

Contributing lives,
thriving communities

Report of the National Review of Mental Health Programmes and Services

Summary

30 November 2014



Australian Government
National Mental Health Commission



I just want to emphasise that people with mental health issues are a part of the community and that our lives matter. Not only that, but by denying people like me the chance to have a stable life, with stable housing and a reduction in poverty-related stress, you are also denying our kids and loved ones relief from those stresses.”

Person with lived experience, Victoria

About this Review

This document provides a summary and list of recommendations of the four-volume report of the National Review of Mental Health Programmes and Services. All volumes can be downloaded from www.mentalhealthcommission.gov.au. A complete list of the Commission's publications is available from our website.

A number of electronic fact sheets for the Review are available on our website.

Many of the quotes in this publication come from people and organisations in Australia who participated in the Commission's Call for Submission process.

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I think having two bureaucracies (federal and state) isn't working. The money needs to go into one very efficient and competently run system—not be fragmented across NGOs, GP-referred groups and a lot of semi-trained/unregistered service providers. It should be a one-stop-shop where people tell their story once and an appropriate referral for follow-up is made.”

Member of the public, New South Wales

Executive Summary

This summary document presents an overview of the findings of the National Review of Mental Health Programmes and Services. The Review responds to the Terms of Reference provided to the National Mental Health Commission by the Commonwealth Government early in 2014.

On the basis of our findings, it is clear the mental health system has fundamental structural shortcomings. This same conclusion has been reached by numerous other independent and governmental reviews.

The overall impact of a poorly planned and badly integrated system is a massive drain on peoples' wellbeing and participation in the community—on jobs, on families, and on Australia's productivity and economic growth.

Despite almost \$10 billion in Commonwealth spending on mental health every year, there are no agreed or consistent national measures of whether this is leading to effective outcomes or whether people's lives are being improved as a result.

This Review is framed on the basis of making change within existing resources. We consider that Australia has a once-in-a-generation opportunity to improve the lives of millions of Australians without additional funding.

For example, the Review identifies measures to help the Commonwealth maximise value for taxpayers' dollars by using its resources as incentives to leverage desirable and measurable results, and funding outcomes rather than activity. It also proposes reallocating funding from downstream to upstream services, including prevention and early intervention.

The ultimate goal of this Review is to make a set of recommendations for Government to consider, that will create a system to support the mental health and wellbeing of individuals in a way that enables them to live contributing lives and participate as fully as possible as members of thriving communities.

All of our recommendations and actions are designed to collectively lead us to that destination.

To achieve the required system reform, the Commission recommends changes to improve the longer-term sustainability of the mental health system based on three key components:

1. Person-centred design principles
2. A new system architecture
3. Shifting funding to more efficient and effective 'upstream' services and supports.

These principles underpin the Commission's 25 recommendations across nine strategic directions. They guide a more detailed implementation framework of activity over the next decade, which provides a comprehensive plan for action in mental health reform. The planned, coordinated implementation strategy outlined in the Review report will give strength to the recommendations by establishing a transparent and collaborative governance structure to work with communities, people, experts and those with lived experience to hone the recommendations for national adoption.

Taken together, they form a strong, achievable plan to take advantage of this unique opportunity to reform Australia's mental health system for the wellbeing of Australia and Australians.

Background

This Review

In conducting this Review, the Commission's primary areas of focus have been the efficiency and effectiveness of Commonwealth services and programmes and overall investment and spending patterns. We considered programme evaluations where available. We did not evaluate specific clinical treatments and could not evaluate state and territory-funded programmes, services and systems.

The Review has been informed by the Commission's 2012 *Contributing Life Framework*—a whole-of-person, whole-of-life approach to mental health and wellbeing. Accordingly, we have undertaken a cross-portfolio assessment of the strengths and weaknesses of the mental health and support system as a whole. The public call for submissions was a significant input to these considerations.

Setting the scene

There have been considerable changes in mental health and suicide prevention policy, systems and services in the past three decades, featuring:

- the commencement in the 1990s of a National Mental Health Strategy and four subsequent National Mental Health Plans
- the initiation of a National Suicide Prevention Strategy and release of a National Recovery Framework in 2013
- increasing recognition of the rights of individuals and the need for least restrictive treatments, and involvement of people and their families and other support people in planning and making decisions about their care and support
- the development of the community mental health movement, supporting people in their community, with a growing role of the non-government, not-for-profit and private sectors
- the closure or downsizing of many large-scale dedicated psychiatric institutions (the policy of deinstitutionalisation)
- greater mainstreaming of services and attempts to fully integrate them across health, housing, employment, education, justice and welfare and around people's needs

- a growing recognition of the different social and emotional needs of Aboriginal and Torres Strait Islander people, and the need for community-based and controlled services
- greater community understanding of mental health, mental illness and suicide, and a greater willingness to talk about issues and seek help.

System reform

The need for mental health reform enjoys long-standing bipartisan support. Yet as a country we lack a clear destination in mental health and suicide prevention. Our "mental health system"—which implies a planned, unitary whole—is instead a collection of often uncoordinated services introduced on an often ad hoc basis, with no clarity of roles and responsibilities or strategic approach that is reflected in practice.

We need system reform to:

- **redesign** the system to focus on the needs of users rather than providers
- **redirect** Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding activity
- **rebalance** expenditure away from services which indicate system failure and invest in evidence-based services like prevention and early intervention, recovery-based community support, stable housing and participation in employment, education and training
- **repackage** funds spent on the small percentage of people with the most severe and persistent mental health problems who are the highest users of the mental health dollar to purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high-cost care
- **reform** our approach to supporting people and families to lead fulfilling, productive lives so they not only maximise their individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia's wealth.

