



Australian Government
Productivity Commission

Mental Health

Productivity Commission
Inquiry Report
Actions and Findings

No. 95, 30 June 2020

The findings and actions from throughout the report have been collated here for ease of access. The number of each finding and action is aligned with the relevant chapter that provides the supporting detail.

PART I The case for major reform

FINDING 1.1 — FACTORS AFFECTING MENTAL HEALTH AND WELLBEING

A person's mental health reflects the interaction of a lifetime of individual and lifestyle factors with a range of environmental, community and family risk factors. Regular exercise, eating a healthy diet and consistently getting enough sleep can reduce the risks of mental illness. But genetic vulnerability and experiences such as trauma, socioeconomic disadvantage, isolation, discrimination and environmental stressors can all harm people's mental health and wellbeing.

FINDING 2.1 — THE STATE OF MENTAL HEALTH IN AUSTRALIA

Mental illness is the second largest contributor to years lived in ill-health, and almost half of all Australians will experience mental illness at some point in their life. The most common mental illnesses are anxiety disorders and depressive disorders.

Most cases of mental illness have their onset before the age of 21 years, highlighting the need for intervention early in life. Suicide is the leading cause of death for Australians aged 15 to 44 years, and suicide rates are higher in regional areas.

FINDING 3.1 — THE COST OF MENTAL ILL-HEALTH AND SUICIDE TO AUSTRALIA

The costs of mental ill-health and suicide are substantial. They are incurred across the healthcare, education, housing and justice sectors; by workplaces; and by consumers and their families and carers.

The direct economic costs of mental ill-health and suicide in Australia are estimated at \$43–70 billion in 2018-19. These estimates include:

- direct expenditure on healthcare and other supports and services (\$16 billion)
- lower economic participation and lost productivity (\$12–39 billion)
- informal care provided by family and friends (\$15 billion).

The cost of disability and premature death due to mental ill-health, suicide and self-inflicted injury is equivalent to a further \$151 billion. The social and emotional costs of lower social inclusion associated with mental ill-health, if quantified, would add to this.

FINDING 4.1 — A PERSON-CENTRED MENTAL HEALTH SYSTEM

The Australian mental health system should be person-centred, supporting prevention by reducing the risk of an individual developing mental ill-health and enabling early intervention if illness develops.

A person-centred mental health system would comprise the full spectrum of community support and clinical services people may need to recover from mental ill-health and live healthy, productive lives. Consumers and carers should be able to access the services they need when they need them, regardless of administrative or funding structures underpinning them. Wherever possible, such services would reflect the cultural, social and clinical preferences of the consumer.

Services should be delivered by a skilled workforce, supported by technology and comprehensive governance arrangements, to ensure that they are responsive to local needs and can be readily ramped up and down as needs change.

FINDING 4.2 — MODELLED BENEFITS OF KEY RECOMMENDED REFORMS

Improvements to people's mental health increase their likelihood of employment and their expected income, while also improving their health-related quality of life. The benefits from the recommended reforms are substantial and are mainly derived from improvements in people's quality of life — up to \$18 billion per year (corresponding to an improvement in quality-adjusted life years of up to 84 000 annually). There would be additional annual benefits of up to \$1.3 billion per year as a result of increased economic participation and productivity. These benefits would require expenditure of up to \$4.2 billion per year and generate savings of up to \$1.7 billion per year.

PART II Prevention and early intervention

Early childhood and schooling

ACTION 5.1 — PERINATAL MENTAL HEALTH

Governments should take coordinated action to achieve universal screening for perinatal mental illness for all new parents.

Start now

In order to determine current screening rates and prioritise interventions, better data is required.

- The Australian Institute of Health and Welfare (AIHW) should expand the Perinatal National Minimum Data Set, to include indicators of mental health screening in the weeks before and immediately after birth.
- State and Territory Governments should collect data on screening undertaken by maternal and child health nurses and provide this data to the AIHW.
- Using the data from the AIHW, the National Mental Health Commission should commence monitoring and reporting on progress towards universal screening.

Start later

State and Territory Governments should put in place strategies to reach universal levels of screening for perinatal mental illness among new parents. Such strategies should be implemented primarily through existing maternal and child health services, and make use of a range of screening channels, including online screening and outreach services.

ACTION 5.2 — SOCIAL AND EMOTIONAL DEVELOPMENT IN PRESCHOOL CHILDREN

Services for preschool children and their families should have the capacity to support and enhance social and emotional development.

Start now

- State and Territory Governments should use existing guidelines to expand the scope of voluntary early childhood health checks, such that they assess children's social and emotional development before they enter preschool.
- State and Territory Governments should provide funding to enhance the ability of early childhood education and care services to support the social and emotional development of children. This funding should be allocated based on demonstrated need, and services should be required to demonstrate better practices through their quality improvement plan. Services should be able to use funds to:
 - enable staff to attend accredited professional development (including paying for backfilling)
 - access support and advice from qualified mental health professionals.

Start later

- State and Territory Governments should expand the provision of parent education programs through a range of channels, including online platforms and child and family health centres.

ACTION 5.3 — WELLBEING IN THE EDUCATION SYSTEM

Governments should develop a comprehensive set of policy responses to strengthen the ability of schools to assist students and deliver an effective social and emotional learning curriculum.

Start now

The Australian, State and Territory Governments should update the National School Reform Agreement, to include improvements in student wellbeing as one of its outcomes.

In line with other outcomes, the Agreement should include specific targets and measures of student wellbeing that the education system should work towards.

To support the implementation of a national student wellbeing outcome, Governments should develop or commission the development of:

- a nationally consistent minimum dataset, to be collected by all schools on the wellbeing of their students and be included in schools' performance monitoring and reporting (Action 5.7)
- guidelines for the accreditation of initial teacher education programs and professional development courses for teachers, which must include social and emotional learning (Action 5.4)
- guidelines for the accreditation of social and emotional learning programs offered to schools by external providers. (Action 5.5)

ACTION 5.4 — IMPROVING TEACHERS' SKILL SETS

Start later

State and Territory teacher regulatory authorities should accredit initial teacher education programs and professional development programs for teachers, using national guidelines (Action 5.3). Ongoing learning on child social and emotional development and wellbeing should form part of professional development requirements for all teachers. This should include the social and emotional wellbeing of Aboriginal and Torres Strait Islander children.

ACTION 5.5 — ACCREDITING SOCIAL AND EMOTIONAL PROGRAMS IN SCHOOLS

Social and emotional wellbeing programs delivered in schools should be based on rigorous evidence and have the ability to demonstrate improvement in student wellbeing outcomes.

Start now

To support the implementation of a national student wellbeing outcome, Governments should develop guidelines for the accreditation of social and emotional learning programs offered to schools by external providers.

Start later

State and Territory Government departments of education should accredit social and emotional learning programs delivered in schools, using national guidelines (Action 5.3).

ACTION 5.6 — WELLBEING STRATEGIES IN SCHOOLS

All schools should be required to report on their progress against wellbeing outcomes, as set out by in an updated National School Reform Agreement (Action 5.3).

In addition to outcomes, all schools should report to regulators on their dedicated strategies, including leadership and accountability structures, to deliver wellbeing outcomes for students and teachers.

Each school principal should be accountable for the development and monitoring of wellbeing strategies, and progress against national targets.

Start now

State and Territory Government departments of education should roll out nationally consistent wellbeing measures to monitor school performance in improving wellbeing. These measures should be incorporated in school performance processes and annual reports, similar to measures of progress in numeracy and literacy.

Start later

State and Territory Government departments of education should:

- review the wellbeing policies and structures put in place by all schools to ensure they are effective in delivering wellbeing outcomes. Policies should be reviewed annually.
 - develop policies to support schools that identify gaps in their wellbeing strategies and supports, as well as schools where wellbeing measures do not improve over time. This should include dedicated funding through a flexible funding pool.
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ACTION 5.7 — DATA ON CHILD SOCIAL AND EMOTIONAL WELLBEING

Governments should expand the collection of data on child social and emotional wellbeing, and ensure data is consistently used in policy development and evaluation.

Start now

Governments should develop, or commission the development of, a national minimum dataset on student wellbeing.

The Australian Government should fund the Australian Institute of Health and Welfare's work to finalise the development and implementation of an indicator of child social and emotional wellbeing. Where jurisdictions do not collect the required data, the Australian Institute of Health and Welfare should work with departments of health to implement data collection. Data should be collected and reported annually.

Start later

The National Evidence Institute — which is being established as part of the National School Reform Agreement — should create an evidence base on social and emotional wellbeing. This should include funding networks of schools to trial and evaluate innovative approaches. The Institute should also promote the use of existing datasets to inform policy and fund additional research.

The Australian Government should fund new cohorts of the Longitudinal Study of Australian Children at regular intervals.

ACTION 5.8 — EDUCATIONAL SUPPORT FOR VULNERABLE CHILDREN

The education system should review the effectiveness of disability funding structures for children with social-emotional disability, including a review of outreach programs for children who have disengaged from their schooling due to mental illness.

Start now

The Disability Standards for Education are due to be reviewed in 2020. The upcoming review should be independent and:

- include specific consideration of the way the standards support students with mental illness and their educational outcomes
- examine application processes for adjustments and consider if improvements are required.

Mental health professionals (including those working in private practice and community mental health settings) who treat children should be required to include recommendations for parents/carers and teachers in their report to the referring medical practitioner, wherever relevant.

State and Territory Governments should collect data to monitor their progress against agreed measures of social and emotional wellbeing for children in out-of-home care and the child protection system. Data should be used to direct additional investment in support services.

Start later

The Australian Government should use data collected by schools as part of the Nationally Consistent Collection of Data on School Students with Disability to evaluate the effectiveness of its disability funding structures for children with social-emotional disability.

State and Territory Government departments of education should review the funding for outreach services supporting students who have disengaged from education due to mental illness to return to school. Services should be expanded such that they are able to support all students who are at risk of disengagement or have disengaged from their schooling. Departments should put in place clear policies for outreach services to proactively engage with students and families who are referred to them once the student's attendance declines below a determined level, and monitor their implementation.

Young adults

ACTION 6.1 — ONLINE MENTAL HEALTH SERVICES FOR TERTIARY STUDENTS

Online support provided by tertiary education institutions can help maintain students' mental health.

Start now

Tertiary education institutions should continue to expand online mental health services to meet student needs. These services should incorporate de-identified data collection on the mental health of students to enable ongoing improvements in the effectiveness and relevance of mental health support services.

ACTION 6.2 — IMPROVING ACCESS TO MENTAL HEALTH SERVICES FOR INTERNATIONAL STUDENTS

International students need adequate insurance coverage and access to culturally appropriate services to maintain their mental health.

Start now

To improve the treatment and support provided to international students, tertiary education institutions (or their representatives) should make arrangements with insurers providing Overseas Student Health Cover to their international students to ensure there is adequate coverage for any required mental health treatment (including the scheduled fees for treatment and some portion of the student's out-of-pocket expenses).

They should also ensure their counselling services are able to meet the language and cultural diversity needs of their international students.

ACTION 6.3 — STUDENT MENTAL HEALTH AND WELLBEING STRATEGY IN TERTIARY EDUCATION INSTITUTIONS

To support students' mental health, tertiary education institutions should have comprehensive mental health and wellbeing strategies. The implementation of these strategies should be rigorously evaluated to enable continuous improvement.

Start now

The Australian Government should amend the *Higher Education Standards Framework (Threshold Standards) 2015* and the *Standards for Registered Training Organisations (RTOs) 2015* to require all tertiary education institutions to have a student mental health and wellbeing strategy. This strategy would be a requirement for registration and would be assessed by the Tertiary Education Quality and Standards Agency or Australian Skills Quality Authority as part of the registration process.

