident in services delivered by non-government mental health services. So, while there are signs that service use is increasing, a greater understanding of how and why people are using different supports and presenting at different settings is needed to better understand service use across the system.

Treatment rates

Treatment rates are a measure of the proportion of the population who either:

- Received one or more services from state/territory public specialised mental health services; and/or
- Received one or more services from specialist psychiatric care in participating private hospitals with psychiatric beds; and/or
- Received Medicare Benefits Schedule (MBS) or Department of Veterans' Affairs (DVA) subsidised mental health services; and/or
- Received mental health-related prescriptions through the Pharmaceutical Benefit Scheme (PBS).

Monitoring treatment rates helps us to understand the rate at which people are receiving treatment from a mental health professional, helping people to feel supported in their recovery journey, across different care settings.

Nationally, between 2013-14 and 2023-24:

- Between 1.8% and 2.0% of the population accessed public specialised mental health services (hospital, community or residential services).
- Between 0.1% and 0.2% accessed private psychiatric hospitals.
- The rate of Medicare/DVA mental health services increased from 8.4% to 10.6% of the population.
- The rate of dispensed mental health-related prescriptions on the PBS increased from 16.2% to 18.5%.

Cost related delays to accessing care

Monitoring costs and wait times is crucial to understand to what extent the mental health system is responsive to need and provides insights about where government investment should be directed to better support people to access care. Cost-related barriers (in combination with broader barriers such as stigma, cultural appropriateness of care and distance to travel) can mean people delay service access, do not access services at all or access services that are not suitable to their needs.

The estimated proportion of the population aged 15 years and older who indicated cost as a reason for not seeing a mental health professional (including GPs, psychiatrists, psychologists, mental health nurses, social workers, counsellors and occupational therapists) increased from 12% during 2020-2021 to 20% during 2024-2025.[137]

During 2024-25:

- The highest rate was seen for people aged 25-34 (27%) and the lowest for people aged 75 and older (5%).
- Females had a higher rate (23%) compared with males (15%).

Data throughout the accessibility theme highlights that access can be impacted by a person's social and economic circumstances and where they live. The following section presents a more detailed view of these socio-economic and geographical impacts drawing together available data.

Box 7 – Social, economic and geographic circumstances impact mental health care use

Mental health outcomes and access to care are influenced by both where people live and their socioeconomic circumstances. Monitoring service use across these factors helps identify disparities and inform more equitable service delivery.

Remoteness affects access through factors such as service availability, distance to care, workforce shortages and local service capacity.[138] In regional and remote communities, GPs are often the first, and sometimes only, provider of mental health care due to limited availability of specialised services.[139] Conversely, living closer to community mental health care clinics was a factor associated with higher access to those face-to-face services.[140] Compared with people living in Major cities, those in Remote and Very remote areas are less likely to use Medicare-subsidised mental health services, but more likely to use specialised public mental health services and present to emergency departments for mental health-related care.

Socioeconomic status influences access to the resources, opportunities and support networks that support mental health and wellbeing. People living in areas of greater disadvantage are more likely to delay seeking care due to cost and use Medicare-subsidised mental health services at lower rates. Findings from the Better Access evaluation also indicated affordability as a barrier impacting use of subsidised mental health services, with people on low incomes less likely to receive treatment following their mental health plan, and waited longer for their first treatment session.[141]

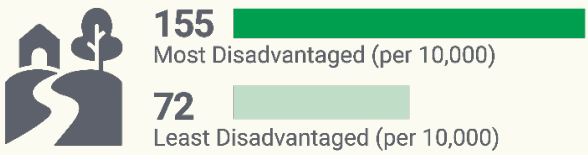
These findings suggest that geographic barriers, service availability and affordability can limit access to timely mental health care. While data clearly indicates that people living in areas of most socio-economic disadvantage were more likely to indicate cost as a reason for not seeing a mental health professional than people living in areas of least disadvantage, disparities across other service types are more nuanced and varied. Remoteness and socio-economic status do not fully reflect individual experiences or levels of need. Many regional and remote communities also benefit from strengths such as strong community connections and local support networks.[142] The data therefore provide a broad overview of patterns in service use and access rather than a complete picture of lived experience.

Cost-related delays to seeing a mental health professional

- In 2024-25, more than 1 in 5 people living in Major cities (21%) indicated cost as a reason for not seeing a mental health professional, compared with 13% of people living in Outer regional and Remote areas.
- In 2024-2025, almost 1 in 4 people (23%) living in the most disadvantaged SEIFA quintile indicated cost as a reason for not seeing a mental health professional, compared with 16% of people living in the least disadvantaged quintile.

Mental health-related emergency department presentations

- In 2024-25, people living in Remote/Very remote areas had the highest rate of mental health-related emergency department presentations (253 per 10,000 people).
- In contrast, people living in Major cities had the lowest rate (98 per 10,000 people).
- In 2024-25, people living in the most disadvantaged SEIFA quintile had the highest rates of mental health-related Emergency Department presentations (155 per 10,000 people), while people living in the least disadvantaged quintile had the lowest (72 per 10,000 people).



Community mental health service use

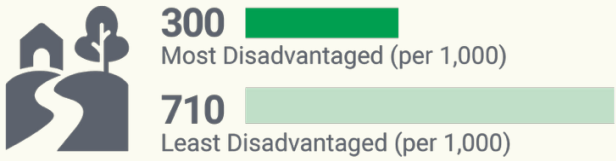
- In 2023-24, people living in Remote areas had the highest rate of community mental health care contacts (419 per 1,000 people), while people living in Major cities had the lowest rate (333 per 1,000 people).
- In 2023-24, people living in the most disadvantaged SEIFA quintile had the highest rate of community mental health care contacts (462 per 1,000 people), while people living in the least disadvantaged quintile had the lowest (267 per 1,000 people).

Residential mental health service use

- In 2023-24, people living in Inner regional areas had the highest rate of residential mental health care episodes (5 per 10,000 people), while people living in Major cities had the lowest (3 per 10,000 people).
- In 2023-24, people living in the most disadvantaged SEIFA quintile had the highest rate of residential mental health care episodes (5 per 10,000 people), while people living in the least disadvantaged quintile had the lowest (2 per 10,000 people).

Medicare service use

- In 2024-25, people living in Major cities had the highest rate of Medicare mental health-related service use (507 per 1,000 people), while the lowest rate was seen for people living in Remote/Very remote areas (156 per 1,000 people).
- In 2024-25, people living in the least disadvantaged SEIFA quintile had the highest rate of Medicare mental health-related service use (710 per 1,000 people), while people living in the most disadvantaged SEIFA quintile had the lowest rate (300 per 1,000 people).



Geographic spread of the Mental Health workforce:

During 2024:

- 86% of psychiatrists, 83% of psychologists, 78% of mental health nurses, 81% of mental health occupational therapists and 70% of accredited mental health social workers lived in Major cities.
- The full-time equivalent (FTE) rate for psychiatrists was highest for Major cities (18 per 100,000 people) and lowest for Very remote areas (2 per 100,000 people).
- The FTE rate for psychologists was highest for Major cities (130 per 100,000 people) and lowest for Very remote areas (28 per 100,000 people).
- The FTE rate for mental health nurses was highest for Major cities (107 per 100,000 people) and lowest for Very remote areas (40 per 100,000 people).
- The FTE rate for mental health occupational therapists was highest for Major cities (12 per 100,000 people) and lowest for Very remote areas (2 per 100,000 people).
- The number of accredited mental health social workers was highest for Major cities (12 per 100,000 people) and lowest for Very remote areas (2 per 100,000 people).

Understanding this data

Data sources in this section classify remoteness areas according to the Australian Statistical Geography Standard (ASGS) Remoteness Area. Due to different data sources being used, some report Remote and Very remote areas grouped together, whilst others report on them separately. For more information on the ASGS Remoteness Area classification, please see https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs/latest-release. The data above explores socioeconomic status considering Socio-Economic Indexes for Areas (SEIFA) which is a product developed by the ABS that ranks areas in Australia according to relative socio-economic advantage and disadvantage. SEIFA indexes are based on information from the five-yearly Census. For more information on SEIFA, please see https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release

Theme Accessibility – Indicators with identified data gaps

A number of indicators in this theme do not have robust, reliable national data sets on which to assess performance over time.

Box 8 - What do we mean by data gap?