Overview of mental illness in our community

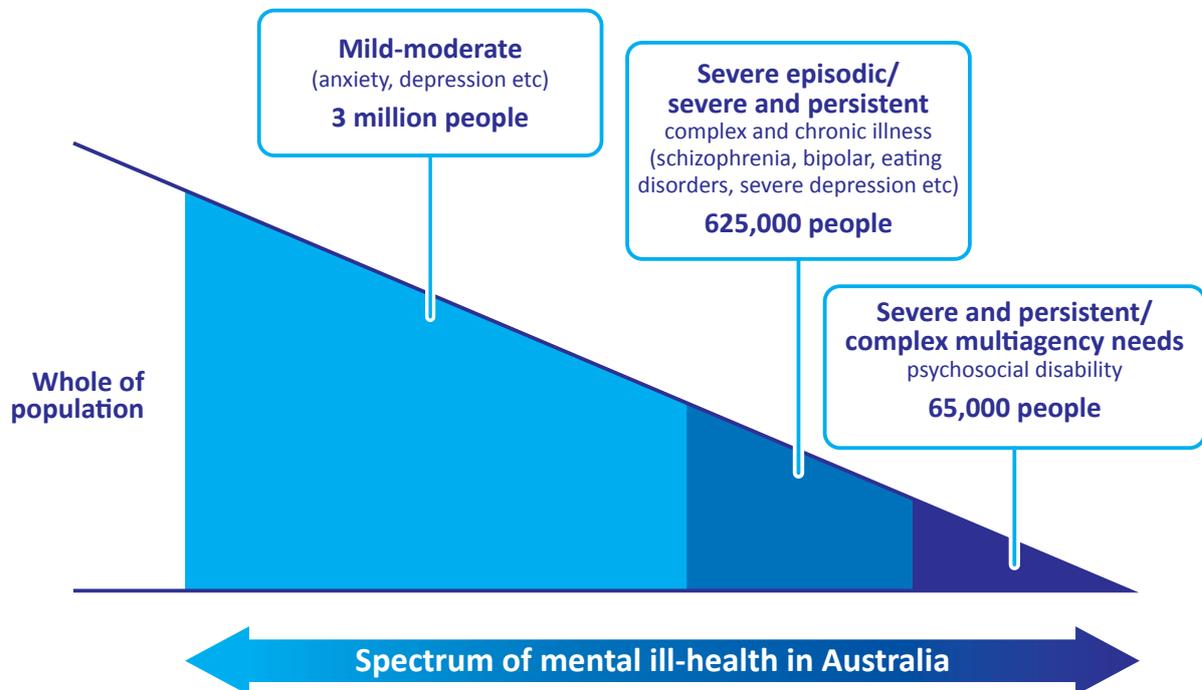


Figure 1: Annual distribution of mental ill-health in Australia

Each year, it is estimated that more than 3.6 million people (aged 16 to 85 years) experience mental ill-health¹—representing about 20 per cent of adults. In addition, almost 600,000 children and youth between the ages of four and 17 are affected by a clinically significant mental health problem.² Over a lifetime, nearly half of the Australian adult population will experience mental illness at some point—equating to nearly 7.3 million Australians aged 16 to 85.¹ Less than half will access treatment.¹

There are an estimated 9,000 premature deaths each year among people with a severe mental illness.³ The gap in life expectancy for people with psychosis compared to the general population is estimated to be between 14 and 23 years.⁴

In 2012 more than 2,500 people died by suicide,⁵ while in 2007 an estimated 65,000 Australians attempted to end their own life.¹ Suicide is the leading cause of death among people between aged 15 and 44 years,⁵ and is more likely among men, Aboriginal and Torres Strait Islander people, and people living outside of major cities (see further in Volume 2).⁶

Our work has identified that many people with mental health difficulties face compounding disadvantage—particularly Aboriginal and Torres Strait Islander people, people living in rural and remote regions,

those who are marginalised due to their sexuality, gender, cultural background or their job, people who have difficulties with alcohol or other drugs, people living with an intellectual disability and people who experienced childhood trauma.

The mental health needs of Aboriginal and Torres Strait Islander people are significantly higher than those of other Australians. In 2011–12 nearly one-third (30 per cent) of Aboriginal and Torres Strait Islander adults (aged 18 years and older) had *high* or *very high* levels of psychological distress, almost three times (2.7) the rate for other Australians.⁷ Nationally, there were 22.4 suicides per 100,000 Aboriginal and Torres Strait Islander people during 2012, more than double the rate of 11.0 for other Australians.⁵ Aboriginal and Torres Strait Islander people aged 15 years and older report stressful events at 1.4 times the rate of non-Indigenous people.⁷

Many people with experience of mental illness do not seek support for their condition. The rates of help-seeking and treatment are much lower than prevalence in the community.

The experience of mental ill-health ranges across a wide spectrum, as illustrated in Figure 1.

Economic and social costs to Australia

The economic cost of mental ill-health to Australia is enormous. Estimates range up to \$28.6 billion a year in direct and indirect costs,⁸ with lost productivity and job turnover costing a further \$12 billion a year⁹—collectively \$40 billion a year, or more than two per cent of GDP. The OECD estimates that the average overall cost of mental health to developed countries is about four per cent of GDP (including intangible costs such as the costs of reduced wellbeing, emotional distress, pain and other forms of suffering).¹⁰ In Australia, this would equate to more than \$60 billion or about \$4,000 a year for each person who lodges a tax return.

Mental illnesses are the leading cause of the non-fatal disease burden and account for about 13 per cent of Australia's total burden of disease. This means that of the non-fatal disease burden (i.e. years of healthy life lost through illness and disease) in Australia, 24 per cent were lost through the effects of mental illness. Anxiety and depression, alcohol abuse and personality disorders accounted for almost three-quarters of this burden.¹¹

The significance of these direct and indirect costs means that mental ill-health not only affects individuals and their families and other support people, but also the standard of living of every Australian and our communities more broadly.

Commonwealth expenditure

Based on information received by the Commission from 16 Commonwealth agencies, the Commonwealth spent almost \$10 billion on mental health and suicide prevention programmes in 2012–13.

As illustrated in Figure 2, in 2012–13, the 16 agencies spent:

1. \$8.4 billion (87.5 per cent) on **benefits and activity-related payments** in five programme areas:
 - Disability Support Pension (DSP) \$4,700m
 - National Health Reform Agreement (Activity Based Funding—ABF) \$1,000m
 - Carer Payment and Allowance (CP) \$1,000m
 - Medicare Benefits Schedule (MBS) \$900m
 - Pharmaceutical Benefits Scheme (PBS) \$800m
2. \$533.8 million (5.6 per cent) through **programmes and services with Commonwealth agencies and payments to states and territories**:
 - DVA and Defence programmes (\$192.3m)
 - Private Health Insurance Rebate for mental health-related costs (\$105.0m)
 - Payments to states and territories for specific programmes (perinatal depression, suicide prevention, National Partnership Agreement Supporting Mental Health Reform) (\$169.0m)
 - National Mental Health and Medical Research Council (NHMRC) research funding (\$67.1m).