This strategy should cover:

- how they will meet their requirements under the *Disability Discrimination Act 1992 (Cth)* and *Disability Standards for Education 2005 (Cth)*
- how they will meet their requirements under the Higher Education Standards Framework (Threshold Standards) 2015, Standards for Registered Training Organisations (RTOs) 2015 and National Code of Practice for Providers of Education and Training to Overseas Students. This should encompass information on their internal and external support, including partnerships with providers of external supports
- a requirement that onsite counselling services, where available, provide appropriate links into the broader health system and are adequately resourced to meet the needs of students who require these services
- the prevention and early intervention support institutions provide
- training and guidance for staff, including:
 - that all staff who have direct interaction with students would undertake training on student mental health and wellbeing
 - guidance for staff on what they should do if a student approaches them with a mental health concern and how they can support student mental health.

Start later

The Tertiary Education Quality and Standards Agency and the Australian Skills Quality Authority should monitor and collect evidence from interventions initiated by tertiary education providers to improve mental wellbeing and mental health of students and staff. They should disseminate information on best practice interventions to tertiary education providers.

ACTION 6.4 — GUIDANCE FOR TERTIARY EDUCATION PROVIDERS

All tertiary education providers — including non-university higher education and Vocational Education and Training — would benefit from guidance on how to best support their students' mental health.

Start now

To supplement guidance being developed for universities to address student mental health, the Australian Government should develop or commission guidance for non-university higher education providers and Vocational Education and Training providers on how they can best meet students' mental health needs. This should include best-practice interventions that institutions could adopt to build students' resilience and support their mental health.

Mentally healthy workplaces

ACTION 7.1 — PSYCHOLOGICAL HEALTH AND SAFETY IN WORKPLACE HEALTH AND SAFETY LAWS

The model workplace health and safety (WHS) laws should be amended to ensure psychological health and safety in the workplace is given similar consideration to physical health and safety. Similar amendments are required to WHS laws in those jurisdictions not currently using the model laws.

Start now

- All WHS legislation should clearly specify the protection of psychological health and safety as a key objective.
- Necessary amendments should be made to ensure that the relevant legislation and regulation addresses psychological health and safety in a similar way to physical health and safety.

ACTION 7.2 — CODES OF PRACTICE ON EMPLOYER DUTY OF CARE

Codes of Practice can play an important role in supporting mental health in the workplace.

Start now

Workplace Health and Safety authorities, in conjunction with Safe Work Australia, should develop codes of practice to assist employers to meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Codes of practices should be industry- or occupation-specific and developed to reflect the different risk profiles of different industries and occupations.

FINDING 7.1 — RETURN TO WORK CAN BE MORE DIFFICULT IN SMALLER BUSINESSES

Return to work for those with a psychological injury or mental illness is difficult if the injury or illness was related to personal conflict or wider cultural issues in that workplace that have not been addressed prior to return to work. These difficulties of return to work, where the illness is workplace-related, are more acute for smaller businesses operating from a single location. Unlike larger organisations that have multiple sites, smaller businesses are often unable to provide return to work at a different location or for different duties.

ACTION 7.3 — LOWER PREMIUMS AND WORKPLACE INITIATIVES

Incentives for employers to reduce the risks of workplace-related psychological injury and mental illness can be improved through workers compensation schemes.

Start later

Workers compensation schemes should provide for more flexibility in premiums for employers who implement workplace initiatives and programs that have been considered by the relevant Workplace Health and Safety authority to be highly likely to reduce the risks of workplace-related psychological injury and mental illness for that specific workplace.

ACTION 7.4 — NO-LIABILITY TREATMENT FOR MENTAL HEALTH-RELATED WORKERS COMPENSATION CLAIMS

In dealing with mental health claims, workers compensation schemes can improve outcomes for employers and employees by providing for early intervention, early treatment and rehabilitation and successful return to work.

Start now

Workers compensation schemes should be amended to provide and fund clinical treatment (including any required rehabilitation) for all mental health-related workers compensation claims, regardless of liability, until the injured worker returns to work, or up to a period of six months following lodgement of the claim. Similar provisions should be required of companies that self-insure.

ACTION 7.5 — MINIMUM STANDARDS FOR EMPLOYEE ASSISTANCE PROVIDERS

Employee Assistance Programs can support workplace mental health. But employers need guidance as to which programs are likely to be most effective for their workplace.

Start later

Employee assistance program providers and their industry bodies, in conjunction with employers, and with employer and employee representatives, should develop minimum standards for employee assistance programs and for the evaluation of these programs.

ACTION 7.6 — DISSEMINATING INFORMATION ON WORKPLACE INTERVENTIONS

Creating an evidence base on employer-initiated mental health interventions in the workplace can help all employers choose the most appropriate intervention for their workplace.

Start later

Workplace health and safety (WHS) agencies should monitor and collect evidence from employer initiated interventions to create mentally healthy workplaces and improve and protect the mental health of their employees. This evidence should be captured by Safe Work Australia on a national basis, and provided back to WHS agencies in a timely manner and in a form that they can use to advise employers of effective interventions that would be appropriate for their workplace.

Social inclusion and stigma reduction

FINDING 8.1 — SOCIAL EXCLUSION AND DISADVANTAGE ARE STRONGLY ASSOCIATED WITH MENTAL ILL-HEALTH

Social exclusion and disadvantage are strongly associated with mental ill-health. People with mental illness are likely to be socially excluded, and people facing social exclusion for other reasons are likely to subsequently experience mental ill-health.

People likely to experience both social exclusion and mental ill-health include those on lower incomes and with poor access to material resources, single parents, Aboriginal and Torres Strait Islander people, people who live in public rental accommodation, and people who did not complete secondary school.

Recognition in all government policies, payments and programs, of the importance of social exclusion and disadvantage as ongoing risk factors for mental illness, could form a basis for improvement in mental health outcomes.

ACTION 8.1 — NATIONAL STIGMA REDUCTION STRATEGY

Much progress has been made over time in reducing the stigma that affects people with mental illness; however, more should be done to address the stigma that remains.

Start now

- The National Mental Health Commission should develop, and lead the implementation of, a National Stigma Reduction Strategy that builds on the work started under the Fifth National Mental Health and Suicide Prevention Plan and focuses on the experiences of people with mental illness that are poorly understood in the community. The National Stigma Reduction Strategy should:
 - rely on the leadership and direction of people with lived experience, including as national ambassadors for mental health
 - promote meaningful interactions between people with and without mental illness
 - focus on the experiences of people with mental illness that are poorly understood by the community, including those with schizophrenia and borderline personality disorder
 - target stigma reduction messages for different audiences, and address different aspects of stigma, including the desire for social separation, and perceptions of danger and unpredictability
 - develop an evidence base of effective anti-stigma activities, including through the trial and assessment of different interventions in different areas
 - recognise that effective stigma reduction requires a sustained commitment to ensure that reductions in stigma persist.
- The Strategy should actively target stigma and discrimination directed towards people with mental illness by health professionals, including by developing contact interventions that involve interactions between health professionals and mental health consumers, on an equal footing outside of a clinical setting. Stigma reduction programs should initially be included in training programs for mental health nurses, with the aim of developing evidence as to their effectiveness.
- All Australian governments should meet their previously agreed commitments to reducing stigma and discrimination made under the Fifth National Mental Health and Suicide Prevention Plan, and should adequately resource the National Mental Health Commission to develop and implement the National Stigma Reduction Strategy.

ACTION 8.2 — AWARENESS OF MENTAL ILLNESS IN THE INSURANCE SECTOR

The insurance sector should improve the way it collects information about, and relating to, people with mental illness.

Start now

- The Financial Services Council (FSC) should update the mental health training requirements for insurers in FSC Standard No. 21, in consultation with a national consumer and carer organisation to reflect contemporary thinking about mental illness. The Financial Services Council should also:
 - expand the coverage of FSC Standard No. 21 to include all employees of covered insurers to ensure that the industry as a whole has a better understanding of mental illness
 - publish data it receives on industry compliance with the Standard.
- The Australian Securities and Investments Commission should review, within two years, the operation and effectiveness of the insurance industry Codes of Practice and industry standards that relate to the provision of services to people with mental illness. The review should consider whether the insurance industry:
 - has removed blanket exclusions relating to mental illness
 - differentiates between types of mental illness, takes into account the history, severity and prognosis of individual applicants or claimants and uses up-to-date prevalence, prognosis and pricing information to assess risk and make decisions about claims
 - meets maximum timeframes for the resolution of insurance claims consistently and whether these timeframes are adequate
 - has implemented industry guidelines that require claimants and applicants be provided with written advice when insurance coverage is declined or a claim refused on the basis of mental illness.
- Where the review finds these changes have not been achieved, regulation should be used to require change.
- The Australian Law Reform Commission should review whether the protocols for insurer access to clinical records have resulted in more targeted requests for clinical information, and whether they give sufficient protections to people with histories that include seeking psychological treatment or counselling. The review should include consideration of whether the protocols are sufficient, whether there is a need for legislative change and whether insurance premiums are actuarially fair.

This review should be conducted in 2022, after the protocols have been operating for two years.

ACTION 8.3 — TRADITIONAL HEALERS

Traditional healers have the potential to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

Start later

- The Australian Government should evaluate best practices for partnerships between traditional healers and mainstream mental health services for Aboriginal and Torres Strait Islander people.
- This evaluation should incorporate the knowledge and views of Aboriginal and Torres Strait Islander people and seek to improve the evidence about how a partnership between traditional healers and mainstream mental healthcare can most effectively support Aboriginal and Torres Strait Islander people with mental illness and facilitate their recovery in their community.

FINDING 8.2 — SOCIAL AND EMOTIONAL WELLBEING OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The social and emotional wellbeing of Aboriginal and Torres Strait Islander people is profoundly influenced by their connection to land, culture, spirituality, family and community, in addition to the broader social determinants of health and wellbeing. The accumulated effects of traumatic experiences over many generations, and racism and discrimination that are endemic in many communities, can impede efforts to improve wellbeing.

Improvements in the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander people require improvements in the conditions of daily life, as well as actions to promote healing of past traumas and address discrimination.

Government actions that support inclusion and empowerment of Aboriginal and Torres Strait Islander people to positively shape and control their futures are likely to improve social and emotional wellbeing both for Aboriginal and Torres Strait Islander people and the broader community.

Suicide prevention

FINDING 9.1 — SUICIDAL BEHAVIOURS ARE COSTLY FOR EVERYONE

Suicide and suicide attempts have enormous social, emotional and economic effects on individuals, families and the broader Australian community. The quantifiable cost of suicide and suicide attempts in Australia is estimated to be about \$30 billion each year.

FINDING 9.2 — SCHOOL-BASED AWARENESS PROGRAMS CAN BE COST-EFFECTIVE

Universal, school-based suicide prevention awareness programs can be effective at reducing suicide attempts and are likely to be cost-effective. Governments can encourage the use of these programs by accrediting evidence-based programs through the process outlined in Action 5.5.

ACTION 9.1 — UNIVERSAL ACCESS TO AFTERCARE

The Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or community mental health service following a suicide attempt.

Start now

- Effective aftercare should be directly provided or the consumer referred to support.
- Effective aftercare should be provided before people are discharged or leave a service, with proactive follow-up support within the first day, week and three months of discharge.
- Aftercare should include culturally capable support.

ACTION 9.2 — EMPOWER INDIGENOUS COMMUNITIES TO PREVENT SUICIDE

Indigenous communities should be empowered to prevent suicide.

Start now

- The Australian, State and Territory Governments should support development of a renewed *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* and associated *Implementation Plan* to guide suicide prevention activities in Indigenous communities. The development of this strategy and its implementation plan should be led by Aboriginal and Torres Strait Islander people.
- Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people.
- All organisations providing suicide prevention programs or activities in Indigenous communities should recognise the importance of building on existing capabilities within the Indigenous workforce.
- Performance monitoring, reporting and evaluation requirements for programs to prevent suicide among Aboriginal and Torres Strait Islander people should be adapted to ensure they are appropriate to the cultural context in which they are delivered and consistent with Indigenous evaluation principles.

ACTION 9.3 — APPROACH TO SUICIDE PREVENTION

Australia's approach to suicide prevention holds promise, but there are opportunities for improvement. Governments should make changes to ensure a cross-portfolio approach to suicide prevention in Australia.