The Commission draws on high quality, nationally available, and reliable datasets to monitor system performance over time. In the context of the Commission's monitoring and reporting work, data gaps are areas where there is not enough national data to understand and track how aspects of the mental health system are performing. Data gaps can also occur when data is collected too infrequently. For example, representative survey data undertaken at irregular intervals, such as national estimates of mental health prevalence, limits the ability to monitor changes and trends over time, as highlighted in Domain 1.

We recognise that jurisdiction-specific, local and emerging data sources can provide valuable insights into local contexts. Where appropriate, we may draw on these sources when national data is not available.

Should every data gap be filled?

Not all data gaps can be addressed immediately. Developing high quality data can take time and resources, and if not well co-ordinated, can increase reporting demands on service providers. Given that national data requires substantial time and resources, the Commission's Report Card focuses on making the most impactful use of available data, while identifying data gaps that need addressing over time.

The Commission is working closely with data custodians to identify further analysis opportunities using available data sets, as well as new or emerging sources. This work is being undertaken alongside efforts to incorporate qualitative insights where available and appropriate.

The indicators with data gaps for the Accessibility theme are explored below.

Indicators	Why these indicators matter despite limited data
Access to non-government mental health services	Non-government mental health services are a substantial, but not well measured, component of the mental health service system. Without integrating national data and insights across sectors we cannot fully understand how people are accessing the mental health system, and with what effect. Refer **Box 9** for what the Commission is doing to progress work in this important area.
Services received that did not meet needs	The extent to which services meet consumers' needs and preferences is a critical dimension to understanding access but is not well understood from the data available.
Unmet need for mental health care	There is a clear distinction between actual access and unmet need which cannot be understood from the available data. There is currently no long term, ongoing data source to measure unmet need, moving beyond measures of service activity and use to better understand who is not accessing care.

Wait times following referral	Extensive wait times following referral can be a barrier to care and contribute to worsening outcomes if people cannot access the care they need, when they need it. However, national data on wait times across service types is limited, making it difficult to identify opportunities for improvement.
Capability and capacity of families, carers and kin to effectively support people experiencing mental health challenges	Mental health challenges can have broader impacts on families, carers and kin, including effects on wellbeing, financial security and relationships. However, these broader impacts are not consistently measured in the data, which can limit opportunities to design appropriate supports.
Knowledge and awareness of how to navigate to relevant mental health care	The range of mental health services across funding systems and breadth of models of care can make it hard for consumers and those supporting them to identify the right services for them, and whether they are available locally. Knowledge about the services available, their suitability, and how to access them, is a critical enabler of a functioning mental health system, but not easily measurable.
Mental health literacy	Improved mental health literacy can influence seeking support earlier; however recent national data on mental health literacy is limited. The last National Health Survey: Health Literacy was undertaken in 2018.
Proportion of people who report receiving effective support to navigate between multiple mental health providers	A person's journey through care can often involve navigating between more than one mental health provider and moving between services and models of care. Although effective support to navigate between services is crucial, this is not currently easily understood or measurable.
Experience of stigma in mental health services	Past and/or anticipated experiences of stigma are a barrier to accessing support from mental health services. A key emerging data source on Stigma is the 2026 National Stigma and Discrimination Report Card (refer **Box 5**) and may support enhanced reporting on this indicator in Report Card 2026.

The Commission continues to build understanding of these indicators over time, including through working with the Australian Institute of Health and Welfare (AIHW) on scoping options for improved data reporting.

The following section explores recent work undertaken to better understand available data for non-governmental mental health services.

Box 9 - Work underway to better understand and address data gaps - Access to non-government mental health services

Current understanding of Australia's mental health system is largely based on public hospital and specialist community mental health data, with limited national data available on Non-Government Organisation (NGO) delivered services. Given the range and scope of mental health programs delivered by NGOs in Australia, the need for a holistic understanding of the sector cannot be understated.

To progress this, the Commission partnered with Mental Health Australia (MHA) to explore opportunities for representing NGO services in the National Report Card. As the national, independent peak body for the mental health sector, MHA's insights and findings have helped strengthen the Commission's understanding of system performance to build on through future Report Cards.

Between September 2025 and March 2026, MHA consulted NGO services and data custodians through targeted engagement, a desktop scan and a sector-wide online consultation and presented their findings and recommendations for the Commission's consideration.

Defining and understanding the non-government mental health sector

MHA's work found there is no nationally agreed definition of NGO mental health services, reflecting the sector's diversity. Broadly, these services are delivered by not-for-profit and for-profit organisations that receive Commonwealth or state or territory government funding to support mental health and wellbeing. This includes Community Managed Organisations (CMOs), which provide a wide range of recovery-oriented supports in community and residential settings.[143] Not-for-profit organisations deliver a broad range of mental health supports, spanning prevention and early intervention through to services for people with complex needs. Mental health services are also provided by registered charities.

Many mental health organisations are funded through a mix of government funding, fee-for-service arrangements, donations, partnerships, philanthropy and private insurers. Sole traders also play a key role in service delivery, yet their services are not easily reportable at a national level. This can include MBS-subsidised mental health services, alongside supports delivered through the NDIS.

Recognising the breadth and complexity of the sector, MHA developed a nuanced definition of NGO mental health services as:

"…services delivered by private organisations (both not-for profit and for-profit) primarily intended to promote mental wellbeing, prevent mental ill-health and/or support people experiencing mental health challenges and their family, carers and kin. We note that it is often valuable to further differentiate between for-profit and not-for profit organisations."

MHA's definition was tested with stakeholders and adopted by the Commission as a working definition in this year's Report Card. It captures a broader range of generalist social service and disability organisations delivering mental health and psychosocial supports.

Reporting on mental health services delivered by NGOs

MHA identified significant challenges in NGO mental health data collection and reporting. Data is largely driven by funding requirements, with limited national coordination and a strong focus on service activity rather than consumer outcomes and experiences. Workforce and resource constraints, alongside data collection across multiple sectors, further complicate reporting. While some NGOs collect additional data to support service improvement and understanding of consumer experience, this is generally not widely available or comparable across services. In addition, there is a need to better understand consumer experiences and outcomes across their full-service journey, rather than relying on measures taken primarily at entry and exit points.

How can we use evidence and insights for improved reporting?

Despite this challenging environment for NGOs to deliver consistent data and outcomes measures, MHA's work identified examples of NGO data collections that represent components of service activity and some consumer outcomes. Where possible, MHA's recommendations are being incorporated into this Report Card or being considered for future Report Cards. This includes:

- Including data about eheadspace and headspace services (noting that this inclusion in the Report Card reflects data availability, rather than encompassing the full spectrum of service activity by other organisations in the NGO sector).
- Including data about NDIS participants with psychosocial disability.
- Ongoing work to address the gap in visibility of primary mental health and suicide prevention services.
- Continuing work with data custodians about feasibility of including data in the short and longer term. This includes MHA's recommendation to include the Primary Mental Health Care Minimum Data Set (PMHC-MDS) as a key data source in the Report Card. The PMHC-MDS is the main collection measuring the activity and impact of mental health services commissioned by Primary Health Networks (PHNs).

The Commission's approach will be guided by the need for national reporting to appropriately consider differences in local community contexts, funding, and workforce pressures, in consultation with data custodians.

Finally, the Commission supports MHA's recommendation that expertise from people with lived experience of mental health challenges, their family, carers and kin should inform improvements in data collection and reporting. The Commission thanks MHA and their members for contributing invaluable insights and expertise to support future monitoring and reporting over time. For a full copy of MHA's findings and recommendations, please refer to MHA's full report https://www.mentalhealthaustralia.org.au/articles/research-projects/increasing-ngo-data-national-report-card-report/

Theme Continuity and integration of care

To understand this theme, we consider the following guiding questions:

To what extent do consumers, carers, family and kin experience supported, connected navigation across all parts of their care journey?

To what extent do carers, family and kin experience connected navigation across all parts of the care journey of the people they support?

The Commission draws on the following indicators:

- Community follow-up after hospitalisation for mental health
- Mental health workforce satisfaction rates (e.g. mental health workers, nurses, GPs, etc.) **Identified data gap**
- Proportion of consumers reporting supported navigation across their care journey **Identified data gap**
- Rate of discontinuing treatment services following referral **Identified data gap**
- Rates of standardised assessment and referrals **Identified data gap**
- Consumer and family rated measures of referral "warmth" **Identified data gap**

Monitoring and reporting on continuity and integration of care provides insight into how parts of the system are supporting consumers, family, carers and kin throughout their care journeys. As highlighted in our Accessibility theme, the service system is complex and at times, consumers and those who support them may be navigating care across and between multiple service types. Interfaces and transitions between services, such as referral pathways and continuity of care, are critical points that shape how well the system operates holistically. Work published in 2025 by SANE Australia and consortium partners highlights this, noting mental health services are delivered by multiple systems that are not well connected nor well explained by clear navigation pathways. [144] This can make it difficult for people to access timely support suited to their needs. Monitoring this complex theme will support us to better understand opportunities to improve experiences for people towards receiving and navigating connected care.