3. \$606 million allocated by the Department of Health (DoH), the Department of Social Services (DSS) and the Department of the Prime Minister and Cabinet (DPMC) on **programmes delivered by NGOs**.

- DoH spent \$362 million on 55 grant programmes, including payments to 213 NGOs, representing 11 per cent of total mental health-related expenditure from this department.
- DSS spent \$180 million on six grant programmes, including payments to 196 NGOs, representing three per cent of total mental health-related expenditure from this department.
- DPMC spent \$64 million on three grant programmes including payments to 133 NGOs (the proportion of total mental health-related expenditure that this represented was not available).

These figures show that 87.5 per cent of Commonwealth funding on mental health is through five major programmes. That equates to \$7 out of every \$8 spent by the Commonwealth on mental health.

Four of these are demand-driven programmes providing benefits to individuals. The fifth major area of expenditure is an estimated \$1 billion per year provided to the states and territories under the 2011 National Health Reform Agreement (NHRA) for treatment of patients with a mental health need in the public hospital system, including an estimated \$280 million for patients in standalone psychiatric institutions.

Commonwealth expenditure on mental health 2012-13

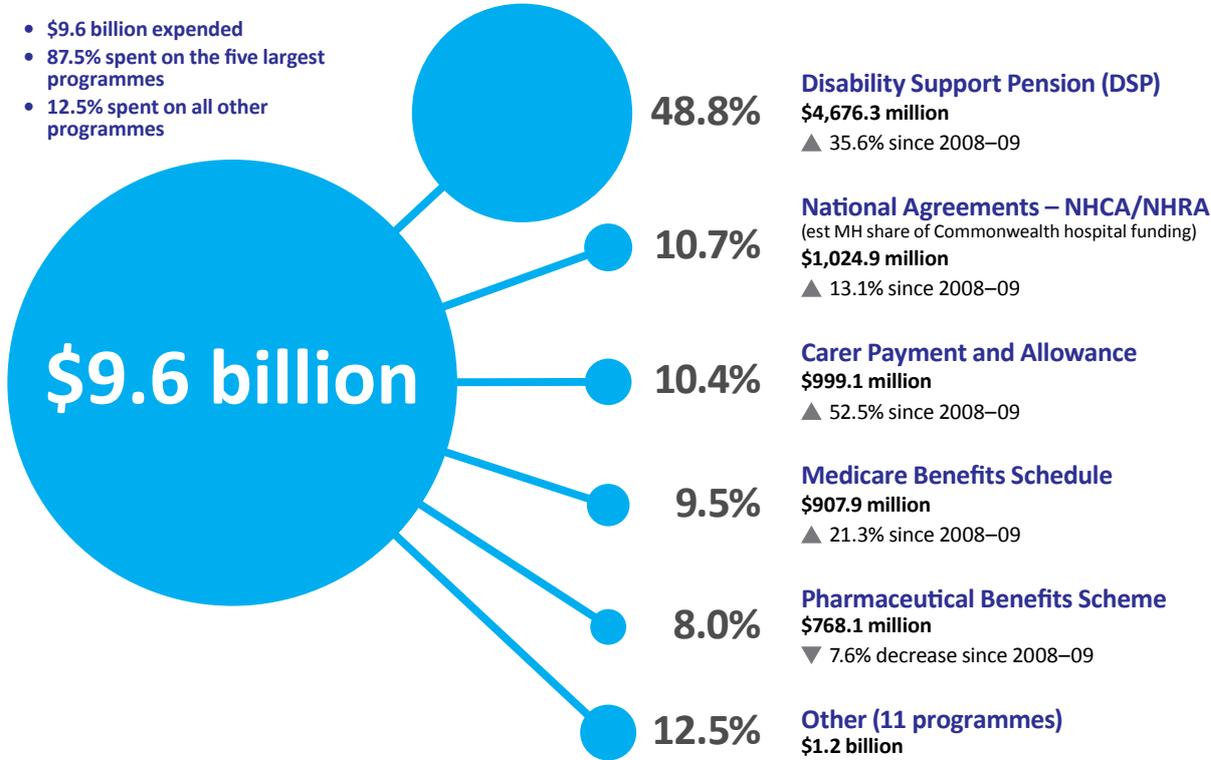


Figure 2: Commonwealth expenditure on mental health

In 2012–13 these three departments ran 64 programmes with total funding of \$606 million allocated to 542 organisations. These grants ranged from the highest of \$69.4 million (headspace) and \$29.5 million (*beyondblue*) down to numerous much smaller amounts below \$1.0 million.

Financial risk

The Commonwealth’s major funding role in mental health creates significant exposure to financial risk. As a major downstream funder of benefits and income support, any failure or gaps in upstream services means that as people become more unwell, they consume more of the types of income supports and benefits which are funded by the Commonwealth.

Those risks also fall back on state and territory crisis teams, emergency departments (EDs) and acute hospital services, so it is in the best interests of the Commonwealth and the states and territories to work together to achieve the best outcomes for individuals and communities and minimise costs to taxpayers.

The Commonwealth’s five major programmes are focused on funding activity, and include outlays in areas which in many ways can indicate system failure. Very importantly, as they involve payments of pensions and health-related benefits, these are largely areas which constitutionally are Commonwealth responsibilities (*Australian Constitution, s51*). The one exception is the payment to the states and territories for hospital care.

If future growth in costs is to be managed, the focus must be on these programmes.