Start now

- The recommended National Mental Health and Suicide Prevention Agreement (Action 23.3) should identify responsibilities for suicide prevention activities across different levels of government and across portfolios to create a truly whole-of-government approach to suicide prevention. Responsibilities should be informed by, and consistent with, the *National Suicide Prevention Implementation Strategy* under development.
- The *National Suicide Prevention Implementation Strategy* should be extended to include strategic direction for non-health government portfolios that have influence over suicide prevention activities.

Start later

- The National Mental Health Commission should assess the results of the trials of a 'systems approach' to suicide prevention that are currently underway. It should consider whether they are likely to be successful at reducing suicide rates and behaviours in Australia. If this is found to be the case, a systems approach to suicide prevention should be implemented across all Australian regions.

PART III Re-orienting healthcare

Informed access to mental healthcare

ACTION 10.1 — INCREASE CONSUMER CHOICE WITH REFERRALS

Australians have the right to choose their preferred mental health specialist, but the referral system masks these rights and, in effect, limits consumer choice.

Start now

The Australian Government should amend the Medicare Benefits Schedule (MBS) regulations to require that all referrals to psychiatrists and allied health professionals providing mental health services include a prominent and easy to understand statement advising people that they can use an alternative to any provider mentioned in the referral.

The Australian Government should include on the Medical Costs Finder website the fees and areas of specialty practice of all individual psychiatrists, paediatricians and allied health providers of MBS-rebated therapy. It should also consider including information about how long people must wait for an appointment with each clinician.

ACTION 10.2 — MENTAL HEALTH RELATED PRESCRIBING

The prescribing of mental health medications should be based on informed consumer choice and follow evidence-based guidelines.

Start now

The Australian Government should require that all mental health prescriptions include a clear and prominent statement saying that clinicians should have discussed possible side effects and proposed evidence-based alternatives to medication, prior to prescribing.

Start later

The Australian Government should commission a review into off-label prescribing of mental health medications in Australia.

ACTION 10.3 — PSYCHIATRIC ADVICE FOR GPs AND PAEDIATRICIANS

GPs and paediatricians should be able to access psychiatric advice when they need it, to assist with the care of people with mental illness.

Start now

The Australian Government should introduce an MBS item for psychiatrists to provide advice to a GP or a paediatrician over the phone on diagnosis and management issues for a person who is receiving care from the GP or paediatrician.

- The MBS item would be available only in relation to a consumer who is not receiving treatment from any psychiatrists.
- The consumer may or may not be present for the call. In either case, the consumer should be not be charged a co-payment for the call.

Start later

The effectiveness and ongoing need for this MBS item should be evaluated after three years.

ACTION 10.4 — MENTAL HEALTH ASSESSMENT AND REFERRAL TOOL

A new assessment tool, that is consistent with the Australian Government Department of Health Guidance on Initial Assessment and Referral, should be developed and implemented across the mental health system, to ensure a robust and person-centred approach to assessment and referrals.

Start now

- The Australian Government should fund the development and ongoing provision of a national digital mental health platform. The platform should provide:
 - a tool for free person-centred assessment and referral, to be used by GPs and by individuals to access online assessment and referral, underpinned by a mental health clinician. The assessment and referral tool should:
 - ... provide clear guidance to referring clinicians and consumers about the evidence-based interventions and services that are likely to best meet the consumer’s needs, as well as those that are not recommended, given the consumer’s circumstances
 - ... enhance consumer choice, by recommending a broad range of services and modes of delivery, including clinical and non-clinical services delivered digitally and face-to-face.
 - ... be given to the consumer, to share with providers of their choice
 - ... replace the Mental Health Treatment Plan as a requirement for accessing MBS-rebated Psychological Therapy Services and Focused Psychological Strategies.
 - low-cost, accessible and evidence-based digital low-intensity services; at launch, this should include supported online treatment (Action 11.1) and short-course, structured therapy delivered by videoconference or phone
 - be capable of being connected to the recommended navigation portals to draw on links to other digital and face-to-face treatment and support services (Action 15.2)
 - provide data on assessment and referral practices to enable the Australian Government Department of Health to observe how GP treatment and referral practices align with the tool’s recommendations, to inform ongoing improvements to the tool, and indicate where additional GP education and training is required.
- The Australian Government should appoint an expert panel to oversee the development of the new mental health assessment and referral tool, to be co-designed with consumers and clinicians. The Government should tender for the construction of the platform, and for a small number of digital low-intensity services to be provided on the platform.

Supported online treatment

ACTION 11.1 — SUPPORTED ONLINE TREATMENT OPTIONS SHOULD BE INTEGRATED AND EXPANDED

The Australian Government should facilitate greater integration of, and access to, supported online treatment.

Start now

The Australian Government should:

- increase the number of supported online treatment services available for people with high prevalence mental illness and distress
- collect and publish data on the use, type and outcomes of supported online treatment
- instigate two separate information campaigns for consumers and health professionals to raise awareness of the effectiveness, quality and safety of government funded supported online treatment.

It should require supported online treatment providers to offer treatment:

- only if it has demonstrated efficacy
- to children, youth and/or adults
- for people from culturally and linguistically diverse backgrounds, subject to demand
- at minimal cost to the consumer
- that includes the option for outcomes data to be forwarded to a nominated GP or other treating health professional.

Start later

The Australian Government should, within five years, commission an independent evaluation of online treatment services, examining performance of supported online services and technological developments in online treatment approaches.

Bridging the mental healthcare gaps

ACTION 12.1 — ENCOURAGE MORE GROUP PSYCHOLOGICAL THERAPY

The Australian Government should change the Medicare Benefits Schedule (MBS) to encourage more group therapy.

Start now

- The Australian Government should change the MBS so that group therapy is allowed with a minimum of 4 people (instead of 6 people), and with fewer than 4 people, as long as the course of group therapy began with at least 4 in the group.
 - The Australian Government should create new MBS items for group sessions that run for ‘at least 90 minutes’ and ‘at least 120 minutes’.
 - The Australian Government should clarify that unless explicitly stated otherwise, referrals for MBS-rebated Psychological Therapy Services and Focused Psychological Strategies can be used for either group therapy or individual therapy — at the discretion of the consumer, after discussion with their referring clinician. The Government should communicate this to clinicians that refer to or provide these services.
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ACTION 12.2 — PSYCHOLOGICAL THERAPY AND PSYCHIATRY BY TELEHEALTH

Widening access to psychological therapy and psychiatry by videoconference and telephone would offer significant benefits for consumers.

Start now

- The Australian Government should make permanent the MBS items introduced during the COVID-19 pandemic that allowed people in any part of Australia to access:
 - MBS-rebated Focused Psychological Therapies and Psychological Therapy Services by videoconference and by telephone from clinical and registered psychologists, and credentialed social workers, occupational therapists, GPs and other medical practitioners
 - certain MBS-rebated psychiatric services by videoconference (and by telephone where videoconference is unavailable).
 - Standard psychiatry consultations by videoconference and phone should be limited to 12 MBS-rebated consultations per year.
 - These new MBS items — which expand access to telehealth — should replace existing telehealth items, including those that provide higher rebates to psychiatrists for telehealth services than for face-to-face services.
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ACTION 12.3 — PSYCHOLOGICAL THERAPY TRIALS AND EVALUATION

MBS-rebated psychological therapy should be evaluated, and additional sessions trialled.

Start now

The Australian Government should commission an evaluation of the effectiveness of MBS-rebated psychological therapy. The evaluation should consider the effectiveness of therapy delivered in different ways (including group therapy and telehealth), and should include a long-term follow-up.

As part of this evaluation, the Australian Government should trial:

- allowing consumers to choose to access up to 20 MBS-rebated sessions of individual or group therapy over a 12-month period, if their clinical condition has been assessed as requiring more than the current 10 MBS-rebated sessions
- allow referring clinicians to delay the need for re-referral of a consumer to be after the first 10 sessions rather than after 6 MBS-rebated sessions
- the use of feedback-informed practice.

Prior to the evaluation, the Australian Government should change the MBS so that the maximum number of sessions of MBS-rebated psychological therapy (Psychological Therapy Services and Focused Psychological Strategies) is per 12-month period, as opposed to per calendar year.

Start later

Based on the results of these trials and evaluation, the Australian Government should determine whether to roll out the above changes to the MBS more widely.

ACTION 12.4 — DELIVERING COMMUNITY AMBULATORY SERVICES

Across Australia, community ambulatory services fall well short of population needs. Addressing this shortfall requires both more resources and greater productivity.

Start now

- State and Territory Governments should investigate and address the reasons for the disparity between the amount of time that community ambulatory clinical staff in their jurisdiction actually spend on consumer-related activities, and what is considered optimal (assumed to be 67% in the National Mental Health Service Planning Framework).
- The Australian Institute of Health and Welfare should estimate and make public the shortfalls in specialist mental health community ambulatory services for each State and Territory, with the agreement of these jurisdictions.
- State and Territory Governments, with support from the Australian Government, should, over time, increase funding for these services to the level required to meet population needs.

Mental healthcare for people in crisis

ACTION 13.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES

Hospitals and crisis response services should be able to support a person's recovery in a safe environment that meets their needs.

Start now

- State and Territory Governments should provide more and improved alternatives to hospital emergency departments for people with acute mental illness, including peer- and clinician-led after-hours services and mobile crisis services.
- State and Territory Governments should consider best practice approaches to improving the interactions of people with mental illness with paramedics, including providing paramedics with access to mental health resources when undertaking medical assessments in the field.
- Public and private hospitals should take steps to improve the emergency department experience they provide for people with mental illness. This could include providing separate spaces for people with mental illness, or otherwise creating environments that do not escalate the severity of their illness.

Start later

- State and Territory Governments should, when building or renovating emergency departments, design them to take account of the needs of people with mental illness by collaborating with, and incorporating the lived experience of consumers and carers as part of the process.

ACTION 13.2 — MENTAL HEALTH BEDS FOR PEOPLE WITH ACUTE CARE NEEDS

Inpatient services need to be safe spaces for children, adolescents, and women.

Start now

State and Territory Governments should provide child and adolescent mental health beds that are separate to adult mental health wards. If it is not possible to provide these beds in public hospitals, State and Territory Governments should create the capacity to offer alternative services for children and adolescents, such as hospital-in-the-home or day programs, or explore options for contracting the services from private providers.

Start later

When designing and renovating acute inpatient wards, State and Territory Governments should establish wards that can be configured to allow for gender segregation.

ACTION 13.3 — DELIVERING BED-BASED MENTAL HEALTH SERVICES

People who require treatment provided by bed-based services should be able to access these services.

Start now

The shortfalls in sub-acute and non-acute mental health bed-based services should be estimated and published at both State and Territory and regional levels.

Start later

State and Territory Governments, with support from the Australian Government, should increase funding for these services, in line with agreed commitments to rectify service shortfalls over time.

Comorbidity

ACTION 14.1 — IMPROVING CARE FOR PEOPLE WITH CONCURRENT MENTAL ILLNESS AND PHYSICAL HEALTH CONDITIONS

The Australian, State and Territory Governments should introduce the reforms outlined in the *Equally Well Consensus Statement*.

Start now

- As part of the broader target-setting process (Action 24.4), the Australian, State and Territory Governments should agree to a target to reduce the gap in life expectancy between people with severe mental illness and the general population.
- The Australian, State and Territory Governments should release clear statements covering how they intend to implement the initiatives in the Equally Well Consensus Statement, including time frames and outcomes against which progress can be measured.