Community follow-up after hospitalisation for mental health

Following a person's in-patient stay in hospital for a mental health-related need, they should receive within 7 days a follow-up interaction with a public community mental health team. Post-discharge community mental health care is a national performance indicator for mental health.[145] Increasing rates of community follow-up after hospitalisation for mental health care can reflect that parts of the system are providing continuity of care in relation to transitions between hospital and community services.

The data presented below captures activity within public community mental health services only. Some people may choose to receive follow-up care from a General Practitioner (GP) or private psychiatrist instead; these services are not included in the data presented.

The national rate for community follow-up within 7 days following hospitalisation **has increased over time, from 67% in 2013-14 to 78% in 2023-24.**

During 2023-24:

- The highest rate of community follow-up was seen for people aged 65 years and older (82%) and the lowest for people aged less than 25 years (76%).
- Males had a lower rate (76%) compared with females (79%).
- Aboriginal and Torres Strait Islander people had a lower rate (73%) compared with non-Indigenous people (78%).

Follow-up after hospitalisation provides partial insight in relation to transitions between hospital and community services. This measure does not tell us how effectively services communicate and coordinate care, what happens to people who do not receive follow-up, and how consumers experience referrals and transitions between services.

Theme  Continuity and integration of care - Indicators with identified data gaps

Several indicators in this theme do not have robust, reliable national data sets on which to assess performance over time. These are explored below.

Indicators	Why these indicators matter despite limited data 
Mental health workforce satisfaction rates (e.g. mental health workers, nurses, GPs, etc.)	The satisfaction and wellbeing of the mental health workforce are critical for workforce retention,[146] and to sustain a connected system of care. However, national data on workforce satisfaction over time remains limited.
Proportion of consumers reporting supported navigation across their care journey	Although some national initiatives are underway to help people navigate services and find timely support, it is difficult to assess how effectively these tools support navigation based on data available.
Rate of discontinuing treatment services following referral	Understanding the extent to which people discontinue treatment or disengage following referral, and the factors that can influence this disengagement, can help support service and process improvements. These factors are not easily measurable.
Rates of standardised assessment and referrals	Greater understanding of assessment and referral information and how they are used to support consumers' journey through care is important but challenging to understand from the data currently available.
Consumer and family rated measures of referral "warmth"	Warm, supported referrals between different services and parts of the system are an important indicator of continuity of care, but not currently measured.

As noted previously, the Commission is working with data custodians to make the best use of available data and on opportunities to build understanding over time.

Theme Safety and quality

To understand this theme, we consider the following guiding questions:

To what extent do consumers, carers, family and kin receive care that feels safe, respects their rights, and is responsive to their preferences, culture and identity?

To what extent are consumers, carers, family and kin feeling safe and respected in interactions with the mental health system?

The Commission draws on the following indicators:

- Use of restrictive and involuntary practices in mental health care
- Consumers feel safe in interactions with the mental health system **Identified data gap**
- Consumers and carers are involved and supported in decision-making about care **Identified data gap**
- Cultural and gender responsiveness of care **Identified data gap**
- Experiences of stigma, discrimination, and coercion in mental health care **Identified data gap**
- Awareness and confidence in complaints mechanisms and safeguards **Identified data gap**

The concept of safety in mental health care is complex, multidimensional and interpreted differently depending on the framework applied, cultural context and individual perspective. This section seeks to approach discussions of safety with a respect for and sensitivity to these different perspectives.

In Australia there are a range of safety and quality standards and frameworks relevant to mental health care, including but not limited to those established by the Australian Commission on Safety and Quality in Health Care (ACSQHC):

- The National Standards for Mental Health Services in health settings, which represent the framework for mental health services in public and private hospitals and community services provided by local hospital networks;
- The National Safety and Quality Digital Mental Health (NSQDMH) Standards, which aim to improve the quality of digital mental health service provision, and to protect users from harm; and
- The Mental Health Standards for Community Managed Organisations which provides best practice guidance for Community Managed Organisations providing mental health services.

While health systems have traditionally focused on harm minimisation and risk management, consumer advocates argue instead for a rights-based conception of safety that emphasises autonomy, self-determination, respect and freedom from coercion. Quality and safety are therefore not solely matters of clinical standards and regulatory compliance; consumers should be afforded the right to determine whether care is safe, respectful and of good quality from their perspective. Quality and safety should be defined by consumers as well as through clinical standards, with mechanisms for learning and adaptation built in. An effective mental health system not only seeks to prevent harm, but also support and promotes recovery, wellbeing, autonomy, participation and quality of life.

The Commission continues to support national approaches to regulate, reduce and where possible eliminate coercive practices, and advocates for:

- the development of agreed definitions, data and reporting requirements on all forms of restraint and involuntary treatment;
- greater research into factors that may reduce the use of restrictive practices; and

- evaluation and development of alternative, positive, best practice, lived-experience informed interventions for behavioural emergencies involving people experiencing mental health challenges.[147]

Use of restrictive and involuntary practices in mental health care

The use of seclusion and restraint is a fundamental breach of an individual's human rights, and while there may be very limited circumstances where their use may be necessary, we must continue to strive to eliminate these practices. Monitoring national data on restrictive and involuntary practices is important to support this aim. The data presented below relates to public sector specialised psychiatric services.

Under international human rights frameworks, the use of these practices is recognised as a human rights violation.[148] In their 2024 Human Rights Report, the National Mental Health Consumer Alliance concluded that the restrictive practices which continue to be experienced by Australian mental health consumers are inconsistent with Australia's obligations under these international standards.[149]

A 2024 international comparative study of coercive measures, including involuntary psychiatric admissions across nine countries (Australia, England, Germany, Ireland, Japan, New Zealand, the Netherlands, the USA, and Wales) found substantial variation in rates of use.[150] Robust monitoring and reporting are essential for accountability and tracking progress towards reducing and, where possible, eliminating coercive practices. Consistent reporting is particularly important because definitions, classifications, and recording practices vary internationally.

Seclusion

Seclusion practices are those involving confinement of a person at any time of the day or night alone in a room or space from which a person's free exit is prevented.

- National seclusion rates for all services halved from 16 events per 1,000 bed days in 2008-09 to 8 events per 1,000 bed days in 2013-14.
- National seclusion rates for all services remained relatively steady between 7 and 8 events per 1,000 bed days through to 2021-22.
- There has been a small decrease in seclusion events in recent years, to between 5 and 6 events per 1,000 bed days (between 2022-23 and 2024-25).

Data on rates of seclusion across settings focusing on different cohorts (children and young people, older people and people in forensic settings), varies.

- Nationally, services that focus on the general population followed the pattern seen for all services and have had the most stable reduction in event rates and smaller year on year volatility compared to services focusing on other population groups.
- Child and adolescent services also followed the same pattern as seen for all services but have shown some year-on-year volatility in the years following the initial reduction in the event rate.
- Older persons services have had low rates since the data collections commenced and zero events since 2017-18.
- The pattern over time for forensic services does not match that seen for all services and shows considerable year-on-year volatility in event rates.

Restraint

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

Between 2015-16 and 2024-25:

- Nationally, mechanical restraint rates for all services ranged between zero and 2 events per 1,000 bed days.
- Forensic services recorded both the highest mechanical restraint event rates and highest physical restraint event rates.
- National physical restraint rates for all services ranged between 9 and 12 events per 1,000 bed days.

Involuntary treatment

This is the compulsory assessment and/or treatment of a person in a mental health service without their consent and requires approval under state and territory mental health-related legislation.

From 2019-20 to 2023-24:

- Between 47% and 50% of public acute-hospitalisations were involuntary.
- Between 27% and 31% of public non-acute hospitalisations were involuntary.
- Between 15% and 16% of public specialised community mental health care episodes were involuntary.
- Between 16% and 20% of public specialised residential mental health care episodes were involuntary.