From: Where we are now

- ▶ **Stigma persists**
- ▶ **People with lived experience, families and support people have a poor experience of care**
 - A myriad of sources of information and advice
 - Distressed individuals having to provide the same information to multiple organisations
 - Vulnerable people left to navigate a complex and fragmented service system
 - Families and support people excluded from consultations and planning
 - Limited choice
 - Specialist services where the clients have to come to them
- ▶ **A mental health system that doesn't prioritise people's needs**
 - The Commonwealth's main programmes focus on generating activity: not necessarily on making anyone better
 - A high level of unmet need, with many people not seeking necessary support. A person's mental health and circumstances may deteriorate and become more complex
- ▶ **A system that responds too late**
- ▶ **A mental health system that is fragmented**
 - Fragmentation of services
 - A myriad of providers, many of them with limited capacity and poor economies of scale
- A myriad of siloed funding streams and programmes focused on providers
- Highly variable access to quality services largely depending on the "luck" of where people live—or their income—leading to great variation in services provided and the outcomes achieved
- Poor planning, coordination and operation between the Commonwealth and the states and territories, resulting in duplication, overlap and gaps in services
- ▶ **A system that does not see the whole person**
 - People being discharged from hospital and treatment services into homelessness, or without adequate discharge planning
 - High rates of 16–25 year olds with a mental health condition who are 'Not in Education, Employment, or Training' (NEET)
 - Poor physical health among those with severe and persistent mental health problems
 - High rates of unemployment among adults with a mental illness and their support people
- ▶ **A system that uses resources poorly**
 - A fragmented mental health workforce where many clinicians work in isolation of each other, and do not operate at the top of their scope of practice
 - The greatest level of funding goes into high cost areas such as acute care, the criminal justice system, and disability support, indicating that the system has failed to prevent avoidable complications in people's lives
 - Research is carried out in isolation of mental health strategic objectives, with a haphazard approach to evidence translation into practice

To: Where we want to be

▶ **Widespread public knowledge and understanding**

▶ **People with lived experience, families and support people encounter a system that involves them in decisions, is easily navigable and provides continuity of care**

- People, families, businesses, schools, etc. know where to go to get practical information and advice
- Provide once, use often: people with a mental health condition a priority group using e-health records
- Clear pathways provided for individuals and their support people, with care coordination and case management for those who need it
- Families recognised and included as vital members of the care team
- Enhanced choice of providers
- Specialists reaching out into the community

▶ **An outcomes-focused mental health system**

- A focus on funding outcomes, to achieve value for money for individuals and society. Commonwealth funding to be focused on providing incentives to achieve outcomes, rather than on simply generating activity
- More people getting the services they need, when and where they need them, with enhanced access and participation in services which aim to keep people mentally healthy, improve participation and focus on recovery

▶ **Access in the right place at the right time**

▶ **A mental health system that wraps around the person**

- Integration of services around the needs of individuals, with increased use of pathways and management plans which cover the continuum of needs of the person e.g. primary and community based care, housing, employment, and acute care when necessary
- Integration of providers around the needs of individuals and communities: larger provider organisations or networked providers providing integrated services and economies of scale

- A person focused approach, where funding is wrapped around support for the individual and their families
- Greater consistency in access to services which meet safety and quality standards
- Clarification of roles and responsibilities between the Commonwealth and the states and territories, with shared policy development, system design, implementation and monitoring and reporting

▶ **A system that responds to whole-of-life needs**

- No one is discharged from hospitals, custodial care, mental health or drug and alcohol related treatment services without an appropriate discharge plan which provides for necessary supports and includes regular follow-up
- Increased productivity, participation and economic impact: continuous improvement measured by reductions in the NEET rate
- Reductions in risk factors resulting in high morbidity and premature mortality of people with a mental illness (e.g. reduced smoking rates and obesity levels)
- Improved financial position for individuals, families and support people, better economic participation and productivity

▶ **A proactive, strategically aligned system**

- A team based approach where the person, their family and support people are at the centre of the team, and the various members work together in providing support and services, with an enhanced role for peer workers. No one works alone, or in isolation
- Shifting the centre of gravity of funding away from the acute, crises end, towards prevention, early intervention and community services which reduce the onset of illness, complications and crises
- Research is priority driven in accordance with targets and objectives, with clear pathways for translation into practice

Future approaches and funding priorities

A person-centred approach

This Review considers a person-centred approach to be the fundamental principle guiding its recommendations. In a person-centred mental health system, services are organised around the needs of people, rather than people having to organise themselves around the system.

Figure 3 illustrates an example of the design of a person-centred approach.

A person-centred approach means that, as a person’s acuity and functional impairment increase, the care team will expand to include different support providers. As acuity diminishes and functional capacity is improved, the team will contract as the person can take on more self-care. People are not transferred from one team to another but remain connected throughout, to a general practice or community mental health service, and with an ongoing core relationship with their family and other support people.

An ideal person-centred mental health system features clearly defined pathways between health and mental health. It recognises the importance of non-health supports such as housing, justice, employment and education, and emphasises cost-effective, community-based care.

The first priority of a person-centred system is to enable individuals and their families to look after themselves. For most people, self-care and support from those closest to them are the most important resources they have to build and sustain good mental health and overall wellbeing, from birth until death. Conversely, relationships that are unhealthy or traumatic have an adverse effect, especially for children. Resilience and wellbeing can also come from life within a local community through social contacts and participation in employment, education, clubs and other activities.