Start later

- The Australian, State and Territory Governments should implement all the actions in the Equally Well Consensus Statement, including:
 - requiring all mental health services to screen for physical health conditions that people with mental illness are at higher risk of developing
 - requiring all mental health services to directly provide, or refer consumers to other services that provide prevention and lifestyle interventions, including interventions aimed at improving diet and increasing physical activity
 - requiring all mental health services to provide smoking cessation support tailored to people with mental illness
 - ensuring workers in the mental health sector have access to the training and support they need to provide person-centred, effective and coordinated care to people with comorbidities
 - working with professional colleges, associations, and education providers to ensure that mental health services and workers have access to comprehensive guidelines and other resources on physical health in people with mental illness
 - ensuring people with mental illness and their carers have access to information on physical health problems, managing medications and their side-effects, and the range of care and treatment options available to them
 - implementing effective and person-centred monitoring and reporting, as would be required under the recommended monitoring and reporting framework (Action 24.10).
 - The National Mental Health Commission should report annually on Australian, State and Territory Governments' progress in implementing the Equally Well Consensus Statement and reducing the gap in life expectancy between people with severe mental illness and the general population.
-

ACTION 14.2 — INTEGRATING MENTAL HEALTH AND SUBSTANCE USE PLANNING, COMMISSIONING AND SERVICE PROVISION

Many people with mental illness also have a substance use disorder. Services to deal with both these conditions should be seamless from the consumers' perspective.

Start now

Regional commissioning bodies, in conjunction with the relevant State and Territory Government departments, should integrate commissioning of substance use and mental health services.

Start later

- Governments should require mental health services, including hospitals and clinical community health services, to ensure treatment is provided for both substance use and other mental disorders for people with both conditions.
- Governments should provide for this treatment within specialised, integrated mental illness and substance use disorder services ('dual diagnosis' services) to meet regional needs or by ensuring integrated treatment and care delivery where the mental health service and the alcohol and other drug services are organisationally separated.
- Governments should require mental health services and alcohol and other drug services to jointly develop and implement operational guidelines, including:
 - screening for substance use and mental illness
 - referral pathways between alcohol and other drug and mental health services, where service arrangements exist for the consumer with a comorbid condition
 - working with professional colleges, associations, and bodies, and education providers to develop and provide training, guidelines and other resources for mental health and alcohol and other drug workers so they can provide evidence-based, coordinated care for comorbid conditions.
- Governments should continue to monitor and report on outcomes for people with substance use comorbidities, consistent with the Productivity Commission's framework for monitoring, evaluation and research (chapter 24).

Towards integrated care

ACTION 15.1 — LINKING PEOPLE TO THE SERVICES THEY NEED

Assistance phone lines and websites offering support for people with mental ill-health and their carers should improve the information provided on the services available and facilitate better exchanges of information between service providers.

Start now

- The Australian Government should continue to develop and improve Head to Health, including expanding the range of services listed.

Start later

- Head to Health could eventually be integrated with the national digital mental health platform (action 10.4) to provide a one-stop-shop for digital mental health resources.
 - The Australian, State and Territory Governments should ensure that government-funded real time consumer assistance services provided by voice or text are receiving sufficient funding to meet consumer demand.
 - The Australian, State and Territory Governments should include in contracts with real time consumer assistance services a requirement to implement warm referral processes that minimise the need for consumers to repeat information.
-

ACTION 15.2 — ONLINE NAVIGATION PORTALS TO SUPPORT REFERRAL PATHWAYS

Commissioning agencies should ensure service providers have access to online navigation portals offering information on pathways in the mental health system.

Start now

- All regional commissioning bodies should, either individually or collaboratively, develop and maintain an online navigation portal, including detailed clinical and non-clinical referral pathways. The HealthPathways portal model, which is already used by most PHNs, could be used as a basis.
- Access to these portals should be expanded beyond the health sector, in particular to schools and psychosocial service providers. Each regional commissioning body should also, either individually or collaboratively, fund a small dedicated team supporting the users of the online portals.

Start later

- All online navigation portals should be integrated with the national digital mental health platform (Action 10.4) and support the ability to book consultations with service providers directly from the platform.
-

FINDING 15.1 — DIGITAL RECORDS WOULD FACILITATE INFORMATION SHARING

Expanding the use of digital records in the mental healthcare system would facilitate greater information sharing and improve consumer experience. Existing digital health record systems, such as My Health Record, would provide an adequate platform for information sharing between providers of mental healthcare services, but only if consumers and service providers use them consistently.

ACTION 15.3 — SINGLE CARE PLANS FOR PEOPLE WITH MODERATE TO SEVERE MENTAL ILLNESS

Governments should support the development of single care plans for people with moderate to severe mental illness who are receiving services across multiple clinical and non-clinical providers.

Start later

Governments should develop and promote protocols for:

- consumer and, where appropriate, carer involvement in single care plans
- allocating responsibility for plan development and review, with consumers being directly involved in plan development and having choice over which of their service providers manages their care plan
- sharing consumer information between service providers and updating the plan, with consideration given to any legal issues that may arise as to who (apart from the consumer) is able to share the information contained in the plan.

ACTION 15.4 — CARE COORDINATION SERVICES

People with severe and persistent mental illness should receive care coordination services where this is required to ensure their complex health and social needs are adequately met.

Start now

All Governments and regional commissioning bodies should:

- assess the number of people who require care coordination services in their region of responsibility, and the extent to which they are already accessing effective care coordination through existing programs, including the National Disability Insurance Scheme (NDIS)
- streamline care coordination arrangements and ensure that people with severe and persistent mental illness and complex needs requiring support from multiple agencies have access to effective care coordination. This includes care coordination services for those people with severe and persistent mental illness and complex needs who do not qualify for the NDIS, and people with severe mental illness who require care coordination for only brief periods of time.

To enable care coordination services to be delivered effectively, consumers would need to provide their consent for service providers to share any relevant information with other organisations.

Start later

Governments should set a national benchmark, based on the improved National Mental Health Service Planning Framework (Action 25.9) to ensure effective care coordination services are available and any gaps are addressed.

FINDING 15.2 — SUPPORTING COLLABORATION BETWEEN SERVICE PROVIDERS

A range of approaches to collaboration, including co-location, alliances and networks, can improve service delivery and benefit consumers. However, each of these alone cannot overcome all the barriers to providing integrated, coordinated care. Addressing gaps and duplication in services, clear delineation of roles and responsibilities, workforce development, addressing cultural barriers and integrated systems are also required.

Mental health workforce

ACTION 16.1 — THE NATIONAL MENTAL HEALTH WORKFORCE STRATEGY

The forthcoming National Mental Health Workforce Strategy and the National Medical Workforce Strategy should enable a person-centred mental health system.

Start now

The Australian Government should ensure that its development of a new Workforce Strategy includes the following actions:

- Set the objective of achieving a health workforce that aligns the skills, costs, cultural capability, substitutability, availability and location of mental health practitioners with consumer needs. This should be done by integrating the workforce strategy with service and infrastructure planning.
- Ensure that planning consultations give weight to the perspectives of consumers, carers, mental health workers and service providers, including the non-clinical community mental health sector.
- Examine how workforce needs would change under a business-as-usual scenario as well as under scenarios where alternative workers deliver service (particularly leveraging the non-medical workforce), where technologies can assist or replace face-to-face services, and where practices not supported by clinical evidence are de-funded.
- Assess the estimated future supply of specific skill sets and health professions, the extent to which these could fall short of needs, and policy measures that could meet needs cost-effectively.
- Identify data gaps or methods that limit the capacity to link workforce planning to broader mental healthcare reform, and develop strategies to address those data gaps. The data should cover community mental health workers and carers providing informal care, and workforce characteristics (for example, cultural capability to work with people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander communities).

This work should also inform the workforce development program being undertaken for the National Mental Health and Suicide Prevention Plan.

ACTION 16.2 — INCREASE THE NUMBER OF PSYCHIATRISTS

There is a shortage of psychiatrists, particularly in rural and regional Australia and in some sub-specialities.

Start now

The Australian, State and Territory Governments should collectively develop a national plan to increase the number of psychiatrists in clinical practice, particularly outside major cities and in sub-specialities with significant shortages, such as child, adolescent and old age psychiatry.

This should be done in collaboration with the Royal Australian and New Zealand College of Psychiatrists, and form part of the broader Australian Government medical workforce strategies that are under development.

The plan should include actions to increase the availability of supervision for trainees, including by considering interventions recommended in the 2016 report by the National Medical Training Advisory Network, such as remote models of supervision for trainees outside major cities.

ACTION 16.3 — IMPROVED MENTAL HEALTH TRAINING FOR MEDICAL PRACTITIONERS

Medical practitioners' training on medications and non-pharmacological interventions requires improvement.

Start now

Medical training and continuing professional development requirements for GPs should incorporate person-centred approaches to practice that recognise the importance of personal recovery (in addition to clinical improvement). This training should also include information on the indications for non-pharmacological interventions, appropriate prescribing of mental health medications and the management of medication side-effects.

- As part of this, the Australian Government should request the Australian Medical Council to review current medical training and continuing professional development requirements through a consultative process and make any changes necessary.
- Any such changes should be assessed for their impact on practices and outcomes for consumers.

In addition, for GPs and psychiatrists, the Australian Government should:

- promote and fund further trials of social prescribing as alternatives to other clinical interventions
 - promote and fund de-prescribing initiatives that change practitioner and consumer expectations about the need for mental health medications once they are no longer clinically indicated.
-

ACTION 16.4 — MORE SPECIALIST MENTAL HEALTH NURSES

Mental health nurses are expected to form an important part of the workforce needed for a recommended expansion in services to bridge gaps in mental healthcare, particularly in community mental health services.

Start now

- A curriculum standard should be developed for a three-year direct-entry (undergraduate) degree in mental health nursing, similar to the option already available to midwives. The new standards should be developed by the Australian Government in collaboration with stakeholders. Nurses who complete the degree would have a notation on their registration restricting their scope of practice to mental health.
- The training of all nurses should include a discrete unit on mental health, though there should be no requirement that this apply to currently registered nurses.

ACTION 16.5 — STRENGTHEN THE PEER WORKFORCE

Peer workers are a valuable but under-utilised part of the mental health workforce.

Start now

The Australian Government should provide once-off seed funding to create a professional association for peer workers.

Start later

The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role and value of peer workers in improving outcomes for consumers.

ACTION 16.6 — TARGETING STIGMA AMONG HEALTH PROFESSIONALS

Mental health stigma reduction programs should be incorporated in the initial training and continuing professional development requirements of all health professionals, subject to periodic evaluation as to their appropriateness and effectiveness.

Start now

The Australian, State and Territory Governments should, in collaboration with professional bodies:

- increase interactions of health students and practising health professionals with people with mental illness (and their carers) outside of clinical environments
- incorporate stigma reduction programs targeted at health professionals and students into the National Stigma Reduction Strategy (Action 8.1).

ACTION 16.7 — MENTAL HEALTH SPECIALISATION AS A CAREER OPTION

Governments and specialist medical colleges should take further steps to reduce the negative perception of, and to promote, mental health as a career option.

Start now

- The Australian, State and Territory Governments should, in collaboration with professional bodies, rebalance where mental health trainees undertake clinical placements and internships to a more representative mix of settings. This includes increasing placements and internships in the private sector, community mental health services (including Aboriginal Community Controlled Health Organisations) and settings other than inpatient units.
- State and Territory Governments should mitigate burnout and poor mental health among the mental health workforce by targeting the key organisational and operational factors that may reduce the risk of adverse outcomes, including adequate supervision, professional support, resourcing and reducing the risk of exposure to work-related violence and aggression.

FINDING 16.1 — SUPPORTING THE RURAL, REGIONAL AND REMOTE MENTAL HEALTH WORKFORCE

Physical access to mental health professionals, especially for specialist care, is significantly lower outside of major capital cities, and is particularly low in remote parts of Australia. There are many government programs aimed at alleviating these shortages, but there are practical and budgetary obstacles to ensuring that physical access is equal across different locations.

Several recommendations in this report would assist Australians with mental illness in regional Australia, including:

- greater use of clinician-supported online mental health treatment to overcome lower physical accessibility to services (Action 11.1)
- increased scope for GPs in regional Australia to consult psychiatrists in other parts of Australia about how best to help individual consumers (Action 10.3)
- increased use of videoconference and telephone for people to interact with, and receive therapy from, their psychologist or psychiatrist. (Action 12.1)

PART IV Re-orienting services and supports beyond health

Psychosocial support

ACTION 17.1 — EXTEND THE CONTRACT LENGTH FOR PSYCHOSOCIAL SUPPORTS

Short funding cycles create uncertainty for providers of psychosocial supports, which can negatively affect consumers and support workers.