There are acknowledged data gaps towards understanding use of chemical restraint largely driven by ongoing lack of consensus on definition and reporting requirements.[151 152]

Theme  Safety and Quality - Indicators with identified data gaps

Some indicators within this theme do not yet have robust, reliable national data to support an assessment of performance over time. These indicators are explored below.

Indicators	Why these indicators matter despite limited data
Consumers feel safe in interactions with the mental health system	Definitions of both safety and harm can vary substantially between consumers and clinicians. Most existing measures of safety focus on harm minimisation and risk management, rather than whether consumers feel safe when receiving care.
Consumers and carers are involved and supported in decision-making about care	Involving consumers in decision making about their care, as well as providing opportunities for family and carers to be involved as appropriate, are important parts of person-centred care, but not easily measurable.
Cultural and gender responsiveness of care	The extent to which services are culturally appropriate and provide gender responsive care have important considerations for both accessibility and safety and quality. However quantitative datasets alone cannot capture appropriateness or cultural safety of mental health care.
Experiences of stigma, discrimination, and coercion in mental health care	Stigma and discrimination are barriers to accessing quality mental health care but can be difficult to measure and monitor over time. Improved data can help inform efforts to reduce and, where possible, eliminate coercive practices in mental health care.
Awareness and confidence in complaint mechanisms and safeguards	Everyone has a right to make a complaint about their experiences in mental health care; however, in practice, doing so is not straightforward. Knowing how and where to submit a complaint about a mental health service can be unclear within a landscape of complex service and funding arrangements.

Theme Sustainability and efficiency

To understand this theme, we consider the following guiding questions:

To what extent are consumers, carers, family and kin supported by a well-resourced and efficient mental health system now and into the future?

To what extent are consumers, carers, family and kin included in stewardship of the mental health system?

The Commission draws on the following indicators:

- Proportion of public and private expenditure on mental health related services
- Workforce distribution (FTE) of psychiatry, psychology, allied health professionals and peer workforce
- Participation of peer workers in the mental health workforce **Identified data gap**
- Involvement of consumers and people with lived and living experience in national mental health research activities **Identified data gap**
- Consumers have meaningful, decision-making power in the governance, design delivery and evaluation of the mental health system **Identified data gap**

Monitoring aspects of the mental health workforce such as supply, demand and need, alongside expenditure, can support a broader understanding of system sustainability. Evaluation activities can identify learnings and inform ongoing improvements to mental health services and supports, so they can better meet the needs and preferences of those who need them, in a sustainable and efficient way.

Proportion of public and private expenditure on mental health related services

Expenditure data for government-funded programs provides a consistent and readily available way to monitor whether resourcing for services is increasing, decreasing or being maintained. Current expenditure information is limited to Commonwealth, and State and Territory expenditure, which does not yet provide a full picture of the mental health system including NGOs, NFP organisations, philanthropic and other community-based and run programs and services. Further, this doesn't capture broader mental health related programs beyond the health system (such as in educational and social service settings).

Noting these limitations, between 2013-14 and 2023-24, spending on mental health by governments has increased from $10.7 billion to $14.5 billion, an increase of 35% in real terms.

- Over this period, per capita spending increased from $460 to $537.
- Australian Government mental health spending was $4.8 billion during 2023-24 and state and territory spending was $9.0 billion.
- For the Australian Government mental health spending, 32% was for Medicare and 15% for the PBS.
- For state and territory governments mental health spending, 41% was on public hospitals and 39% on specialised community services.

Recent national expenditure in mental health reflects sustained investment in mental health services aimed at improving access and reducing barriers to care. In the 2025-26 Mid-Year Economic and Fiscal Outlook,[153] we saw Australian Government investments of $1.1 billion to deliver more free mental health care announced. This included:

- $490.3 million for a new network of 20 Youth Specialist Care Centres

- $267.3 million for 32 new and upgraded Medicare Mental Health Centres
- $225.3 million for 58 new, upgraded or expanded headspace services and
- $83.9 million for additional training places for mental health professionals and peer workers.

The Commission will continue to monitor the impact of this expenditure over time.

Workforce distribution (FTE) of psychiatry, psychology, and peer workforce

The mental health workforce is a critical resource with significant influence on the quality, accessibility, effectiveness and sustainability of the mental health system. Monitoring changes in workforce over time can help us understand the likelihood that the workforce will be sufficient to meet need in the community.

Between 2015 and 2024:

- The Full Time Equivalent (FTE) rate of psychiatrists (per 100,000 people) increased from 13 to 15.
- The FTE rate of psychologists increased from 88 to 113.
- The FTE rate of mental health nurses increased from 84 to 101.
- The FTE rate of mental health occupational therapists increased from 7 to 10.

Understanding the extent to which the size and distribution of the mental health workforce is sufficient in supporting the needs of people with mental health concerns is key to understanding the sustainability of our mental health system. While monitoring the above figures and trends is important in understanding workforce trends, these findings are not able to tell us the extent to which the mental health workforce is meeting demand and the degree of unmet need across the population. The following section explores whether projected psychology and psychiatry workforces are adequate to meet projected need.

Box 10 - Workforce Supply and Demand - Psychology and Psychiatry workforces

Since the release of Report Card 2024, the Department of Health, Disability and Ageing has published two reports providing estimates of supply and demand for professionals in the mental health workforce. These inform the ongoing evidence-base for future mental health workforce planning and policies:

- The Psychology Supply and Demand Compendium Report (April 2026) produced long term projections of supply and demand for psychologists working in health settings from 2025 to 2038. This report projected an overall shortfall of psychologists over the next 15 years, with demand expected to exceed available workforce supply. The report's baseline demand projections indicate the psychology workforce in health settings will face a 3% shortfall in 2025, rising to 28.4% by 2038. When unmet demand is considered, the findings highlight a much larger shortage of psychologists in health settings across Australia.
- Unmet demand projections indicated a 57.3% undersupply of psychologists in 2025, increasing to an alarming 96.6% undersupply by 2038.
- The Psychiatry Supply and Demand Compendium Report (November 2025) indicated a likely undersupply of psychiatrists over the next 25 years. The demand for psychiatric services delivered in the community will likely exceed the supply of psychiatrists available in the workforce. The report's baseline demand projections indicated an undersupply of psychiatrists in 2024 (2.7%), with a peak at 7.4% in 2033, declining to 4.3% in 2048. Considering unmet need, the findings highlight a much larger shortage of psychiatrists across Australia. Projections indicate a 19.6% undersupply of psychiatrists in 2024, with an expected increase to 20.7% in 2048.
- Crucially, psychiatrists are one of the only professions authorised to prescribe mental health-related medications. Psychiatry workforce shortages can have implications for this type of treatment now and into the future.

Both studies used the National Mental Health Service Planning Framework[xvii] (NMHSPF) to estimate the level of unmet demand for psychology and psychiatry services, respectively. Going forward, both models will be refreshed every two years using the most current available data.

Although the number of new psychologists and psychiatrists are gradually increasing, this is generally not at a rate expected to keep up with projected demand for services. Australia's ageing and growing population is expected to increase demand and shift the types of mental health services needed in the future. Findings from both studies acknowledge that the psychology and psychiatry workforces are ageing. There is a need to increase the respective workforces where feasible and seek opportunities to enhance the capability and capacity of the broader multidisciplinary mental health workforce.[154] [155]

As previous Report Cards have highlighted, there is no co-ordinated, national data representing the activity and impact of the NGO workforce across a range of settings. This includes the community-managed mental health and psychosocial support workforce, the peer workforce and early intervention/digital support workers. However, there are encouraging signs of a developing national picture on the peer workforce, noted in the indicator below.

xvii 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.

Participation of peer workers in the mental health workforce

The peer workforce plays a uniquely valuable role in mental health care and support for consumers, carers, families and kin; however national data is limited to specific service settings. Monitoring peer workforce participation can help us understand the growing involvement of the lived experience workforce in the mental health system.

From a national view, we are largely limited to data about public sector services who employ consumer and carer workers. However, across these services, data indicates strong growth.

Nationally in 2023-24, 53% of specialised mental health organisations employed *consumer workers,* who are engaged based on their lived experience expertise and are often involved in peer support roles and service planning:

- Between 2014-15 and 2023-24, the rate of FTE **consumer** workers **increased** from 37 to 139 (per 10,000 mental health care provider FTE). This increase remained relatively steady from 2014-15 to 2019-20, with a **large increase** in 2020-21 (from 70 in 2019-20 to 104 in 2020-21).
- In 2023-24, 35% of specialised mental health organisations employed **carer** workers, who draw on their lived experience of caring for someone with a mental health challenge, and are largely involved in advocacy and support roles.
- Nationally, between 2014-15 and 2023-24, **the rate of FTE carer workers greatly increased** from 13 to 59 (per 10,000 mental health care provider FTE).