Figure 3: Design of a person-centred approach

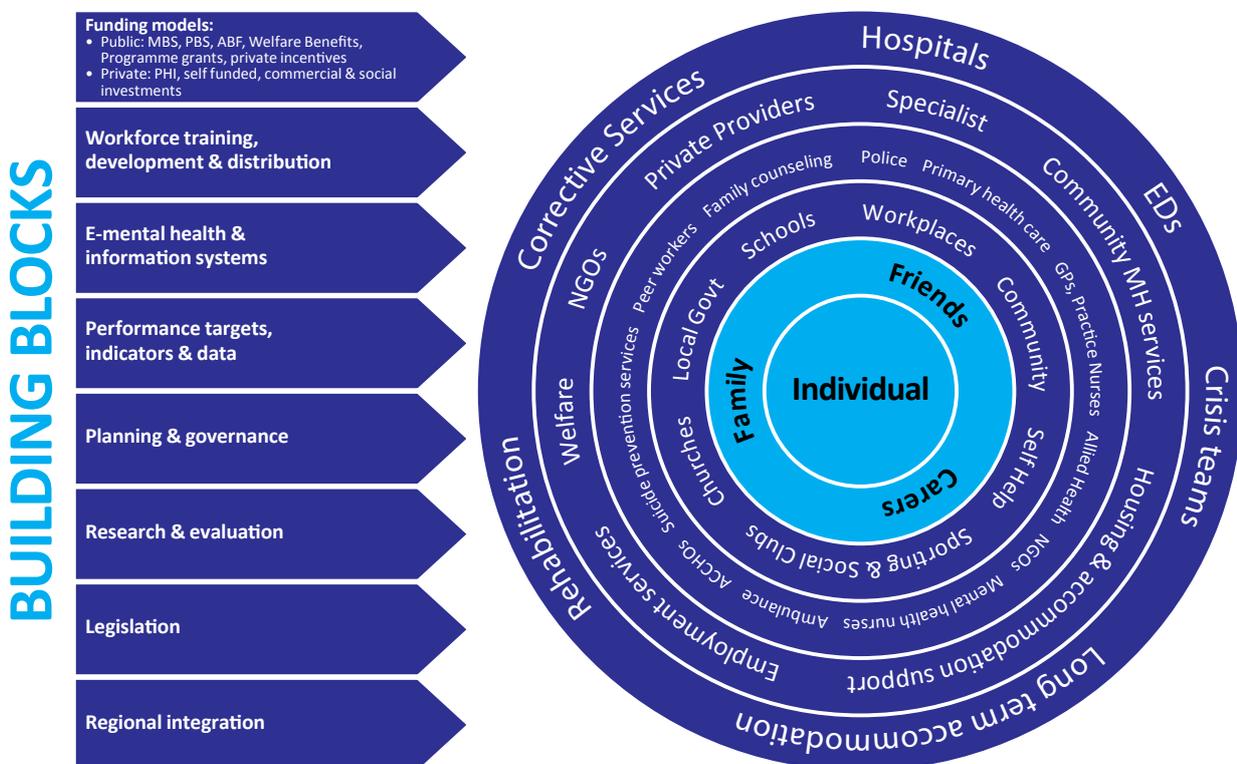
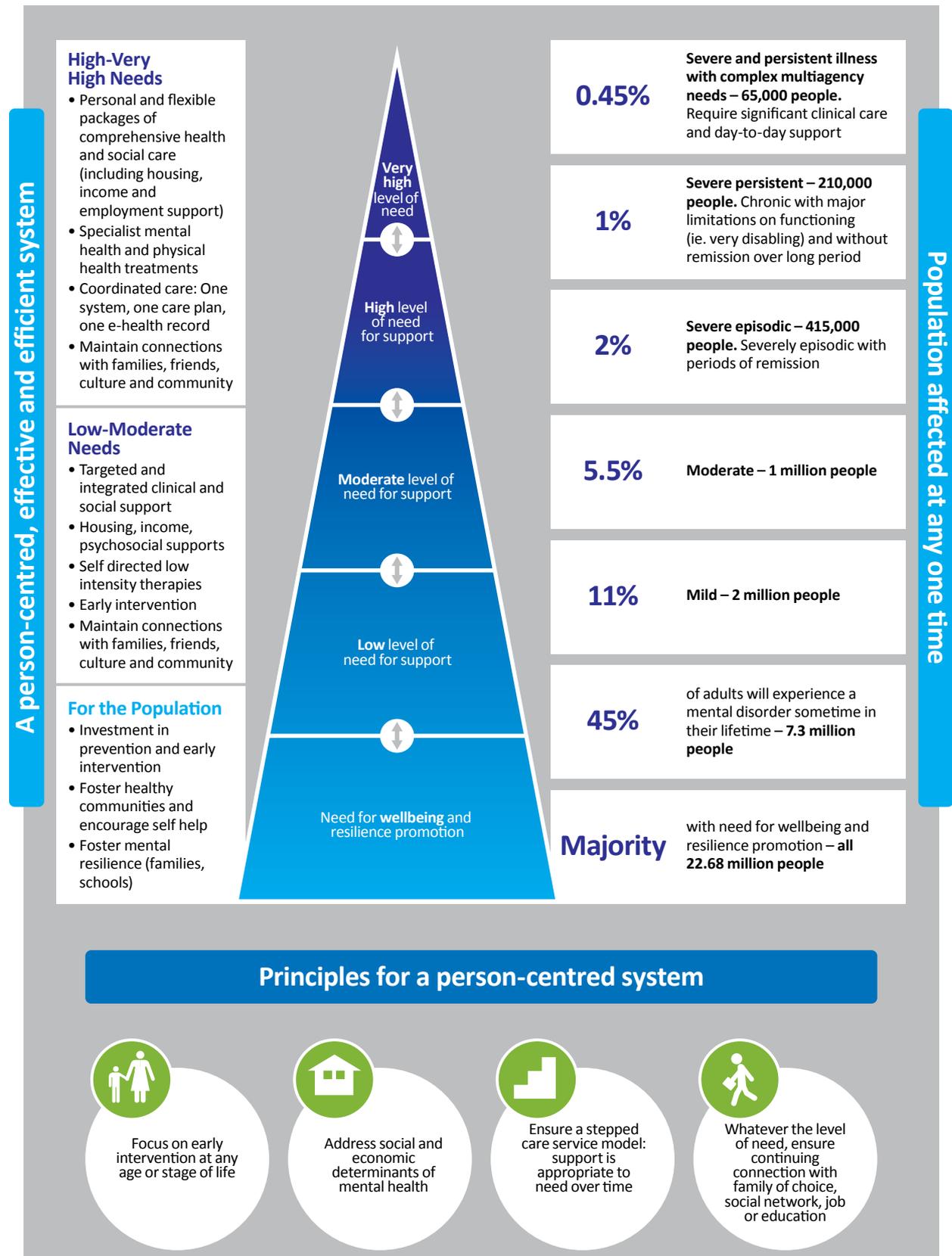


Figure 4: Population-based architecture



System architecture

Alongside the guiding principle of a person-centred mental health system, the main objectives underpinning the proposed changes to the system are that it must be:

- **effective:** scarce resources used cost-effectively to achieve identified objectives
- **efficient:** programmes and services maximise net benefits to the community
- **evidence-based:** decisions based on meaningful data.