Start now

The Australian, State and Territory Governments should extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years, and ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle.

The Australian Government should require Primary Health Networks to enter into longer-term contracts when commissioning psychosocial services, in line with the longer funding cycles that have been introduced more generally for Primary Health Networks.

ACTION 17.2 — GUARANTEE CONTINUITY OF PSYCHOSOCIAL SUPPORTS

People with mental illness who require psychosocial supports should be able to continue accessing them, regardless of changes to the source of funding for the service.

Start now

People who choose to apply for the National Disability Insurance Scheme (NDIS) should continue to be supported by their current service providers during the application process.

People who choose not to apply for the NDIS should be allowed to continue to access support through the National Psychosocial Support Measure, should they require it, until it has been phased out.

Start later

The Australian Government should evaluate the National Psychosocial Support Measure. Evaluation outcomes should be used to remove barriers that people with mental illness face when applying to the NDIS. When the National Psychosocial Support Measure is phased out, participants should either access support through the NDIS, if appropriate, or access the replacement psychosocial support.

ACTION 17.3 — MEET UNMET DEMAND FOR PSYCHOSOCIAL SUPPORTS

All people who have psychosocial needs arising from mental ill-health should have access to adequate psychosocial support.

Start now

- Access criteria for psychosocial supports should be adjusted such that potential participants would not be required to have a diagnosis of mental illness before approaching a service. However, an initial functional assessment must be undertaken by the service to determine the individual's psychosocial needs and the level of support required.
 - Where the information provided by the participant and the functional assessment indicate that the need for psychosocial support arises from a mental illness, the provider should work with the participant to facilitate their timely access to a clinical assessment and any necessary clinical intervention.
- The shortfall in the provision of psychosocial supports outside of the National Disability Insurance Scheme should be estimated and published at both State and Territory and regional levels.
- State and Territory Governments should continue working with the National Disability Insurance Agency to clarify the interface between the mainstream mental health system and the National Disability Insurance Scheme.

Start later

- State and Territory Governments, with support from the Australian Government, should, over time, increase the quantum of funding allocated to psychosocial supports to meet the estimated shortfall.
- The demand for psychosocial support services by people with mental illness in a region should be estimated as a component of integrated regional planning.
- Psychosocial support services should provide data to their regional commissioning body on the number and nature of functional assessments they have undertaken of individuals receiving their support services.

Carers and families

ACTION 18.1 — FAMILY- AND CARER-INCLUSIVE PRACTICES

Family- and carer-inclusive practices require mental health services to consider family members' and carers' needs, and their role in contributing to the recovery of individuals with mental illness. This includes children in families affected by mental illness.

Start now

- Where this is not already occurring, state and territory community and inpatient mental healthcare services should routinely collect responses to the Carer Experience Survey. The data collected should be sufficient to enable benchmarking and to provide services with evidence of their compliance against the related sections of the National Standards for Mental Health Services and the National Safety and Quality Health Service Standards.
- The Australian Institute of Health and Welfare should use the data to report annually on survey collection rates and carer experiences at the regional level.
- The Australian Government should amend the Medicare Benefits Schedule so that family interventions provided by psychologists and other allied mental health professionals are rebated.
 - Family and carer consultations with the consumer present should count towards session limits for psychological therapy.
 - Family and carer consultations without the consumer present should be limited to four per 12 month period.
- State and Territory Governments should, over time, work towards ensuring the workforce capacity exists in each region to implement family- and carer-inclusive practices within State and Territory community and inpatient mental healthcare services. These services should identify people with responsibility for:
 - supporting family and carer participation in co-design and service improvement processes
 - providing and supervising carer peer work within mental healthcare services
 - providing advice to clinicians and managers about how to improve family- and carer-inclusive practices
 - facilitating training opportunities to improve family- and carer-inclusive practices
 - promoting the use of effective family interventions.

ACTION 18.2 — FAMILY AND CARER SUPPORT SERVICES

Government responsibilities for family and carer support services should be clarified.

Start now

The recommended National Mental Health and Suicide Prevention Agreement (action 23.3) should state that State and Territory Governments would be responsible for planning and funding:

- carer support services related to the mental health caring role
- family support services for families affected by mental illness.

Start later

The Australian Government Department of Social Services should use data it collects on changes in carer outcomes to evaluate and report publicly on:

- how well the Carer Gateway meets the needs of mental health carers relative to other types of carers
- how well the Carer Gateway meets the needs of young carers, Aboriginal and Torres Strait Islander carers and culturally and linguistically diverse carers
- the effectiveness of Carer Gateway services in achieving carers' employment goals.

The evaluation should also assess the effectiveness of referral pathways between the Carer Gateway and mental health carer support services funded by State and Territory Governments.

FINDING 18.1 — INCOME SUPPORT FOR CARERS IS UNNECESSARILY COMPLEX

The existence of a Carer Payment, Carer Allowance and Carer Supplement that all achieve similar objectives, but have some arbitrary differences in eligibility, contributes to an income support system that is complex and not well understood by carers.

ACTION 18.3 — REDUCE BARRIERS TO ACCESSING INCOME SUPPORT FOR MENTAL HEALTH CARERS

Eligibility requirements for income support payments should change to better address the needs of mental health carers.

Start now

The Australian Government Department of Social Services (DSS) should complete its review of the Adult Disability Assessment Tool used to assess eligibility for Carer Payment and Carer Allowance. DSS should:

- publish its findings from the review and field testing process
- consult with carers and health professionals before setting revised weightings for the new questions and the minimum score required to be eligible for each payment
- expand the list of persons who can complete the health professional questionnaire to include psychologists and accredited mental health social workers.

Start later

The Australian Government should amend the eligibility criteria for Carer Payment and Carer Allowance for mental health carers, and consider adopting these changes for other carers. Amendments for mental health carers should include:

- for both payments, replacing the requirement that care must be provided in a private residence that is the home of the care recipient with a requirement that the care recipient must reside in a private residence
- for Carer Payment, replacing the requirement to provide 'constant care' with the requirement to provide 'care on a regular basis every week'
- for Carer Payment, replacing the 25 hour per week restriction on work, study and volunteering with a 100 hour per month restriction on work only
- for Carer Allowance, replacing the requirement to provide 'care and attention on a daily basis' with the requirement to provide 'care on a regular basis every week'
- for Carer Allowance, removing the requirements for the carer to either live with the care recipient or to provide care that relates to the care recipient's bodily functions or to sustaining their life and for more than 20 hours per week.

Income and employment support

ACTION 19.1 — EMPLOYMENT SUPPORT ASSESSMENT TOOLS

Assessment tools that stream participants into different levels of employment support programs should be made more relevant to people with mental illness.

Start now

- The Department of Education, Skills and Employment should increase the Job Seeker Classification Instrument's relevance for participants with mental illness by:
 - providing more specific guidance to job seekers about the types of impacts on their functionality resulting from illness or disability that are relevant to their employability and work capacity
 - adding a short form mental health assessment tool to the Job Seeker Classification Instrument.
- The Department of Social Services should supplement the Employment Services Assessment with the Personal and Social Performance Scale or similar instrument to more accurately assess the employability of participants with mental illness.
- Once the new mental health assessment tool is developed and in common use (action 10.4), participants should be given a choice to share the information contained in their clinical assessment when completing their employment assessment under the Job Seeker Classification Index or the Employment Services Assessment. Any sharing of information should require the participant's explicit consent.

ACTION 19.2 — TAILOR ONLINE EMPLOYMENT SUPPORT

Ongoing development of the New Employment Services should explicitly consider the needs of participants with mental illness.

Start now

As part of the national rollout of New Employment Services, and drawing on evidence of the trial underway from 2019 to 2022, the Department of Education, Skills and Employment should:

- ensure participants with inadequate digital literacy and/or mental illness are able to choose to maintain access to face-to-face services
- not allocate any participants who have reported a mental illness to Digital First unless they have chosen this stream or been determined to not be at high risk of long-term unemployment (potentially through an in-person assessment by the Job Seeker Classification Instrument or Employment Services Assessment)
- assess the potential for online peer group support for participants with mental illness as part of the Digital First software
- ensure scope for participants to inform service providers of a relapse in mental illness in a timely manner.

ACTION 19.3 — MUTUAL OBLIGATION REQUIREMENTS

Mutual obligation requirements need to be adjusted so that they better assist job seekers with complex mental health needs to find employment.

Start now

The Departments of Human Services; Social Services; and Education, Skills and Employment should:

- provide greater flexibility in the application of the Targeted Compliance Framework and Job Seeker Compliance Framework for job seekers experiencing mental illness
- assess systematically whether employment support providers are meeting their obligations to provide personalised Job Plans that go beyond compliance, targeted at job seekers with complex needs
- extend to five business days the period of time that job seekers with both mental illness and complex needs have to consider and propose changes to their Job Plan.

ACTION 19.4 — STAGED ROLLOUT OF THE INDIVIDUAL PLACEMENT AND SUPPORT PROGRAM

The Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to (potentially) all relevant State and Territory Government community ambulatory mental healthcare services.

Start now

- Governments should roll out and review the IPS program to better establish the factors that influence its cost-effectiveness to different demographic groups.
- The program should initially be open to all non-employed consumers of community ambulatory mental healthcare services who express a desire to participate. Participation in the program should fulfil any mutual obligation requirements for income support recipients.
- IPS specialists should be directly employed by community ambulatory mental healthcare services.

Start later

- The IPS program rollout should be accompanied by information sharing between IPS sites to allow dissemination of best practice. If a site does not demonstrate similar net benefits to the original IPS sites, the program's design for that site (and if necessary, its desirability) should be re-appraised.
- Over the longer term, Governments should fund the IPS program on a fee-for-service basis, and require fidelity to the IPS model as a condition of this funding.

ACTION 19.5 — WORK INCENTIVES FOR DSP RECIPIENTS

Disability Support Pension (DSP) recipients with a capacity to work should have improved incentives to find employment.

Start now

The Australian Government should increase the weekly hour limit above which no DSP is payable from 30 to 38 ordinary full time hours of work. The requirement that a person would lose eligibility for the DSP if they work for more than 30 hours per week for more than two years should be retained.

Services Australia should ensure DSP recipients are well informed of their entitlement to work for a period without losing access to the DSP.

Housing and homelessness

ACTION 20.1 — HOUSING SECURITY FOR PEOPLE WITH MENTAL ILLNESS

Housing services should increase their capacity to reduce the risk of people with mental illness experiencing housing issues (such as housing that is of low quality or of insecure tenure) or losing their home.

Start now

- Each State and Territory Government should provide mental health training and resources to social housing workers. Training should incorporate awareness about how to identify early warning signs of mental illness and the benefits of early intervention. It should also provide advice on appropriate interventions to stabilise existing tenancies for people with mental illness, such as connecting tenants to mental health services.
- State and Territory Governments should work with the relevant bodies, including the real estate institutes, to help organise training and resources on mental health for private sector real estate agents as part of their professional development.
- State and territory social housing authorities should review their policies relating to anti-social behaviour, temporary absences and information sharing between institutional care facilities and housing authorities to provide consideration for people with mental illness, to reduce the risk of eviction.
 - The review of anti-social behaviour policies should take into account the episodic nature of mental illness and ensure a fair balance between the needs of the tenant experiencing mental illness and the needs of other tenants sharing a housing facility.
- Each State and Territory Government, with support from the Australian Government, should ensure that tenants with mental illness who live in the private housing market have the same ready access to tenancy support services as those in social housing by meeting any unmet demand for these services.

Start later

State and Territory Governments should monitor the effects of forthcoming reforms to residential tenancy legislation, including no-grounds evictions, and assess the potential effects for people with mental illness who rent in the private market.

