Mental Health Australia

Attachment A - Mental Health Australia Preliminary Analysis of the Productivity Commission Inquiry into Mental Health Draft Report - 8 November 2019

Introductory note:
Listed below are each of the recommendations from the Productivity Commission Inquiry into Mental Health's Draft Report (listed in the order they are presented in the report) and corresponding Mental Health Australia preliminary position. Please note, this position is intended as a starting point to spark discussion with members, it is by no means Mental Health Australia's formal and final position on each of the recommendations.

Recommendation	Charter 2020 Principle	MHA Position
DRAFT RECOMMENDATION 5.9 — ENSURE ACCESS TO THE RIGHT LEVEL OF CARE The Australian, State and Territory Governments should reconfigure the mental health system to give all Australians access to mental healthcare, at a level of care that most suits their treatment needs (in line with the stepped care model), and that is timely and culturally appropriate.	6: integration and diversity	Support
DRAFT RECOMMENDATION 5.2 — ASSESSMENT AND REFERRAL PRACTICES IN LINE WITH CONSUMER TREATMENT NEEDS In the short term (in the next 2 years) Commissioning agencies (PHNs or RCAs) should promote best-practice in initial assessment and referral for mental healthcare, to help GPs and other referrers match consumers with the level of care that most suits their treatment needs (as described in the stepped care model). In the medium term (over 2 – 5 years) Commissioning agencies (PHNs or RCAs) should establish mechanisms for monitoring the use of services that they fund to ensure that consumers are receiving the right level of care. If service use is not consistent with estimated service demand, commissioning agencies may need to make changes to initial assessment and referral systems (or work with providers to do so).	6: integration and diversity	Further analysis required
DRAFT RECOMMENDATION 5.3 — ENSURING HEADSPACE CENTRES ARE MATCHING CONSUMERS WITH THE RIGHT LEVEL OF CARE headspace centre funding should be conditional on centres following the stepped care model. In the medium term (over 2 – 5 years) headspace grant funding for individual centres should be made conditional on centres meeting targets for the proportion of young people referred to low-intensity services. The targets set by commissioning agencies (PHNs or RCAs) for each centre should depend on the full range of relevant characteristics of the young people they see. The targets should start low and increase over time.	6: integration and diversity	Further analysis required
DRAFT RECOMMENDATION 5.6 — PRACTITIONER ONLINE REFERRAL TREATMENT SERVICE Commissioning agencies could learn from the success of Practitioner Online Referral Treatment Service (PORTS) in Western Australia in improving accessibility and effectiveness of online mental healthcare treatment options. In the medium term (over 2 – 5 years) Commissioning agencies (PHNs or RCAs) in other States and Territories should consider implementing the PORTS model, or incorporating aspects of the PORTS model into their services.	6: integration and diversity	Support
DRAFT RECOMMENDATION 5.8 — INCREASE CONSUMER CHOICE WITH REFERRALS In the short term (in the next 2 years) The Australian Government should amend the MBS regulations for referrals to require: - that general practitioners and other referrers advise people that they can use an alternative to any provider mentioned in a referral to a specialist or allied health professional - that all referrals to specialists and allied health professionals include a prominent and easy to understand statement advising people that they can use an alternative to any provider mentioned in the referral.	2: Person-led	Support