The person-centred approach described above fits within a population-based model that aims to match available resources to identified need, placing particular emphasis on population groups which are at higher risk or have special needs. It is supported by a strong focus on prevention, early intervention and support for recovery that is not just measured in terms of the absence of symptoms, but in the ability to lead a contributing life.

As Figure 4 shows, the main features of such an approach are to differently target the population as a whole, the segment of the population with low-moderate needs and the segment of the population with high-very high needs.

The realignment of system architecture as recommended in this report also involves two other important features:

- A stepped care framework that provides a range of help options of varying intensity to match people's level of need.
- Integrated Care Pathways (ICPs) for mental health, to provide for a seamless journey through the mental health system.

Shifting funding to rebalance the system

This approach shifts groups of people towards 'upstream' services (population health, prevention, early intervention, recovery and participation) and thereby reduces 'downstream', costly services (ED presentations, acute admissions, avoidable readmissions and income support payments).

A stepped care approach can also support people to take greater responsibility for their own mental and physical wellbeing, when accompanied by the appropriate services and supports.

This includes innovative service delivery models such as e-mental health which provide the opportunity to better integrate self-help, where people know where to go and how to access the specific information and support they need.

This does not obviate the need for face-to-face services. But empowering people, their families and other support people to support themselves where appropriate enables more cost-effective use of the time and skills of clinical and other professionals—and frees up the valuable personal time of individuals.

The Commission believes one of the most fundamental elements of the stepped care approach lies in prioritising delivery of care through general practice and the primary health care sector.

There is international evidence that national health care systems with strong primary care infrastructures have healthier populations, fewer health-related disparities and lower overall costs for health care than those countries that focus on specialist and acute care.

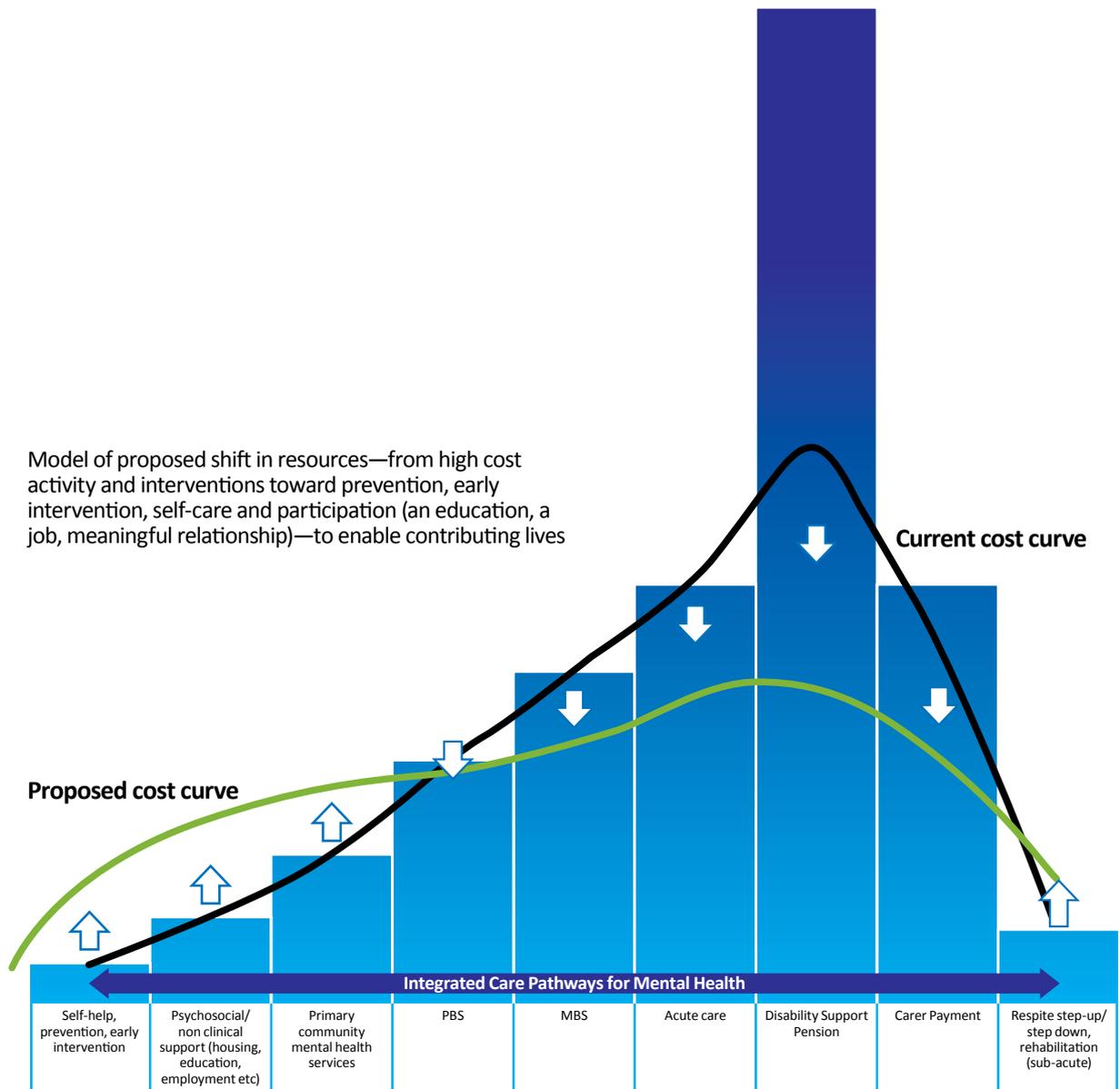
Indeed, the World Health Organization (WHO) has endorsed this approach: Integration of mental health into primary health care “not only gives better care; it cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments.”¹²

The development of 30 Primary Health Networks (or Primary and Mental Health Networks—PMHNs) across Australia provides the ideal opportunity to harness this infrastructure and better target mental health resources to meet population needs on a regional basis.