ACTION 20.2 — NO DISCHARGE INTO HOMELESSNESS

People with mental illness should be supported so that they are not discharged from hospitals, correctional facilities and institutional care into homelessness.

Start now

- Each State and Territory Government, with support from the Australian Government, should commit to a nationally consistent formal policy of no exits into homelessness for people with mental illness who are discharged from hospitals, correctional facilities or institutional care.
- Governments should ensure that people with mental illness who are discharged from hospitals, correctional facilities or institutional care receive a comprehensive mental health discharge plan, and have ready access to transitional housing, while services have the capacity to meet their needs. These programs should integrate care coordination and access to accommodation.

Start later

- As part of the next negotiation of the National Housing and Homelessness Agreement, a requirement should be included for State and Territory Governments to monitor and report on discharging into homelessness.

ACTION 20.3 — SUPPORT FOR PEOPLE TO FIND AND MAINTAIN HOUSING

Housing and homelessness services should have the capacity to support people with severe mental illness to find and maintain housing in the community.

Start now

- The National Disability Insurance Agency should continue to amend its Specialist Disability Accommodation strategy and policies to encourage development of long-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness. This should include lifting the restrictions of the number of people who can reside in newly developed Specialist Disability Accommodation, and providing more detail on how the NDIA will deal with liability problems concerning property damage.
- State and Territory Governments, working with housing support providers and with support from the Australian Government, should address the shortfall in the number of supported housing places for people with severe mental illness by providing a combination of long-term housing options for people with severe mental illness who require integrated housing and mental health supports.
- State and Territory Governments, with support from the Australian Government, should address the gap in homelessness services for people with mental illness, including scaling up longer-term housing options such as Housing First programs.
 - Housing First programs should target people who experience severe and complex mental illness, are persistently homeless, and are unlikely to respond to existing homelessness services.
 - This would require governments to invest in homelessness services that make long-term housing available specifically for these programs.

Start later

- As part of the next negotiation of the National Housing and Homelessness Agreement, governments should increase the quantum of funding for housing and homelessness services, with particular attention to expanding provision of housing and homelessness services for people with mental illness.

Justice

ACTION 21.1 —EARLY INTERVENTION IN THE CRIMINAL JUSTICE SYSTEM

An early intervention approach is needed to address the over-representation of people with mental illness across all stages of the criminal justice system.

Start now

State and Territory Governments should support an early intervention approach that would ensure people who are at high risk of coming into contact with the criminal justice system are identified, and provided appropriate support, such as mental healthcare and housing, to reduce their risk of offending.

In doing so, State and Territory Governments should continue trialling early intervention initiatives, such as the *Youth on Track* program, and ensure associated evaluation and research is undertaken to build an evidence base about specific programs that are effective in reducing offending.

FINDING 21.1 — POLICE RESPONSES RELY ON COMMUNITY MENTAL HEALTH SERVICES

The effectiveness of police responses to mental health related incidents relies heavily on mental health services being available in the community. Police responses are limited by a ‘bounce back’ problem — whereby police respond multiple times to the same individuals experiencing mental health crises. In some cases, these individuals are referred to mental health services by police, but are unable to access appropriate treatment and care, and are discharged without support.

ACTION 21.2 — SUPPORT FOR POLICE

Responses to mental health related incidents should follow a systematic approach, to support both the individual with mental illness and the police responders.

Start now

All State and Territory Governments should implement initiatives that enable police, mental health and ambulance services to collectively respond to mental health-related incidents. Approaches undertaken in Queensland and Western Australia should be considered.

The initiatives should ensure that:

- mental health professionals are embedded in police communication centres to provide real-time information on the individual to whom police are responding, to advise on responses and referral pathways, and to prioritise deployment of co-responder resources
- police, mental health professionals and/or ambulance services are able to co-respond to mental health related incidents if necessary
- roles and responsibilities of all service providers are clearly defined and aligned with existing memoranda of understanding or other protocols between police, mental health services and ambulance services
- approaches are tailored to meet the needs of particular groups, such as Aboriginal and Torres Strait Islander people or people from culturally and linguistically diverse backgrounds.

ACTION 21.3 — IMPROVING ACCESS TO COURT DIVERSION PROGRAMS

Court diversion programs can be beneficial to people with mental illness.

Start now

State and Territory Governments should ensure that all individuals with mental illness who would benefit from court diversion programs — that link individuals to appropriate mental health treatment and social support — can access them. This should include ensuring court diversion programs are:

- available and accessible jurisdiction-wide, including in regional and remote areas
- adequately resourced, including funding and appropriately trained staff.

In doing so, State and Territory Governments should ensure there is adequate coordination with relevant agencies providing services to individuals who are referred by the court diversion program, particularly health and housing.

ACTION 21.4 — MENTAL HEALTHCARE IN CORRECTIONAL FACILITIES AND ON RELEASE

Mental healthcare in correctional facilities should be equivalent to that in the community and mental healthcare should be continued seamlessly as people enter and leave correctional facilities.

Start now

The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Health Service Standards to determine how they apply to, and can be implemented in, correctional settings. All State and Territory Governments should ensure that:

- there is mental health screening and assessment of all individuals (whether sentenced or not) by a mental health professional on admission to correctional facilities, and on an ongoing basis where appropriate
- mental health information obtained from screening and assessment is comprehensive enough to inform resourcing of mental health services in correctional facilities
- with consent from the individual, there is communication with any of their existing mental health providers to further inform mental health needs
- individuals in correctional facilities are able to access timely and appropriate mental healthcare, of a standard equivalent to that in the community
- mental health information obtained from screening and assessment is used to inform transition planning for the individual upon release. Transition planning should be completed and, with consent from the individual, shared with community based mental health services, case managers and other relevant parties, at a time before release that is reasonable for the planning of continued mental healthcare of the individual in the community.

ACTION 21.5 — FORENSIC MENTAL HEALTHCARE

Start now

The Australian, State and Territory Governments should complete the forensic mental health component of the National Mental Health Service Planning Framework, which should then be used by State and Territory Governments to quantify the level of unmet demand for forensic mental healthcare. This should inform planning and funding of forensic mental healthcare, including forensic services and facilities, for adults and young people. The plans developed for forensic mental healthcare should be made publicly available.

ACTION 21.6 — ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE WHO ARE INCARCERATED

Start now

State and Territory Governments should ensure Aboriginal and Torres Strait Islander people in correctional facilities have access to mental health supports and services that are culturally capable. These services should be:

- designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible
- trauma-informed, particularly when services are delivered to Aboriginal and Torres Strait Islander women
- focused on practical application particularly for those on remand or short sentences who need to reintegrate into the community
- connected to culturally capable mental healthcare and psychosocial supports in the community for Aboriginal and Torres Strait Islander people upon release from correctional facilities.

ACTION 21.7 — HEALTH JUSTICE PARTNERSHIPS AND DISABILITY JUSTICE STRATEGIES

Integrating legal and health services for people with mental illness can lead to better outcomes for both individuals and the justice system.

Start now

State and Territory Governments should fund pilot programs of multi-site health justice partnerships to:

- improve access to legal services for people with mental illness
- enable larger volumes of data to be collected and build an evidence base
- inform future policy and program development in this area.

Funding should also be allocated to rigorous evaluations of the pilot programs.

State and Territory Governments should consult with relevant stakeholders to ensure a coordinated approach.

Start later

All State and Territory Governments should continue to develop and implement disability justice strategies to ensure the rights of people with mental illness are protected and promoted in their interactions with the justice system. Disability justice strategies should consider how people with mental illness can be better supported to:

- initiate legal proceedings
- participate in the justice system
- access other appropriate support in the community, where required.

ACTION 21.8 — LEGAL REPRESENTATION AT MENTAL HEALTH TRIBUNALS

People with mental illness require appropriate legal representation to protect their rights.

Start now

State and Territory Governments should ensure people appearing before mental health tribunals and other tribunals that hear matters arising from mental health legislation have a right to access legal representation. To facilitate this, State and Territory Governments should adequately resource legal assistance services for this purpose — for example, through broader legal assistance funding or a specific legal assistance grant.

ACTION 21.9 — INDIVIDUAL NON-LEGAL ADVOCACY SERVICES

Non-legal advocates can help support individuals subject to involuntary detention under mental health legislation.

Start later

State and Territory Governments should ensure individual non-legal advocacy services are available for any individual detained under mental health legislation. In particular, services should:

- focus on facilitating supported decision making by individuals
- be adequately resourced to provide assistance to individuals who require it
- not replace legal advocacy services.

Where an individual is detained under mental health legislation, or agrees to mental health treatment in lieu of being detained under mental health legislation, the treating facility should notify non-legal advocacy services and the individual's family or carer.

ACTION 21.10 — MENTAL HEALTH ADVANCE DIRECTIVES

Mental health advance directives can help ensure that the wishes of a person with mental illness are able to be met.

Start now

State and Territory Governments should ensure that advance directives are:

- formally recognised in mental health legislation
- actively promoted to raise awareness among mental health consumers of the scope to use such an instrument to state their preferences regarding future treatment and recovery, to nominate a carer, and to specify the types of information to be shared with that carer
- contain safeguards that balance consumer choice against urgent treatment needs
- easily accessible by any mental health service.

State and Territory Governments should seek to ensure individuals can access support to help them complete an advance directive, if it is required.

ACTION 21.11 — MUTUAL RECOGNITION OF MENTAL HEALTH TREATMENT ORDERS

State and Territory Governments should ensure there is mutual recognition of mental health treatment orders across Australia.

Start later

The Safety and Quality Partnership Standing Committee should complete work on an appropriate national approach to ensure mutual recognition of mental health treatment orders. The national approach should consider both legislative mechanisms and implementation needs, and be agreed to by all State and Territory Governments. This should be completed by 2025.

All State and Territory Governments should work collaboratively to implement the national approach.

PART V Enablers of reform

Governance

ACTION 22.1 — A NEW WHOLE-OF-GOVERNMENT MENTAL HEALTH STRATEGY

A national strategy that integrates services and supports that are delivered in health and non-health sectors should guide the efficient allocation of government funds and other resources to improve mental health outcomes over the long term.

Start now

The Australian, State and Territory Governments should develop a new National Mental Health Strategy that comprehensively integrates the roles played by health and non-health sectors. In developing the new strategy, they should ensure that:

- it involves broad collaboration with relevant health and non-health portfolios of Australian, State and Territory Governments, consumers and carers, and the private and community sectors
- its vision reflects the outcomes that consumers and carers value and a corresponding level of ambition for mental health reforms
- it is a single coherent document that outlines a comprehensive approach to improving mental health outcomes
- it has the demonstrable support of consumers and carers.

The Australian, State and Territory Governments should request the National Mental Health Commission to lead development of the new national mental health strategy and the next national mental health action plan in collaboration with all jurisdictions and for endorsement by them. The strategy should identify priority areas for whole-of-government action to be considered by all governments for inclusion in the work program of the recommended interjurisdictional Special Purpose Mental Health Council (action 22.3).

To improve accountability for the strategy's implementation, the Australian, State and Territory Governments should:

- request the National Mental Health Commission to undertake annual monitoring and reporting on the strategy's implementation
- ensure that progress in implementing the strategy is independently and transparently reviewed and improvements recommended every five years.

ACTION 22.2 — IMPROVING PLANNING AND SERVICE DELIVERY WITH ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023* has not been fully implemented, to the detriment of the mental health of Aboriginal and Torres Strait Islander people.

Start now

The Australian Government should:

- expedite the development of an implementation plan for the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023*
- entrust development to Gayaa Dhuwi (Proud Spirit) Australia, working with the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group
- ensure that development and operationalisation of the implementation plan is well resourced.

ACTION 22.3 — FACILITATING A CROSS-PORTFOLIO APPROACH

All Governments should commit to a nationally consistent whole-of-government approach to prevention, early intervention and recovery in mental health.

Start later

The Australian, State and Territory Governments should establish a Special Purpose Mental Health Council (SPMHC) to facilitate a whole-of-government approach to prevention, early intervention and recovery in mental health.