There is limited national data about the activity and impact of peer workers in the non-government mental health sector, although there are some examples seen in national programs. As reported in headspace's 2024-2025 Annual Report, their peer work team has grown to 98 workers across 61 headspace centres, supported by continued training and development activities for the peer workforce.[156]

There are promising signs that peer workforce data is set to improve. In 2026 the first Australian National Mental Health and Suicide Prevention Lived Experience (Peer) Workforce Census was fielded from 15 March to 18 April 2026. The Census is being delivered by the Social Research Centre on behalf of the Department of Health, Disability and Ageing,[157] and is anticipated to provide valuable insights into this growing and essential workforce.

Another recent development that will help build understanding of the value and impact of the peer workforce is the establishment of the Australian Association of Peer Workers by the National Mental Health Consumer Alliance in partnership with the Indigenous Australian Lived Experience Centre (IALEC) and Mental Health Carers Australia (MHCA). The Association's leadership roles, governance design and membership are centred on peer workers.[158] This represents an important step in embedding lived experience expertise and practice across the mental health and suicide prevention systems.

Theme Sustainability and Efficiency - Indicators with identified data gaps

The indicators in this theme which do not have robust, reliable national data sets on which to assess performance over time are explored below.

Indicators	Why these indicators matter despite limited data
Participation of peer workers in the mental health workforce	From a national view, we are largely limited to data about public sector services who employ consumer and carer workers. Future reporting of this indicator will look to draw on broader sources of evidence about the participation of this workforce.
Involvement of consumers and people with lived experience in national mental health research activities	It is widely recognised that consumers should have opportunities to be involved in all levels of the co-design, delivery, evaluation and service quality and improvement research of mental health services. Despite pockets of activity underway, there is limited data at a national level to inform this picture. The Commission will look to increase its capability to report on the extent to which consumers and people with lived and living experience are involved in research and evaluation activities that ultimately can inform service design and system improvement.
Consumers have meaningful, decision-making power in the governance, design delivery and evaluation of the mental health system	Consumer participation in the governance and decision-making in the mental health system are important activities that remain underdeveloped in measurement terms.

Theme Effectiveness

To understand this theme, we consider the following guiding question:

To what extent do consumers, carers, family and kin experience improved outcomes after interacting with the mental health system?

To what extent is mental health care for consumers, carers, family and kin informed by best available and emerging evidence?

The Commission draws on the following indicators:

- Consumer, carer, family and kin experiences of mental health services
- Clinical measures of mental health outcomes
- Proportion of people who present to a hospital emergency department (ED) with a mental health related care need who are seen within clinically recommended waiting times
- Person-centred outcomes that matter to consumers **Identified data gap**
- Research and evaluation of service effectiveness and improvement **Identified data gap**

While monitoring access to treatment, support services and mental health investment and expenditure are important indicators of system performance, they do not provide the full picture. Understanding people's experiences of services and support, alongside the experiences of their families, carers, and kin is essential. As highlighted in previous Report Cards, available data continues to provide a limited view of the extent to which consumers receive quality care aligned with their needs and preferences. The following sections draw on latest available data used to measure experiences and outcomes. These key components are used to assess the effectiveness of the mental health system. Substantial data and information gaps remain in measuring the needs, experiences and outcomes of people in Australia, particularly those accessing services and supports outside the public health system.

Consumer, carer family and kin experiences of mental health services

Monitoring and reporting on consumer, carer, family and kin experiences helps us to understand whether the mental health service system is effectively meeting the needs of those it serves. In Australia, there is ongoing work to improve the collection and reporting of experiences from consumers and carers and the mental health care they receive.[159]

The Your Experience of Service (YES) Survey collects information from consumers' self-reported experiences of publicly funded mental health care. These settings include ambulatory (non-admitted) services, admitted (hospital) services and residential (overnight) services. The YES Survey was developed in partnership with mental health consumers across Australia and first became available in 2015.[160] The YES Survey measures experience of mental health services across six domains (i.e., Making a Difference, Information and Support, Individuality, Participation, Respect, and Safety and Fairness).

The intent of the YES Survey is to provide a way for consumers to give feedback about their experiences of care and have that feedback inform service quality and improvement. While survey results are available for New South Wales, Victoria and Queensland, comparison across jurisdictions is difficult given differences in survey collection frequency. It is important to acknowledge that the YES Survey is often administered following experiences of care that have involved involuntary treatment. As reflected in the data below, experience surveys from respondents who received involuntary treatment are less likely to indicate a positive experience of care score.[xviii]

xviii An experience of care score is calculated by determining the average response of questions 1–22 in the YES survey multiplied by 20. The resulting overall score converts the individual question responses into a score out of 100. A threshold score of 80 and above is used to indicate a positive experience of service.

During 2023-2024:

- In admitted mental health care services, the proportion of consumers who had a positive experience of care ranged from 49% of consumers reporting a positive experience in Victoria, 51% of consumers in Queensland, and 72% of consumers in NSW.
- In ambulatory mental health services, the proportion of consumers who had positive experiences of their care was higher across all jurisdictions, with 75% of consumers reporting positive experiences in Victoria, 80% in NSW and 83% in Queensland.

The YES survey provides other information on consumer experience, such as ratings of care they received. During 2023-24:

- 87% of respondents in admitted care rated their care as 'Good', 'Very Good' or 'Excellent' in NSW, 77% in Queensland and 76% in Victoria.
- 94% of respondents in ambulatory care rated their care as 'Good', 'Very Good' or 'Excellent' in Qld, 90% in Victoria and 89% in NSW.

When asked to rate the effect the admitted care service had on the consumer responding to the survey during 2023-24:

- 84% of respondents rated their 'hopefulness for the future' as 'Good', 'Very Good' or 'Excellent' in NSW and 73% in both Victoria and Queensland.
- 83% of respondents rated their 'ability to manage day to day life' as 'Good', 'Very Good' or 'Excellent' in NSW, 74% in Victoria and 71% in Queensland.
- 84% of respondents rated their 'overall wellbeing' as 'Good', 'Very Good' or 'Excellent' in NSW, 73% in Victoria and 72% in Queensland.

When asked to rate the effect the ambulatory care service had on the consumer responding to the survey during 2023-24:

- 89% of respondents rated their 'hopefulness for the future' as 'Good', 'Very Good' or 'Excellent' in Queensland and 85% in both NSW and Victoria.
- 88% of respondents in ambulatory care rated their 'ability to manage day to day life' as 'Good', 'Very Good' or 'Excellent' in Queensland, 86% in NSW and 85% in Victoria.
- 90% of respondents in ambulatory care rated their 'overall wellbeing' as 'Good', 'Very Good' or 'Excellent' in Queensland and 87% in both NSW and Victoria.

The Mental Health Carer Experience Survey (CES) is offered to carers of a mental health consumer to rate their experience of a public sector specialised mental health service including hospitals, community mental health settings and residential mental health settings. The CES was released for use in 2018 and is currently available for New South Wales (see latest Mental Health Carers NSW 2024-2025 survey here) and South Australia (see the latest SA Mental Health Carer Experience Survey Report here). Going forward, the Commission aims to continue to grow our understanding of consumer and carer experience in the mental health care system, including through the CES.

Clinical measures of mental health outcomes

Outcomes data is critical for consistently monitoring, evaluating and improving services. However, nationally available mental health outcomes data is currently based on clinician-rated measures collected within state and territory public specialised mental health services only.[xix] This limits our understanding of outcomes across the wider mental health system and, significantly, does not capture outcomes as reported by consumers themselves.

In terms of clinical outcomes for people accessing specialised public mental health care, for every year between 2013-14 and 2023-24:

- Between 71% and 74% of completed acute inpatient episodes showed 'significant improvement'.
- Between 49% and 52% of completed ambulatory episodes showed 'significant improvement'.

This national data is impacted by the relative acuity of presenting symptoms and experiences of involuntary admission across settings.

While the YES and CES surveys, alongside data on clinical outcomes in a specialised public mental health care context provide some insight, this is far from providing a holistic picture. This is explored further below.