These new entities will be the meso-level organisations responsible for planning and purchasing services on a regional basis. They can work in partnership and apply targeted, value-for-money interventions across the whole continuum of mental wellbeing and ill-health to meet the needs of their communities, enabling a stepped care approach with the aims of:

- promoting mental health and wellbeing
- reducing risk factors
- preventing mental ill-health
- reducing or delaying the onset of mental ill-health experiences
- managing and supporting people in the community as much as possible
- providing timely access when needed to hospital and other acute services
- managing the handover from hospital back into the community, step-down care and rehabilitation, aged care and palliative care
- reducing adverse events, waste and duplication.

Figure 5: Model of proposed shift in resources



Stepped care services would range from no-cost and low-cost options for people with the most common mental health issues, through to options to provide support and wrap-around services for people with severe and persistent mental ill-health, with the aim that all can live contributing lives in the community.

To support this approach, evidence-based ICPs for mental health would need to be developed and supported by PMHNS (Commonwealth) and local hospital networks or equivalent (states and

territories). In developing these, priority should be given to pathways relevant to mental health conditions with the highest contribution to service use.

Based on modelling commissioned from KPMG, the outcome of implementing this change would be to slow the rate of increase in Disability Support Pension (DSP) and Carer Payment costs and the costs of acute care and crisis management.

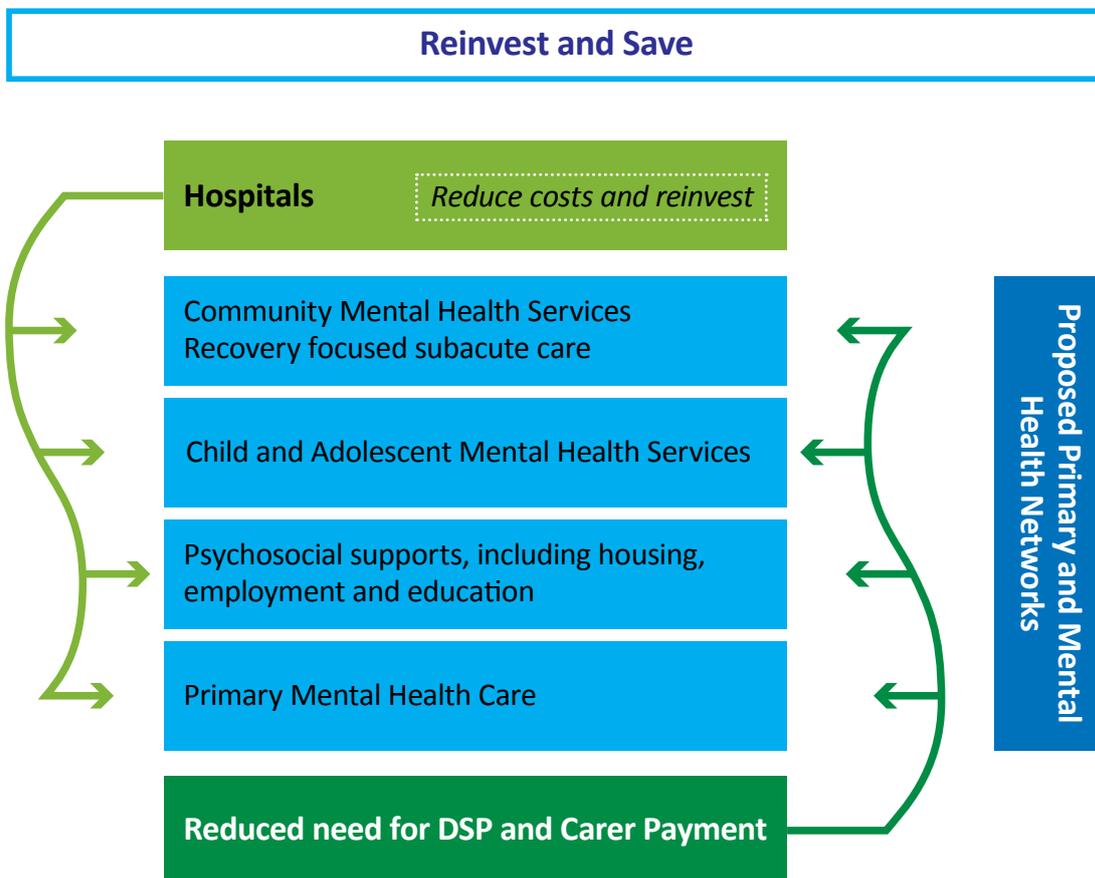
This would provide an opportunity to redistribute these savings through regional integrators, which would identify the 'upstream' system elements most effective in their communities, to reduce avoidable hospitalisations and keep people participating in the community, with the overarching principle of reinvesting to save (Figure 6).

For people who are high users of the mental health system, a system of voluntary enrolment and bundled payment models should be available. Voluntary enrolments through general practice would provide the extra support this group needs by enabling a

more cost-effective and coordinated approach to the provision of wrap-around and whole-of-person supports.

For those with very high needs, or at risk of developing very high needs, as identified under the risk segmentation and stratification approach, PMHNs could work with LHNs (or equivalent) to bundle funds from both their budgets (as well as cashing out of MBS and PBS payments) and purchase packages of care which can be used to keep people well and in the community.

Figure 6: Reinvesting to save through regional integrators



Strategic directions and recommendations

As a result of the work of the Review, consultation and analysis of data and expert advice, the Commission has identified nine strategic directions to guide reform and proposed 25 recommendations. Together these support a detailed framework of activity over the next decade to take advantage of this once-in-a-generation opportunity to reform our mental health system for the wellbeing of Australia and Australians.

The strategic directions and recommendations take a whole-of-life, whole-of-government approach. Some

Another prominent area of consensus was the idea that services and programmes should be designed in consultation with the communities they aim to serve, and that they should be based on formal analyses of need. There were many examples provided to the Review which show this is not happening, resulting in high levels of unmet mental health need. A picture emerged of a hit-and-miss arrangement of services and programmes across the country, seemingly based on no discernible strategy, creating duplication in some areas and considerable unmet need in others.

“ If we look at the data, the business case for this decade of change is not only morally and socially compelling, it is economically fundamental.”