- Membership of the SPMHC should comprise Australian and State and Territory Government health/mental health ministers (permanent members) plus ministers of selected social policy portfolios on 18-month rotations (partnering members).
- The SPMHC should develop and implement a series of national 5-year cross-portfolio action plans that serve to promote prevention, early intervention and recovery in mental health.
- Each partnering portfolio should adequately resource its contribution to the SPMHC.

ACTION 22.4 — ENHANCING CONSUMER AND CARER PARTICIPATION

Consumers and carers should have the opportunity to participate in the design of policies and programs that affect their lives.

Start now

- The Australian, State and Territory Governments should establish a clear, ongoing role for consumers and carers to participate in all aspects of mental healthcare system planning, design, monitoring and evaluation and seek involvement from people with lived experience from the beginning of these processes.
- The National Mental Health Commission should report annually on the state of systemic advocacy in mental health in Australia at a State, Territory and national level.
- The Australian Government should facilitate a process through Mental Health Australia to establish peak bodies that are able to represent the separate views of mental health consumers, and of carers and families, at the national level. It should provide sufficient funding to cover the development, establishment and ongoing functions of these peak bodies.

Start later

- Mental Health Australia should create formal mechanisms to bring the new peak bodies together regularly to progress issues of mutual interest and develop common policy positions and advice.
- The Australian, State and Territory Governments should extend the funding cycle length for their relevant peak bodies to at least five years.

ACTION 22.5 — SIMPLIFYING COMPLAINTS PROCESSES

All consumers should have access to a simpler and more transparent complaints system that is fair, effective and efficient and provides for systemic improvements to the mental health system overall.

Start now

The Australian Government should request the Australian Commission on Safety and Quality in Health Care to develop better practice guidelines for bodies handling mental healthcare complaints.

The Australian, State and Territory Governments should instigate a national, independent review of Australia's system for handling consumer complaints that relate to the use of mental healthcare services and supports.

ACTION 22.6 — STRENGTHENING MENTAL HEALTH CAPABILITY

All States and Territories should have the capability to have innovative and accountable mental health services.

Start now

Where a body does not exist, State and Territory Governments should each establish a body (such as a mental health commission) that is responsible for promoting continuous policy and program improvement, and fostering genuine accountability for their mental health reform commitments. States and Territories should adopt the following principles to ensure that the relevant bodies operate effectively:

- enduring, that is, expected to continue indefinitely
- appropriately resourced to match their roles and responsibilities
- independent of, but integral to, government mental health policy making
- authorised to take a cross-sectoral view
- authorised to request and receive information and data from other government departments and bodies.

ACTION 22.7 — BUILDING A STRONGER EVALUATION CULTURE

A robust culture of program evaluation should inform the allocation of public funds across the mental health system to ensure that they are deployed efficiently and effectively.

Start now

The National Mental Health Commission (NMHC) should have statutory authority and lead the evaluation of mental health and suicide prevention programs funded by the Australian, State and Territory Governments, and other programs that have strong links with mental health outcomes, including those in non-health sectors.

- The NMHC should be an interjurisdictional body. All health ministers should endorse the NMHC to take on a broad-ranging evaluation role.
- The NMHC should be governed by a skills-based Board. It should be granted full powers to act in the interests of the NMHC in fulfilling its statutory functions, including powers to appoint and remove a Chief Executive Officer.
- The NMHC should have legislative provisions to make requests for information from Australian, State and Territory Government agencies in order to fulfil its statutory functions.
- The NMHC should not advocate, defend or publicly canvass the merits of governments' or oppositions' policies.

As part of its annual planning cycle, the NMHC should prepare and publish a rolling 3-year schedule of program evaluations. It should, in consultation with key stakeholders, develop and publish a process for prioritising policy and program evaluations, including decision-making criteria.

The Australian, State and Territory Governments should agree to a set of principles by which the NMHC would undertake its evaluation function and for the mental health sector more broadly. These principles, which should be developed in consultation with relevant stakeholders, should reflect the importance of:

- shifting towards evaluations that focus on measuring the attributable impact of programs (through methods that incorporate control groups), rather than monitoring program outcomes
- promoting processes that enable lessons from program implementation to be determined and disseminated before programs reach their impact evaluation stage.

The Gayaa Dhuwi (Proud Spirit) Declaration should guide any evaluation by the NMHC of programs affecting Aboriginal and Torres Strait Islander people.

Funding and commissioning

ACTION 23.1 — IMPROVING PHN–LHN COOPERATION

Start now

The Australian, State and Territory Government health ministers should significantly strengthen the guidance on joint regional planning for Primary Health Network (PHN)–Local Hospital Network (LHN) groupings to require each to:

- undertake gap analyses of current service provision against National Mental Health Service Planning Framework benchmarks (action 24.8)
- specify the mix of mental health services that they will commission/provide over the next 3 years and update this annually
- include all commissioned psychosocial supports outside of the National Disability Insurance Scheme within the scope of joint regional plans, and require joint regional plans to coordinate clinical mental healthcare with National Disability Insurance Scheme psychosocial supports
- set out how they consulted with consumers and carers in the development of the plan, whether any aspects of their plan conflict with the input of consumers and carers, and justify why this is the case.

Governments should require each PHN–LHN grouping to develop a ‘Consumer and Carer Engagement Framework’ that specifies an organised approach to engaging with consumers and carers and a set of benchmarks against which to report the extent of that engagement.

The National Mental Health Commission (NMHC) should develop a set of key performance indicators that capture the extent to which PHN–LHN cooperation is driving improved outcomes for consumers and carers, and seek to improve these indicators over time.

Start later

Governments should require PHN–LHN groupings to develop joint regional plans that comply with the revised guidelines and ensure that PHN–LHN groupings are adequately resourced to do so. The NMHC should ensure that joint regional plans are compliant.

The NMHC should report annually on the performance of each PHN–LHN grouping. Its reporting should comprise:

- a comparison of actual services commissioned/provided against joint regional plan commitments
- a description of the PHN–LHN grouping’s Consumer and Carer Engagement Framework and the extent of compliance with it
- reporting of key performance indicators at the PHN–LHN grouping level
- observations about the effectiveness of each PHN–LHN grouping.

The Australian Institute of Health and Welfare should provide data and analysis to the NMHC as required to facilitate this work.

The requirements on each PHN–LHN grouping should transfer to Regional Commissioning Authorities in States/Territories where they are established.

ACTION 23.2 — RESPONSIBILITY FOR PSYCHOSOCIAL SUPPORTS

Start later

State and Territory Governments should take sole responsibility for commissioning psychosocial supports outside of the National Disability Insurance Scheme, supported by additional Australian Government funding. The Australian, State and Territory Governments should codify this transition in the National Mental Health and Suicide Prevention Agreement (Action 23.3). Primary Health Networks and Local Hospital Networks should manage the transition ‘on the ground’ through joint regional planning in States/Territories that have not created Regional Commissioning Authorities. To ensure continuity of support during the National Disability Insurance Scheme transition, the formal transfer of responsibility should not occur prior to mid-2022.

If the Australian, State and Territory Governments cannot agree to the State and Territory Governments taking on sole responsibility for commissioning psychosocial supports outside of the National Disability Insurance Scheme, then they should instead agree to the Australian Government taking on this responsibility and tasking the Primary Health Networks with commissioning all psychosocial supports outside of the National Disability Insurance Scheme.

ACTION 23.3 — NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT

Governments should agree to and clarify responsibilities for mental health service delivery, funding, monitoring, reporting and evaluation.

Start now

The Australian, State and Territory Governments should develop a National Mental Health and Suicide Prevention Agreement that:

- sets out the shared intention of the Australian, State and Territory Governments to work in partnership to improve mental health and suicide prevention outcomes for all Australians
- governs the transfer of psychosocial support responsibility outside of the NDIS and associated Australian Government funding to State and Territory Governments
- clarifies the responsibilities of each level of government for providing mental healthcare, psychosocial supports, mental health carer supports and suicide prevention services
- specifies minimum funding commitments by both levels of government and governs the transfer of Australian Government funding to State and Territory Governments to support expansion of mental healthcare and psychosocial supports
- declares the role of the National Mental Health Commission as an interjurisdictional evaluation body and its role in monitoring Primary Health Network–Local Hospital Network cooperation
- commits all governments to establishing Regional Commissioning Authorities if cooperation between Primary Health Networks and Local Hospital Networks does not drive sufficiently improved outcomes
- sets out clear and transparent performance reporting requirements.

The Australian, State and Territory Government health ministers should be responsible for developing and implementing the National Mental Health and Suicide Prevention Agreement. Governments consult thoroughly with consumers and carers to inform the development of the agreement.

ACTION 23.4 — TRANSITION TO REGIONAL COMMISSIONING AUTHORITIES

Start now

The Australian Government should, at any time, permit any State/Territory Government to establish Regional Commissioning Authorities (RCAs) to commission mental healthcare, alcohol and drug services, psychosocial and mental health carer supports outside of the NDIS, and place-based suicide prevention services. State and Territory Governments should establish RCAs if there is not sufficient cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) in their jurisdiction to drive improved mental health outcomes.

As part of this transition, the Australian Government and the relevant State/Territory Government should agree to:

- establish RCAs as separate entities at arm's length from ministerial control
- transfer PHN Mental Health Care Flexible Funding Pool and PHN alcohol and drug funding to the corresponding RCA.

The requirements on PHN–LHN groupings to undertake joint regional planning and the National Mental Health Commission monitoring of PHN–LHN cooperation (Action 23.2) should apply to RCAs.

ACTION 23.5 — PRIMARY MENTAL HEALTHCARE FUNDING ARRANGEMENTS

Start now

The Australian Government Department of Health should reform the methodology that it uses to determine the size of the Primary Health Network (PHN) Mental Health Care Flexible Funding Pool and how it is allocated between regional commissioning bodies to allow for greater geographic equity in primary mental healthcare funding and to reduce funding biases that favour MBS-rebated care.

Once this has occurred, the Australian Government Minister for Health should issue a direction in relation to the *Health Insurance Act 1973* (Cth) to allow regional commissioning bodies to co-fund MBS-rebated mental health services, and allow other Australian, State and Territory Government agencies to co-fund MBS-rebated mental health services with the consent of the corresponding regional commissioning body.

The Minister for Health should also issue a direction in relation to the Health Insurance Act to allow State and Territory Government agencies to co-fund MBS-rebated out-of-hours GP services with the agreement of the corresponding PHN. The Australian Government should direct PHNs to approve these requests if there is a reasonable prospect that additional out of hours GP services would yield reductions in mental health related emergency department presentations.

ACTION 23.6 — CONTROLS ON REGIONAL COMMISSIONING

Start now

The Australian Government Department of Health should reform the controls that it places on the services that regional commissioning bodies (currently PHNs) can commission from the Mental Health Care Flexible Funding Pool.

- It should provide guidance to regional commissioning bodies about the evidence base that underpins different types of interventions, and require regional commissioning bodies to demonstrate that they have commissioned evidence-based services that meet their catchment's needs.
- It should permit regional commissioning bodies to redirect funding hypothecated to headspace centres and other particular providers to alternative services, subject to these services demonstrably not meeting the service needs identified in regional plans. This does not include funding hypothecated for the purpose of ensuring that regional commissioning bodies commission services to Aboriginal and Torres Strait Islander people.
- It should require regional commissioning bodies to treat Aboriginal Community Controlled Health Services as preferred providers of Aboriginal and Torres Strait Islander mental health services.

ACTION 23.7 — ACTIVITY-BASED FUNDING

Start now

The Independent Hospital Pricing Authority (IHPA) should review the Australian Mental Health Care Classification to determine:

- whether its structure and splitting variables should be refined or changed (especially the 'phase of care' variable)
- if the 'phase of care' variable is retained, how it can be refined to improve inter-rater reliability
- if a new costing study is required
- a revised timeframe for implementing the classification.