Box 11 - Gap in understanding experiences and outcomes from people about mental health services

Measuring the effectiveness of the system must reflect consumer and carer experiences, not only clinical or systemic outcomes. As highlighted, most national experiences and outcomes data used to measure effectiveness of mental health services do not capture the full spectrum of care including experiences and outcomes in settings providing non-clinical, psychosocial and community-managed services. Currently reported quantitative measures alone cannot capture person-defined experiences and outcomes. In addition to these gaps, there are inherent complexities in attributing improvements from standardised measures to the performance of the mental health system. This is because there are a range of potential factors that can contribute to improved mental health, beyond the influence of a service or support provided by the system. To continue to improve this picture, the following issues require consideration:

- Carer, family and kin experiences and outcomes are an important indicator of how well services are working; however, **the broader impacts of mental health challenges on families, carers and kin are not consistently measured.** This limits our ability to fully quantify need and to effectively plan and deliver supports. When care is not accessible or is delayed, families and carers may take on additional caring and system-navigation responsibilities, which can in turn impact their own wellbeing.
- Existing nationally representative outcome measures largely assess publicly funded services, highlighting the need for **experiences and outcome measurements** across a broader range of care settings to better understand the extent to which mental health services are improving outcomes for people. This includes data about **experiences and outcomes** for people in Australia who:
  - see a GP for their mental health;
  - interact with mental health services delivered by non-government services, as
  - highlighted through the work of MHA; and
  - manage severe and/or complex mental health needs.

Lack of national data that measures service navigation, care continuity and movement between services is preventing **a holistic understanding of how well the system supports people**.

xix Clinician-rated outcomes are recorded in public specialised mental health services using the Health of the National Outcome Scales (HoNOS) instrument which is reported as part of the National Outcomes and Casemix Collection by the Australian Institute of Health and Welfare.

Proportion of people who present to an emergency department with a mental health related care need who are seen within clinically recommended waiting times.

Emergency Departments play a role in treating mental health conditions, and provide out-of-hours support, but are not designed for longer term care and support. Monitoring how long people with mental health-related needs[xx] wait to be seen in emergency departments provides some insight into how effectively the system is responding to mental-health related needs.

Latest available data shows that people with a mental health-related need are less likely to be seen within the clinically recommended wait time, compared to people presenting at emergency departments in general:

- Of people with a mental-health related need seeking care at a public emergency department, 61% were seen within clinically recommended waiting times (2024-2025). This has decreased from 71% of people with a mental-health related need seen within the recommended wait times over 10 years ago (2014-15).
- In contrast, the overall proportion of people presenting at emergency departments seen within clinically recommended waiting times was slightly higher at 67% (2024-25).

Similarly, a descriptive longitudinal analysis of mental health-related ED presentations in Australian public hospitals between 2016-17 and 2020-21 found that people with mental health-related presentations experienced longer stays in ED than the broader population.[161] The findings highlight the importance of understanding the factors associated with mental health-related demand for emergency care.

The Australasian College of Emergency Medicine's report, *State of Emergency: Regional, Rural and Remote 2024 Report* found that people presenting to ED with mental health concerns experienced longer wait times than any other patient type. [162] Based on analysis of state and territory data from the 2021-2022 National Non-Admitted Patient Emergency Department Care Database, this report provided a comparison of emergency care and workforce in metropolitan and regional, rural and remote areas. The report highlighted the importance of accessible, community-based mental health services to support people remain well in the community, which may reduce likelihood of crisis and need for acute services through emergency departments. For further information on ED experiences refer to **disparities across cohorts for emergency department presentations in Box 7).**

xx Defined as a mental-health related principal diagnosis.

Theme Effectiveness - Indicators with identified data gaps

The indicators in this theme which do not yet have robust, reliable national data sets on which to assess performance over time are explored below.

Indicators	Why these indicators matter despite limited data
Consumer, carer, family, and kin experiences of mental health services	While there are some jurisdictions reporting the YES and CES surveys, there is not a national picture. Refer to **Box 11 - Gap in understanding experiences and outcomes from people about mental health services.**
Person-centred outcomes that matter to consumers	Currently reported quantitative measures alone cannot capture person-defined experiences and outcomes. Effectiveness of the system must reflect consumer and carer outcomes, not only clinical or systemic outcomes.
Research and evaluation of service effectiveness and improvement	Research and evaluation are critical to improving service effectiveness and supporting a well-functioning mental health system, but this activity is not well captured nationally. Over time, the Commission will seek opportunities to incorporate data on mental health research and evaluation activity. The Commonwealth National Mental Health and Suicide Prevention Evaluation Framework provides best practice guidance on the conduct of mental health and suicide prevention evaluations, and promotes publication of evaluation findings where possible.[163]

To grow our understanding of the effectiveness of the mental health service system, the Commission is investing in evaluation activity. This includes commissioning a comprehensive modelling and evaluation of mental health services and supports in April 2026. Work underway is explored below.

Box 12 - Strengthening the evidence base through research and evaluation

Economic modelling and evaluation

Understanding the economic evidence base for mental health services and supports is a longstanding gap, and increasingly important to understand in a tight fiscal environment. In April 2026, the Commission engaged Monash University to deliver a comprehensive economic modelling and evaluation of mental health services and supports in Australia.

This project is expected to generate high quality evidence to inform ongoing national mental health reforms, while strengthening reporting, monitoring and accountability across the mental health system. The project is being delivered in two phases, with initial findings expected later in 2026, with the final report to be delivered in 2027.

System mapping

In June 2026, the Commission engaged Nous Group to develop a series of clear system maps of the mental health system. These maps will help define the boundaries of the mental health system, how services interconnect and consider the consumer experience of the system.

This project addresses one of the biggest complexities in mental health: defining the “mental health system”, understanding how services operate, how individuals move through the system, and how different actors (e.g. Commonwealth, states and territories, service providers) contribute to the strategic system view. The resulting maps will be a practical tool for evidence-based planning, policy advice, and communication.

Evidence for prevention and action in social determinants of mental health

In June 2026, the Commission engaged Sax Institute to design, develop, and deliver a dynamic simulation model to support more effective and coordinated investment in mental health across Australia. The model will enable assessment and quantification of the impact of investment in prevention and social determinants of mental health, supporting evidence-informed policy and investment decisions. The model will be accompanied by an interactive dashboard for scenario testing and reporting.

Developing the National Report Card

Our Reporting Framework

Since 2012, the Commission has been responsible for producing an Annual National Report Card on the performance of the mental health system. To provide consistent and objective monitoring and reporting on Australia's mental health system over time, the Commission has been building on the Report Card's reporting framework introduced in the 2023 edition.

The framework organises information and data under 3 domains:

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

Within the domains there are:

- a series of overarching **guiding questions** (e.g. 'How mentally healthy are people in Australia?'),
- core **indicators** that go towards answering each question (e.g. Prevalence of mental disorders), and
- appropriate **data sources** for each indicator (e.g. National Study of Mental Health and Wellbeing).

In Report Card 2023 and 2024, the Commission reported on 13 core indicators for Mental health: Domain 1 and Social determinants: Domain 2. In System inputs and activities: Domain 3 we provided an overview from the data available for this domain and noted this domain as an area for improvement in future editions.
The selection of indicators and data was informed by a review of existing and proposed mental health indicator frameworks, together with ongoing consultation with stakeholders, and experts in data and measurement, including AIHW.

The Commission works closely with data custodians to ensure that the data we draw on is robust, fit for purpose, and provides meaningful insights on mental health in Australia. The following criteria help guide the development and continual improvement the data we draw on to assess our indicators.

Box 13 - Our data criteria

- **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 Commission also draws on supplementary data sources to support contemporary analysis against each of our domains. We 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.

These criteria, applied across our data sources provide an essential lens through which to assess potential new data sources as they become available or evolve. This helps ensure our reporting remains high quality, consistent and trustworthy.

You can find out more about our approach to establishing this reporting framework in National Report Card 2023 and National Report Card 2024. This work has provided a foundation for building a consistent and objective reporting approach over time. Our focus for iteration and improvement in 2025 is explored below.

Improving the National Report Card

The Commission has been working with stakeholders to build on the strengths of our Report Card to ensure it delivers a comprehensive reporting approach, utilising best available data and evidence. Report Card 2025 builds on previous years, as outlined below.