DRAFT RECOMMENDATION 6.1 — SUPPORTED ONLINE TREATMENT OPTIONS SHOULD BE INTEGRATED AND EXPANDED The Australian Government should facilitate greater integration and use of supported online treatment, into the stepped care model as a low intensity service, for people living with mental ill-health with mild to moderate symptoms. In the short term (in the next 2 years) - Funding should be expanded for services to accommodate up to 150 000 clients per year in supported online treatment. - Supported online treatment programs offered should each have a strong evidence base for their efficacy and be offered to children, youth and adults. - To aid integration of healthcare services, supported online treatment should have the option for outcomes data to be forwarded to a nominated GP or other treating health professional. Online service providers should annually publish summary output on use of their services, treatment provided, and other measurable outcomes. In the long term (over 5 – 10 years) - A review of supported online treatment services as a low intensity option should be undertaken. This review should assess whether there are any barriers to take up, the effectiveness of the services contracted and future funding options.	6: integration and diversity	Support
DRAFT RECOMMENDATION 6.2 — INFORMATION CAMPAIGN TO PROMOTE SUPPORTED ONLINE TREATMENT In the short term (in the next 2 years) The Australian Government should instigate an information campaign to increase awareness of the effectiveness, quality and safety of government-funded clinician-supported online therapy for treatment of mental ill-health for consumers and health professionals.	2: Person-led	Support
DRAFT RECOMMENDATION 5.5 — ENCOURAGE MORE GROUP PSYCHOLOGICAL THERAPYChanges should be made to MBS rules to encourage more group therapy.In the short term (in the next 2 years)- The Australian Government should change MBS rules so that group therapy is allowed with a minimum of 4 people (instead of 6 people), and with less 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 Medicare items for group sessions that run for 'at least 90 minutes' and 'at least 120 minutes'.- The Australian Government should clarify — and communicate with referrers and providers — that unless explicitly stated otherwise, referrals for MBS-rebatedPsychological Therapy Services and Focused Psychological Strategies can be used for either group therapy or individual therapy — at the discretion of the psychologicaltherapist receiving the referral after discussion with the consumer.	6: integration and diversity	Support
DRAFT RECOMMENDATION 5.4 — MBS-REBATED PSYCHOLOGICAL THERAPY MBS-rebated psychological therapy should be evaluated, and additional sessions trialled. In the short term (in the next 2 years) The Australian Government should commission an evaluation of the effectiveness of MBS-rebated psychological therapy. As part of this evaluation, the Australian Government should undertake trials allowing up to 20 sessions of individual or group therapy in total over a year for consumers whose clinical condition requires more than the current 10 sessions. The trials should allow a GP to re-refer a consumer after the first 10 sessions rather than the present 6 sessions. 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. In the medium term (over 2 – 5 years) Based on the results of these trials and evaluation, the Australian Government should determine whether to: - roll out the trialled changes above - continue funding psychological therapy through the MBS, or whether some other mechanism is more appropriate - make any other changes to increase the effectiveness of MBS-rebated psychological therapy.	6: integration and diversity	Support
DRAFT RECOMMENDATION 5.7 — PSYCHOLOGY CONSULTATIONS BY VIDEOCONFERENCE Widening access to psychology consultations by videoconference. In the short term (in the next 2 years) - The Australian Government should change MBS rules so that videoconference can be used for MBS-rebated Psychological Therapy Services and Focused Psychological Strategies by consumers residing in metropolitan areas, regional centres and large rural towns (Monash Modified Model areas 1–3) in addition to those residing in small and medium rural towns, remote and very remote communities (Monash Modified Model areas 4–7). - For consumers in areas 1–3, at least 3 out of each 10 sessions must be face-to-face (including at least one out of the first four), and there should be no restriction that the consumer and clinician must be at least 15 kilometres away from each other.	Other - rural and remote	Support
DRAFT RECOMMENDATION 7.2 — PSYCHIATRY CONSULTATIONS BY VIDEOCONFERENCE In the short term (in the next 2 years) - The Australian Government should introduce a new suite of time-tiered items for videoconference consultations to regional and remote areas (RA2–5), as recommended by the MBS Review Psychiatry Clinical Committee, removing item 288 from the MBS. - In addition, the Australian Government should add new items for videoconference consultations mirroring existing items for psychiatric assessments (item 291) and reviews (item 293), that are available in major cities (RA1) as well as in regional and remote areas (RA2–5), and that are paid at the same rate as items 291 and 293.	Other - rural and remote	Support