As an interim measure, IHPA should work with State and Territory Governments to develop a simpler activity-based payment model for community ambulatory mental healthcare services based on hours of care provided. State and Territory Governments should use this payment model to fund community ambulatory mental healthcare services. It should not be used to determine Australian Government National Health Reform Agreement transfers if this would significantly delay its development.

The Australian Commission on Safety and Quality in Healthcare and IHPA should seek to incorporate mental health-related avoidable hospital readmissions into broader activity-based funding reforms.

ACTION 23.8 — MENTAL HEALTH INNOVATION FUND*Start later*

The Australian Government should establish a Mental Health Innovation Fund to trial innovative service delivery, system organisation and payment models. The Mental Health Innovation Fund should allow Primary Health Network – Local Hospital Network groupings and Regional Commissioning Authorities to apply for funding to trial new models under the proviso that the models are independently evaluated and the findings are published.

ACTION 23.9 — PRIVATE HEALTH INSURANCE AND FUNDING OF COMMUNITY-BASED HEALTHCARE*Start now*

The Australian Government should review the regulations that prevent private health insurers from funding community-based mental healthcare with a view to increasing the scope for private health insurers to fund programs that would prevent avoidable mental health-related hospital admissions.

ACTION 23.10 — LIFE INSURANCE AND FUNDING OF MENTAL HEALTHCARE*Start now*

The Australian Government should permit life insurers to fund mental health treatments for their income protections and total and permanent disability insureds on a discretionary basis. The Australian Securities and Investments Commission should work with the life insurance industry on the preconditions necessary for this to occur.

Monitoring, evaluation and research

ACTION 24.1 — A STRATEGY TO IMPROVE DATA USABILITY

There is significant mental health data currently collected — but much of it is underutilised.

Start now

The Australian, State and Territory Governments should develop a strategy to improve data usability in mental health and suicide prevention including identifying:

- data linkage projects between Australian, State and Territory Government datasets
- datasets that are underutilised due to access barriers, in particular, access barriers faced by State and Territory Governments and regional commissioning bodies
- datasets that are underutilised due to low data quality, including inconsistent definitions and classifications.

This strategy should identify high-priority projects in consultation with relevant stakeholders, assess the barriers to implementing such projects and develop solutions to address them.

ACTION 24.2 — ROUTINE NATIONAL SURVEYS OF MENTAL HEALTH

Mental health data at a national level needs to be systematically updated over time.

Start later

The Australian Government should support the Australian Bureau of Statistics to conduct a National Survey of Mental Health and Wellbeing no less than every 10 years. Its design should enable:

- consistent comparisons over time
- monitoring changes in prevalence and effects of mental health conditions
- analyses to understand patterns of use for mental health and other support services, and their effect on individual outcomes over time.

The survey design should ensure that it adequately represents demographic groups who may have diverse needs and involve consumers and carers in its design. Opportunities for linking the survey data with other datasets should be considered.

ACTION 24.3 — ADDRESSING DATA GAPS

High-quality and fit-for-purpose data should be collected to inform decision making and improve service delivery, and outcomes for people with lived experience and carers.

Start now

- The Australian, State and Territory Governments should complete Action 24 in the Fifth National Mental Health and Suicide Prevention Plan to update the statement on National Mental Health Information Priorities (NMHIP).
- The Australian, State and Territory Governments should develop and adequately fund strategies to address identified data gaps and information priorities in the statement on NMHIP. This should include consultation on how best to:
 - collect the data in a way that imposes the least regulatory burden to ensure data is high-quality and fit-for-purpose
 - publish the data in ways that are useful to policy makers, service providers, and importantly, consumers and the public.
- The Australian, State and Territory Governments should ensure a nationally consistent dataset is established in all States and Territories of non-government organisations that provide mental health services. In doing so, they should:
 - ensure data collection focuses on outcomes for people that are valued by them (not just outputs and activity)
 - ensure data collection informs service planning at the regional level
 - adequately fund and provide ongoing support to non-government organisations to collect this data, to ensure the data is of high quality
 - task and adequately fund the Australian Institute of Health and Welfare to lead and coordinate the implementation nationally.

Start later

- The National Mental Health Commission should publicly report on the progress made against the statement on NMHIP, five and ten years after its release. The National Mental Health Commission should highlight which data gaps and information priorities were addressed, which were not and why.

ACTION 24.4 — ESTABLISH TARGETS FOR KEY MENTAL HEALTH OUTCOMES

Accountability for mental health outcomes should include measurement against predetermined performance targets.

Start now

The Australian, State and Territory Governments should agree on a set of targets that specify key mental health and suicide prevention outcomes that Australia should achieve over a defined period of time.

- To ensure these targets are relevant and fit-for-purpose, they should develop a process for setting them that, among other things, involves co-design with consumers and carers and includes both quantitative and qualitative evidence and data.
- They should engage Aboriginal and Torres Strait Islander people and the National Federation Reform Council Indigenous Affairs Taskforce in discussions about any targets that may affect Aboriginal and Torres Strait Islander people.

Following this collaborative process, the Australian, State and Territory Governments should publish the targets and an explanation of how they were set and they will be monitored and reported.

ACTION 24.5 — MONITORING AND REPORTING AT THE SERVICE PROVIDER LEVEL

The Australian, State and Territory Governments should require monitoring and reporting at the service provider level that is focused on consumer and carer outcomes, to encourage improvements in service quality, improve transparency and accountability, and inform consumer choice.

Start now

- The Australian, State and Territory Governments should fund the facilitation and coordination of benchmarking analyses. In doing so, different models of facilitation and coordination should be considered, such as through a national clinical quality registry in mental health or by tasking a central authority. Different funding arrangements should also be considered, including cost sharing models with service providers. Australian, State and Territory Governments should identify and address any implementation barriers.
- The Australian, State and Territory Governments should require all publicly funded mental health service providers (clinical and non-clinical) to commit to public reporting at the service provider level. This would support consumers and carers to exercise choice, and encourage performance improvement by service providers. Lessons from overseas examples should be drawn on, for example, the National Health Service website that is used to inform consumers and carers in England.

ACTION 24.6 — REPORTING SERVICE PERFORMANCE DATA BY REGION

Transparency at a regional level is required to make sure mental health services are meeting local needs.

Start now

- The Australian Government should release data collected on and by Primary Health Networks for annual publication by the Australian Institute of Health and Welfare (AIHW).
- The Australian, State and Territory Governments should authorise the AIHW to report all data relating to the performance of mental health and suicide prevention services at a regional level, as defined by Primary Health Network and Local Hospital Network regional boundaries, as well as at a State and Territory and national level.
 - The AIHW should ensure that this data is readily accessible to the public, including as historical time series, to maximise its use for planning and research.
 - The Australian Government should continue to provide AIHW with additional resources to establish service performance reporting at the regional level and to make this data accessible to commissioning bodies and the public.

ACTION 24.7 — STANDARDISED REGIONAL REPORTING REQUIREMENTS

Service providers operating in multiple regions should face consistent outcome-focused reporting requirements across those regions.

Start now

The Australian, State and Territory Governments should develop, in consultation with regional commissioning bodies, standardised and outcome-focused reporting requirements for service providers. This should ensure undue regulatory burden is not imposed on service providers and facilitate inter-regional comparisons. The Australian, State and Territory Governments should provide guidance and support to regional commissioning bodies to implement this, and monitor and report on compliance.

ACTION 24.8 — GAP ANALYSES USING THE USING THE NATIONAL MENTAL HEALTH SERVICE PLANNING FRAMEWORK

Start now

As work to map data from existing national mental health data collections with National Mental Health Service Planning Framework (NMHSPF) outputs is completed, the Australian Institute of Health and Welfare (AIHW) should annually publish all relevant data on mental health services in a format that aligns with the NMHSPF at a national, State/Territory, and regional level.

Each Primary Health Network–Local Hospital Network grouping or regional commissioning authority should annually report, in their joint regional plan, a gap analysis using the NMHSPF.

The Australian Government, and all State and Territory Governments, should give the AIHW permission to annually publish, at both a national and State/Territory level:

- independent estimates of NMHSPF benchmarks of all mental health services, including psychosocial support services, included in the NMHSPF, at both a national and State/Territory level
- gap analyses based on a comparison of these benchmarks with services that are currently provided (where this data is available)
- data on the amount of time that clinical staff in community ambulatory mental health services are spending on consumer-related activities (with and without the consumer present).

ACTION 24.9 — INCREASING THE TRANSPARENCY OF THE NATIONAL MENTAL HEALTH SERVICE PLANNING FRAMEWORK

The key planning tool used for mental health — the National Mental Health Service Planning Framework (NMHSPF) — should be transparent to facilitate its improvement.

Start now

The Australian, State and Territory Governments should enhance and make all parts of the NMHSPF publicly available, including the Planning Support Tool and all supporting documentation.

Start later

Over time, the NMHSPF should:

- be able to account for substitution between types of care
- be expanded to include forensic mental health services
- be made more flexible so that it can account for large but temporary ‘shocks’ to population mental health, such as natural disasters, epidemics or recessions.

ACTION 24.10 — STRENGTHENING MONITORING AND REPORTING

Monitoring and reporting should be more focused on consumer and carer outcomes, and broadened beyond health portfolios.

Start now

- The National Mental Health Commission (NMHC) should lead monitoring and reporting on mental health and suicide prevention outcomes, activities and reforms across portfolios. This includes monitoring and reporting on:
 - outcomes derived from the Contributing Life Framework for people with mental illness, their carers and suicidal behaviour annually
 - mental health and suicide prevention expenditure (including in non-health sectors), with the NMHC to determine frequency of reporting
 - the progress of mental health reforms (including strategies and plans) annually.
- The NMHC should consult with stakeholders, including consumers and carers, Aboriginal and Torres Strait Islander people and sector experts in finalising a set of indicators to monitor and report on progress against outcomes derived from the Contributing Life Framework.
- The NMHC should consult with stakeholders and sector experts to identify mental health related expenditure in non-health sectors, such as justice and education, that could be routinely reported on.
- The NMHC should continue to monitor and report on progress against mental health reforms under the National Mental Health Strategy.
- The NMHC’s monitoring and reporting activities should inform and support its recommended evaluation function (Action 22.7).

ACTION 24.11 — REQUIRING COST-EFFECTIVENESS CONSIDERATION AND PILOT TRIALS OF NEW PROGRAMS

New programs should be cost effective and trialled before being scaled up

Start later

- As part of their commissioning processes, governments should require all funding applications for mental health programs or interventions to include an assessment of the expected cost-effectiveness of the proposed program or intervention. Allocation of funding should only be considered for programs or interventions that are expected, on the basis of evidence provided in the funding request, to be cost effective. The Australian Government, in consultation with State and Territory Governments, should develop a set of general principles and reference cases to ensure a consistent approach.
- All new mental health programs or interventions should be first trialled as pilot programs, before they can be progressively scaled up. Only pilot trials with positive impact evaluations that have been shown to improve outcomes in practice should be scaled up.

FINDING 24.1 — SUPPORT FOR PRACTICAL COORDINATED RESEARCH

Mental health and suicide prevention research in Australia has largely been misaligned with both national strategic priorities and current ‘real world’ problems, and has generated evidence that is not translated in practice or widely disseminated. As a result, mental health and suicide prevention research appears to be disconnected from policy making, program development, service models and delivery, and desired consumer outcomes.

While Governments have recognised these shortcomings and are supporting some initiatives to address them — including through steps to align mental health research with national strategic priorities and funds to establish a national centre for innovation — more can be done to ensure research is coordinated and making efficient use of research funds.

ACTION 24.12 — A CLINICAL TRIALS NETWORK SHOULD BE ESTABLISHED

A clinical trials network can improve the community alignment and application of mental health and suicide prevention research.

Start now

The Australian Government should fund the establishment of a national clinical trials network in mental health and suicide prevention. This network should consider research across all areas of the mental health system, including care provided in community settings. In developing this network, the Australian Government should consult with bodies that work in this area including the National Health and Medical Research Council, the Australian Clinical Trials Alliance and other relevant stakeholders, including people with lived experience.