Timeline: Developing the National Report Card

Then	Now	Next
• Report Card 2023 - Commission introduces reporting framework with 3 domains • Based on review of frameworks, assessment against objective criteria • Report Card 2024 – continues to build on framework through identifying and using supplementary data to deepen understanding	• Report Card 2025 – incorporates Mental Health System: Domain 3 components developed with stakeholders • Implements short-term opportunities to include data representing mental health services delivered by NGOs • Publishes standalone National Report Card: Environmental Scan	• Revisit domains 1 and 2 in the reporting framework to ensure they capture relevant elements • Build on our understanding of how stakeholders are using the Report Card for their needs, so our products can continue to evolve • Consider revised reporting framework as a whole and feasibility of further potential data sources • Explore and integrate broader evidence into our Reporting Framework

Progress since last edition

Since releasing Report Card 2024, the Commission has been collaborating with stakeholders, including lived experience organisations, with a primary focus on the development of the mental health system domain of the reporting framework. The Commission has also partnered with Mental Health Australia to identify mechanisms through which sector service delivery could be recognised and reported on in Mental health system: Domain 3. Together, these activities address a key gap in our framework.

Mental health system: Domain 3 (previously "System Inputs and Activities)

To inform the development of the Mental health system: Domain 3 in Report Card 2025, the Commission considered a range of comparable frameworks, reports, reviews and strategies to identify how the system is commonly understood and measured. To build on this evidence and begin to move towards the establishment of a revised domain, the Commission established a small working group with a cross-section of organisations with relevant expertise, including lived experience, policy, data and measurement. This group provided guidance to assist the development of Mental health system: Domain 3, including considering:

- How we can best conceptualise and describe the domain so it effectively encompasses the 'mental health system', including its purpose and scope.
- The identification and logical flow or hierarchy of the domain's sub themes (accessibility, continuity and integration of care, safety and quality, sustainability and efficiency, effectiveness).
- Framing the 'guiding questions' within the domain so they effectively guide areas for enquiry and ensure a focus on people rather than the system.
- Refining indicators that answer the guiding questions, to enable monitoring what is important while minimising duplication.
- Exploring current and potential future data sources for indicators (including where the Commission can highlight data gaps for consideration by relevant authorities).

Informed by the considered input from the group, the Commission has included an initial version of the Mental health system: Domain 3 in Report Card 2025. The Commission intends to continue to build on this domain in future Report Card editions over time, as further data and evidence becomes available and informed by people with lived experience and consumers and carers, as well as feedback from the sector.

Box 14 – Working with available data and acknowledging its limitations

Why are there some indicators with no national data sources identified?

The approach to the Mental health system: Domain 3 has been to identify the guiding questions and indicators that matter most to understand the mental health system – even where there is no data currently available. Through this approach the Report Card focuses on the areas identified as being important to monitor and report, as defined through stakeholder consultation, review of public reports and reviews of mental health in Australia, as well as peer-reviewed literature. This aims to avoid bias that can arise from measuring only those areas where there is currently data available.

Work to improve data and evidence

As identified throughout domain 3, the Commission is working closely with data custodians and broader stakeholders to make the most of available data and build evidence where appropriate and aligned with the Commission's role and scope. As foreshadowed in Report Card 2024, a key part of this has included work to partner with MHA to scope the current and potential future role for non-government sector data as an evidence source for Report Card. This occurs alongside broader activity in the Commission to improve understanding of the effectiveness of our mental health system.

2025 Environmental Scan (January 2025 to December 2025)

Elsewhere, the Commission continues to refine its approach to undertaking the retrospective Environmental Scan of major events and trends that occurred in the calendar year. This seeks to build understanding of factors that had the potential to impact the mental health of people in Australia and to contextualise the data shown in the Report Card.

Each event/trend that emerged was assessed based on:

- The estimated reach and size of the expected impact on the mental health of people in Australia
- The strength of the evidence supporting a potential link between the event/trend and mental health outcomes, and
- The general relevance of the event/trend to the mental health of people in Australia.

Several key themes emerged based on this evaluation that are discussed in this section, with more detail explored through the Extended Environmental Scan, and although they are discussed individually, they are highly interconnected. These provide insight into the contextual environment of the calendar year and are intended to frame the changes in mental health outcomes described in the Report Card without suggesting they had a causal impact.

Our environmental scanning also acts as an opportunity to identify emerging trends which may eventually warrant more regular monitoring and analysis over time, such as through potential incorporation into our Report Card Reporting Framework.

Future Directions to our Reporting Framework

As part of an iterative approach to improving National Report Card over time, the Commission intends to undertake a range of work in coming years to improve our understanding of mental health and the outcomes our support systems are achieving.

Our Reporting Framework represents a strong foundation on which to build. The Commission will evolve our approach as evidence, data availability and community and sector views change. In line with the approach to develop the Mental Health System: Domain 3, the Commission intends to revisit the existing components of Mental health: Domain 1 and Social determinants: Domain 2 to ensure they are asking the questions that matter and reflect contemporary understanding of these areas. We will also further consider where there are improved data sources available for inclusion in Mental health system: Domain 3.

We recognise that quantitative data alone cannot provide a complete understanding of what is happening in the mental health system in Australia and why. The Commission is currently exploring approaches to embed diverse lived experience perspectives within the Report Card, recognising lived experience as a key form of evidence that can enrich interpretation of the data and provide insight how the mental health system is performing.

Finally, the Commission is considering how the Report Card can best meet the needs of stakeholders, particularly those who use the report's analysis to inform their development or implementation of mental health policy.

How are things tracking overall?

As highlighted in our Key Insights:

- Need for mental health support in Australia remains high, but is not fully visible in the data.
- Overall, people with mental health conditions face greater social pressures and poorer wellbeing outcomes.
- The mental health service system is doing more, but uneven access, system fragmentation and data gaps limit impact and opportunity to improve.

Our observations highlight the need for future reform to focus on prevention, service system improvement, workforce growth, and strong national data. Australia must strengthen prevention by addressing the social and economic factors that influence mental health and wellbeing, while also improving the mental health system so people can access the right support earlier, regardless of where they live or their personal circumstances.

This includes continuing efforts to promote social inclusion, reduce stigma and discrimination, and ensure key services, such as housing, employment, education and community support, can effectively respond to people with mental health needs, particularly those facing multiple and overlapping forms of disadvantage.

There are significant opportunities to improve mental health service planning so that services better meet community needs, provide support earlier, and ensure timely access to affordable care for those who need it. Ongoing effort is also needed to build and sustain a skilled mental health workforce across all roles, in line with the National Mental Health Workforce Strategy 2022–2032.

By strengthening both service planning and workforce capacity, Australia can improve access to the right care at the right time and better support positive mental health outcomes.

The Commission will continue to refine the Reporting Framework to ensure it reflects emerging issues and trends affecting mental health in Australia. This will help build a clearer picture of where reform is delivering meaningful improvements.

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AEDC	Australian Early Development Census
AIHW	Australian Institute of Health and Welfare
ASGS	Australian Statistical Geography Standard
CALD	Culturally and Linguistically Diverse
CES	Carer Experience Survey
DVA	Department of Veterans' Affairs
ED	Emergency Department
ECHC	Early childhood checks
FTE	Full Time Equivalent
GP	General Practitioner
GSS	General Social Survey
HILDA survey	Household, Income and Labour Dynamics in Australia survey
ICD-10	World Health Organization International Classification of Diseases, Tenth Revision
LGBTIQA+	The acronym LGBTIQA+ has been used to describe lesbian, gay, bisexual/bi+, trans and gender diverse, people with innate variations of sex characteristics, queer, asexual/ aromantic and other sexuality and gender diverse people and communities.
LSIC	Longitudinal Study of Indigenous Children
MHA	Mental Health Australia
MBS	Medical Benefits Schedule
NATSIHS	National Aboriginal and Torres Strait Islander Health Survey
National Agreement	National Mental Health and Suicide Prevention Agreement
NDIS	National Disability Insurance Scheme
NFP	Not-for-Profit
NHS	National Health Survey
NGO	Non-Government Organisation
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
PBS	Pharmaceutical Benefits Scheme
PESTEL	Political, Economic, Social, Technological, Environmental and Legal
QLD	Queensland
PHN	Primary Health Networks
RC2023	National Report Card 2023
RC2024	National Report Card 2024
RC2025	Report Card 2025
SEIFA	Socio-Economic Indexes for Areas
SEWB	Social and emotional wellbeing
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.

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 illness who uses, has used or may use a mental health service.

Loneliness
A negative subjective appraisal of social relationships, arising when an individual perceives their social connections as insufficient in meeting their social needs.

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 that restricts them in their everyday activities, and which has lasted or is likely to last for six 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 and/or 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[164]'. The term itself covers a range of disorders including anxiety, affective and substance use disorders.