DRAFT RECOMMENDATION 7.1 — PLANNING REGIONAL HOSPITAL AND COMMUNITY MENTAL HEALTH SERVICES In the short term (in the next 2 years) State and Territory Governments should determine, through regional service planning, the numbers of public acute mental health beds in hospitals, specialist mental health community treatment services and subacute/non-acute mental health bed-based services that would meet the specific needs of each region and undertake to provide these on an ongoing basis.	6: integration and diversity	Support
DRAFT RECOMMENDATION 8.1 — IMPROVE EMERGENCY MENTAL HEALTH SERVICE EXPERIENCES In the short term (in the next 2 years) - 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 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 a mental illness. This could include providing separate spaces for people with mental illness, or otherwise creating an environment more suitable to their needs. In the long term (over 5 – 10 years) - State and Territory Governments should, when building or renovating emergency departments, design them to take account of the needs of people with mental illness	Other - acute services	Support
DRAFT RECOMMENDATION 8.2 — CHILD AND ADOLESCENT MENTAL HEALTH BEDSIn the short term (in the next 2 years)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 contract with private facilities, or provide care as hospital-in-the-home.	Other - acute services	Support
DRAFT RECOMMENDATION 11.1 — THE NATIONAL MENTAL HEALTH WORKFORCE STRATEGY The forthcoming update of the National Mental Health Workforce Strategy should align health workforce skills, availability and location with the need for mental health services. In the short term (in the next 2 years) The Australian Government should ensure that its development of a new National Mental Health Workforce Strategy includes the following actions. - Set the objective of achieving a health workforce which aligns the skills, cultural capability, availability and location of mental health service providers with demand. This goal should be given effect by integrating the workforce strategy with service and infrastructure planning. - Quantify the future supply of specific skills and health professions under a business-as-usual scenario, and the extent to which this will fall short of what is needed. - Specify what will be done to address any forecast shortages in skills or professions, and quantify the expected timing and reduction in those shortages. - Include a commitment to implement the recommendations that this inquiry has made on specific skills and professions, including a more efficient allocation of tasks. - Set targets to attract and retain workers, and establish a system to monitor and report progress in achieving the targets. This work should also inform the workforce development program which is being undertaken for the National Mental Health and Suicide Prevention Plan.	8: Workforce	Support
DRAFT RECOMMENDATION 11.2 — INCREASE THE NUMBER OF PSYCHIATRISTS In the medium term (over 2 – 5 years) 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 and adolescent psychiatry. This should be done in collaboration with the Royal Australian and New Zealand College of Psychiatrists, and form part of the broader National Medical Workforce Strategy which is currently being developed. The plan should include actions to: - raise the number of funded training placements and supervisors, with State and Territory Governments doing so in public sector health facilities, and the Australian Government contributing funding for more positions in the private sector and rural and remote areas - increase the availability of supervision for trainees, including by considering interventions recommended in the 2016 report by the National Medical Training Advisory Network (titled Australia's Future Health Workforce – Psychiatry) such as remote models of supervision for trainees outside major cities. The size of the targeted increase in psychiatrists should be based on assessments of future workforce needs to be undertaken as part of broader workforce planning by governments, including for the National Mental Health Workforce Strategy (draft recommendation 11.1).	8: Workforce	Support
DRAFT RECOMMENDATION 5.1 — PSYCHIATRIC ADVICE TO GPS In the medium term (over 2 – 5 years) The Australian Government should introduce an MBS item for psychiatrists to provide advice to a GP over the phone on diagnosis and management issues for a patient who is being managed by the GP. The effectiveness of the new item should be evaluated after several years.	8: Workforce	Support