Jennifer Westacott, Chair, Mental Health Australia¹³

are targeted at reform of individual programmes and services; others are focused on leveraging change at the system level to ensure that system and funds are best spent to enable people with mental health difficulties and their families and carers to enjoy contributing lives and progress their recovery journey.

Through the more than 1800 submissions made to the Review, the voices of people with lived experience of mental illness, their families and support people, as well as the views of professionals, advocates and peak bodies were clear. The most prominent theme to emerge from this wide range of submissions was that the way the mental health ‘system’ is designed and funded across Australia means that meaningful help often is not available until a person has deteriorated to crisis point. This is either because no mental health supports are accessible to them, they do not exist in their area, or they are inappropriate to their needs. Along the way they may have lost their job, their family or their home. Countless submissions pointed out that this makes neither economic nor humanitarian sense.

This unmet need was highlighted particularly strongly in relation to people living in regional, rural and remote areas of Australia, including farmers and fly-in-fly-out workers. Submissions conveyed that programmes and services currently did not meet the needs of communities with particular mental health challenges; if services are available, they often feel inappropriate and irrelevant to the people they are designed for. Programmes for Aboriginal and Torres Strait Islander communities and people who have migrated to Australia were given as examples. People with interrelated and complex difficulties which include a mental health problem (including those with substance misuse, history of trauma and abuse or intellectual disability) also are poorly served by a lack of collaboration across agency or disciplinary boundaries—each of their intertwined problems is viewed and treated in isolation.

The findings and recommendations of our report to the Government were informed by these voices, which revealed considerable consensus about which elements of our mental health system are working, and which elements need fixing.

The nine strategic directions and associated recommendations are as follows:

1. Set clear roles and accountabilities to shape a person-centred mental health system

Recommendations:

1. Agree the Commonwealth's role in mental health is through national leadership and regional integration, including integrated primary and mental health care.
2. Develop, agree and implement a National Mental Health and Suicide Prevention Plan with states and territories, in collaboration with people with lived experience, their families and support people.
3. Urgently clarify the eligibility criteria for access to the National Disability Insurance Scheme (NDIS) for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 system of community supports.

2. Agree and implement national targets and local organisational performance measures

Recommendations:

4. Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.
5. Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health.
6. Tie receipt of ongoing Commonwealth funding for government, NGO and privately provided services to demonstrated performance, and use of a single care plan and eHealth record for those with complex needs.

3. Shift funding priorities from hospitals and income support to community and primary health care services

Recommendations:

7. Reallocate a minimum of \$1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.
8. Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.
9. Bundle-up programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters.
10. Improve service equity for rural and remote communities through place-based models of care.

4. Empower and support self-care and implement a new model of stepped care across Australia

Recommendations:

11. Promote easy access to self-help options to help people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.
12. Strengthen the central role of GPs in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule and staged implementation of Medical Homes for Mental Health.
13. Enhance access to the Better Access programme for those who need it most through changed eligibility and payment arrangements and a more equitable geographical distribution of psychological services.
14. Introduce incentives to include pharmacists as key members of the mental health care team.

5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life

Recommendations:

15. Build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties.
16. Identify, develop and implement a national framework to support families and communities in the prevention of trauma from maltreatment during infancy and early childhood, and to support those impacted by childhood trauma.
17. Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.

6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people

Recommendations:

18. Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.

7. Reduce suicides and suicide attempts by 50 per cent over the next decade

Recommendation:

19. Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

8. Build workforce and research capacity to support systems change

Recommendations:

20. Improve research capacity and impact by doubling the share of existing and future allocations of research funding for mental health over the next five years, with a priority on supporting strategic research that responds to policy directions and community needs.
21. Improve supply, productivity and access for mental health nurses and the mental health peer workforce.
22. Improve education and training of the mental health and associated workforce to deploy evidence-based treatment.
23. Require evidence-based approaches on mental health and wellbeing to be adopted in early childhood worker and teacher training and continuing professional development.

9. Improve access to services and support through innovative technologies

Recommendations:

24. Improve emergency access to the right telephone and internet-based forms of crisis support, and link crisis support services to ongoing online and offline forms of information/education, monitoring and clinical intervention.
25. Implement cost-effective second and third generation e-mental health solutions that build sustained self-help, link to biometric monitoring and provide direct clinical support strategies or enhance the effectiveness of local services.

Conclusion

It is clear that our current mental health system suffers fundamental structural shortcomings that contribute to poor social and economic outcomes for individuals, communities and the nation as a whole.

The only way to address this is through whole-of-system reform to build a better integrated, person-centred system that achieves desired outcomes through the effective use of existing resources, and a flexible approach that recognises diversity of people, culture, circumstance and location. Our consultation and submissions received from the community have confirmed this direction.

We believe that significant change is possible and affordable.

We have provided an implementation strategy for a clear and collaborative governance structure to advance the directions recommended in the Review. These structures establish a framework for the engagement with the community, people with lived experience of mental health difficulties and their families and other support people; government, non-government and private sector, and clinical and non-clinical experts.

The Commission looks forward to the Government's consideration of the findings of the Review, and in working with Government to support implementation of the mental health reform agenda set by Government.

Where can I get further information?

This is a summary of a report to Government in response to the Terms of Reference which was presented in four volumes:

Volume 1: *Strategic directions, practical solutions 1–2 years*

This volume sets out high-level findings, our strategic directions, recommendations and practical actions for pursuing transformational change **over the next two years**.

Volume 2: *Every service is a gateway: response to Terms of Reference*

This volume presents findings against the Review's Terms of Reference, provides the evidence behind these findings and sets out a **10-year implementation agenda**.

Volume 3: *What people told us: analysis of submissions to the Review*

This volume provides an overview of key findings received in the generous public response to the call for written submissions to the Review.

Volume 4: *Supporting papers*

This volume is a collection of work undertaken throughout 2014 in support of the Review.

Access to these volumes can be found on the National Mental Health Commission website.

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Services need to be more family oriented to support the family unit as a whole. It is the carers/families/support people who are the one constant... family needs to be included, listened to and informed and educated... and not be looked on as part of the problem. The family is very important in supporting consumers to lead better quality of lives. We need more understanding, less stigmatisation, more education, and support.”

Support person, Australian Capital Territory



Australian Government
National Mental Health Commission