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

Psychological distress
Measured using the Kessler Psychological Distress Scale. The scale measures the level of current anxiety and depressive symptoms a person may have experienced in the 4 weeks before the interview.

Restraint
The process of holding down or stopping a person from moving freely, either through use of an item or device (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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Appendix 1

Report Card Reporting Framework

Core Question: How well is the mental health system faring in meeting the needs of people in Australia?

Domains	Guiding Questions	Indicators	Data sources (including drawing on supplementary data sources when there are no updates to the primary data sources since last Report Card)
Mental Health - Domain 1 What is the status of key mental health and wellbeing outcomes for people with lived experience of mental health challenges?	**How mentally healthy are people in Australia?** **Is it the same for everyone?**	• Prevalence of mental disorders	National Study of Mental Health and Wellbeing (2020-2022) *National Health Survey* and *National Aboriginal and Torres Strait Islander Health Survey (2022-2023)*
		• Psychological distress	National Health Survey (2022) *General Social Survey (2025)*
		• Overall life satisfaction	General Social Survey (2025) *Household Income and Labour Dynamics in Australia Survey (HILDA) (most recent module for this indicator is 2024)*
		• Feeling in control	HILDA Survey (most recent module for this indicator is 2023)
Social Determinants - Domain 2 How are the broader social factors that have an impact on mental health of people	**Are the factors that influence mental health improving?** **What are the experiences of people with mental health challenges compared to the community?**	• Proportion of children who are developmentally vulnerable	Australian Early Development Census (2024)
		• Housing security (homelessness)	National Study of Mental Health and Wellbeing (2020-2022) *Census of Population and Housing (most recent is 2021)* and *Specialist Homelessness Services Collection (most recent 2024-25)*

in Australia, as well as the whole of life outcomes for people with lived experience, tracking?			• Financial stress	General Social Survey (2025) *HILDA Survey (most recent module for this indicator is 2024), Scanlon Mapping Social Cohesion Survey (2025)*
			• Employment rate	National Health Survey (2022)
			• Engagement in employment or study for young people	National Health Survey (2022)
			• Prevalence of physical health conditions	National Study of Mental Health and Wellbeing (2020-2022) *National Health Survey (2022)*
			• Alcohol consumption	National Drug Strategy Household Survey (2022-23)
			• Feeling lonely	HILDA Survey (2024)
			• Experiences of discrimination	General Social Survey (2025) *Scanlon Mapping Social Cohesion Survey (2025)*
Mental Health System - Domain 3 How are the system activities that impact the mental health outcomes of people in Australia performing?	**Accessibility**	**Are consumers, carers, family and kin getting the right care and support when they need it?**	• Mental health care is timely, affordable and geographically accessible for all communities	AIHW analysis of National Hospital Morbidity Database 2023-24, National Residential Mental Health Care Database 2023-24, National Non-admitted Patient Emergency Department Care Database 2024-25, National Community Mental Health Care Database 2023-24, AIHW analysis of MBS data maintained by the Australian Government Department of Health Disability and Ageing 2024-25, AIHW analysis of PBS data maintained by the Australian Government of Health, Disability and Ageing 2024-25
			• Treatment rates	AIHW analysis of data from State and Territory governments (unpublished); Private Mental Health Alliance Centralised Data Management Service data (unpublished) 2007–08 to 2014–15; Private Psychiatric Hospitals Data Reporting and Analysis

				Service (unpublished) 2015–16 onwards; Department of Health, Disability and Ageing MBS Statistics (unpublished); Department of Veterans' Affairs Treatment Account System data (unpublished).
			• Unmet need for mental health care	Identified data gap in national data source, with scoping of future options underway.
			• Access to non-government mental health services	Identified data gap in national data source, with scoping of future options underway.
			• Services received that did not meet needs	Identified data gap in national data source, with scoping of future options underway.
		To what extent are consumers, carers, family and ki n unable to access the mental health supports they need, trust and prefer?	• Cost related delays to accessing care	ABS Patient Experience Survey (ABS) (2024-2025)
			• Wait times following referral	Identified data gap in national data source, with scoping of future options underway.
			• Capability and capacity of families, carers and kin to effectively support people experiencing mental health challenges	Identified data in national data source, with scoping of future options underway.
		To what extent do consumers, carers, family and kin have awareness, understanding, and trust towards available mental health supports?	• Knowledge and awareness of how to navigate to relevant mental health care	Identified data gap in national data source, with scoping of future options underway.
			• Mental health literacy	Identified data gap in national data source, with scoping of future options underway.

			• Proportion of people who report receiving effective support to navigate between multiple mental health providers	Identified data gap in national data source, with scoping of future options underway.
			• Experience of stigma in mental health services	Identified data gap in national data source, with scoping of future options underway.
	Continuity and integration of care	**To what extent do consumers, carers, family and kin experience supported, connected navigation across all parts of their care journey?** **To what extent do carers, family and kin experience connected navigation across all part of the care journey of the people they support?**	• Community follow-up after hospitalisation for mental health	AIHW analysis of unpublished State and Territory data (2023-24)
			• Mental health workforce satisfaction rates (e.g. mental health workers, nurses, GPs, etc.)	Identified data gap in national data source, with scoping of future options underway.
			• Proportion of consumers reporting supported navigation across their care journey	Identified data gap in national data source, with scoping of future options underway.
			• Rate of discontinuing treatment services following referral	Identified data gap in national data source, with scoping of future options underway.
			• Rates of standardised asse ssment and referrals	Identified data gap in national data source, with scoping of future options underway.
			• Consumer and family rated measures of referral “warmth”	Identified data gap in national data source, with scoping of future options underway.

	Safety and quality	**To what extent do consumers, carers, family and kin receive care that feels safe, respects their rights, rights-respecting and aligned with and is responsive to their preferences, culture and identity?**	• Use of restrictive and involuntary practices in mental health care	AIHW analysis of National Seclusion and Restraint Database 2024-25
			• Consumers feel safe in interactions with the mental health system	Identified data gap in national data source, with scoping of future options underway.
			• Consumers and carers are involved and supported in decision-making about care	Identified data gap in national data source, with scoping of future options underway.
			• Cultural and gender responsiveness of care	Identified data gap in national data source, with scoping of future options underway.
		To what extent are consumers, carers, family and kin feeling safe and respected in interactions with the mental health system?	• Experiences of stigma, discrimination, and coercion in mental health care	Identified data gap in national data source, with scoping of future options underway.
			• Awareness and confidence in complaints mechanisms and safeguards	Identified data gap in national data source, with scoping of future options underway.
	Sustainability and efficiency	**To what extent are consumers, carers, family and kin supported by a well-resourced and efficient mental health system now and into the future?**	• Proportion of public and private expenditure on mental health related services	Australian Government Department of Health, Disability and Ageing (unpublished) 2023-24 National Mental Health Establishments Database 2023-24

			• Workforce distribution (FTE) of psychiatry, psychology, allied health professionals a nd peer workforce	AIHW analysis of National Health Workforce Dataset (NHWDS) 2024, and data from Australian Association of Social Workers (AASW) (unpublished) 2024
			• Participation of peer workers in the mental health workforce	Identified data gap in national data source, with scoping of future options underway.
		To what extent are consumers, carers, family and kin included in stewardship of the mental health system?	• Involvement of consumers and people with lived and living experience in national mental health research activities	Identified data gap in national data source, with scoping of future options underway.
			• Consumers have meaningful, decision-making power in the governance, design delivery and evaluation of the mental health system	Identified data gap in national data source, with scoping of future options underway.
	Effectiveness	**To what extent do consumers, carers, family and kin experience improved outcomes after interacting with the mental health system?**	• Consumer, carer, family and kin experiences of mental health services	AIHW analysis of Your Experience of Service (YES) Survey Database 2023-24 But identified data gap in experiences across cohorts of carers, family and kin.
			• Person-centred outcomes that matter to consumers	Identified data gap in national data source, with scoping of future options underway.
			• Clinical measures of mental health outcomes	AIHW analysis of data from National Outcomes and Casemix Collection (NOCC) (2023-24)

			• Proportion of people who present to a hospital emergency department (ED) with a mental health related care need who are seen within clinically recommended waiting times	AIHW analysis of National Non-admitted Patient Emergency Department Care Database (2023-2024)
		To what extent is mental health care for consumers, carers, family and kin informed by best available and emerging evidence?	• Research and evaluation of service effectiveness and improvement	Identified data gap in national data source, with scoping of future options underway.


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