DRAFT RECOMMENDATION 11.3 – MORE SPECIALIST MENTAL HEALTH NURSES In the short term (in the next 2 years) - Accreditation standards 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 Nursing and Midwifery Accreditation Council in consultation with stakeholders, including the Australian College of Mental Health Nurses and the Nursing and Midwifery Board of Australia. Nurses who complete the three-year direct-entry degree would be registered as having an undergraduate qualification in mental health and (if the above recommendation results in a specialist registration system for nurses with advanced training in mental health) be distinguished from registered nurses with a post graduate degree in mental health. In the medium term (over 2 – 5 years) - The merits of introducing a specialist registration system for nurses with advanced qualifications in mental health should be assessed. The assessment should be independent and be commissioned by the Australian, State and Territory Governments through the COAG Health Council. If specialist registration is found to have merit, the COAG Health Council should direct the Nursing and Midwifery Board of Australia to provide it with a formal proposal to amend the registration arrangements for nursing to recognise nurses who have specialist qualifications in mental health.	8: Workforce	Support
DRAFT RECOMMENDATION 11.4 — STRENGTHEN THE PEER WORKFORCEGovernments should strengthen the peer workforce.In the short term (in the next 2 years)-The National Mental Health Commission should, when submitting its finalised national guidelines on peer workers to governments for approval in mid-2020,recommend how the guidelines should be supported by work standards for particular areas of practice.- The National Mental Health Commission should, by the end of 2019, submit a recommendation to the Australian Government on how to establish of a professionalorganisation to represent peer workers. This should include advice on how governments should, if at all, make a financial contribution, such as by providing seed funding to establish the professional organisation.In the medium term (over 2 – 5 years)- The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role andvalue of peer workers in improving outcomes. The program will need leadership to improve workplace cultures.- The Australian Government should, in consultation with State and Territory Governments and other stakeholders, commission a national review to develop a comprehensive system of qualifications and professional development for peer workers. This should consider of how peer worker qualifications would be recognised as prior learning for health professional qualifications.	8: Workforce	Support
DRAFT RECOMMENDATION 11.5 — IMPROVED MENTAL HEALTH TRAINING FOR DOCTORS Improve medical practitioners' training on medication side effects and consider specialist registration for GPs who have advanced specialist training in mental health. In the short term (in the next 2 years) - Continuing professional development requirements for GPs and psychiatrists should incorporate best-practice approaches to managing the side effects of medication prescribed to treat mental illness. To ensure this is the case, the Australian Government should request the Australian Medical Council to review current CPD requirements and make any changes necessary. This should be done in consultation with stakeholders, including the Medical Board of Australia and relevant colleges for GPs and psychiatrists. - The merits of introducing a specialist registration system for GPs with advanced specialist training in mental health should be assessed. The assessment should be independent and be commissioned by the Australian, State and Territory Governments through the COAG Health Council. If specialist registration is found to have merit, the COAG Health Council should direct the Medical Board of Australia to provide it with a formal proposal to amend the registration arrangements for GPs to recognise those who have specialist qualifications in mental health.	8: Workforce	Support
DRAFT RECOMMENDATION 11.6 — 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. In the short term (in the next 2 years) The Australian, State and Territory Governments should, in collaboration with specialist medical colleges, act to reduce the negative perception of, and to promote, mental health as a career option by: - exposing health students and practising health professionals to people with a mental illness (and their carers) outside a clinical environment to help break down negative perceptions - rebalancing where trainees undertake clinical placements and internships to a more representative mix of settings, including in the private sector and settings other than inpatient units.	8: Workforce	Support
DRAFT RECOMMENDATION 11.7 — ATTRACTING A RURAL HEALTH WORKFORCE In the short term (in the next 2 years) The Australian, State and Territory Governments should make working in rural and remote areas a more attractive option for health professionals by reducing professional isolation, increasing opportunities for professional development, and improving the scope to take leave. This should include: - greater use of videoconferencing, subject to the availability of communications infrastructure, for health workers to remotely participate in professional development activities and meetings and conferences with peers - expanding initiatives such as the Rural Locum Assistance Program to fund visiting health professionals to temporarily stand in for rural and remote health workers, including psychiatrists, while they attend professional development activities, meetings and conferences with peers, and take leave.	8: Workforce	Support

DRAFT RECOMMENDATION 10.1 — CONSUMER ASSISTANCE PHONE LINES Assistance phone lines offering support for people with mental ill-health and their carers should facilitate better exchanges of information between service providers. In the medium term (over 2 – 5 years) - In its funding contract with existing assistance phone lines, the Australian Government should require providers to implement timely referral processes that minimise the need for consumers to repeat information. - The phone line that will be part of the Australian Government's mental health portal, Head to Health, should use a similar approach to referrals. The range of services listed on Head to Health should be expanded. The Australian Government can also consider funding an advertising campaign, to raise community awareness of the phone line and the online portal.	6: integration and diversity	Further analysis required
DRAFT RECOMMENDATION 10.2 — ONLINE NAVIGATION PLATFORMS TO SUPPORT REFERRAL PATHWAYSCommissioning agencies should ensure service providers have access to online navigation platforms offering information on pathways in the mental health system.In the short term (in the next 2 years)- All commissioning agencies (PHNs or RCAs) should, either individually or collaboratively, develop and maintain an online navigation platform, including detailed mental health referral pathways. The Health Pathways portal model, which is already used by most PHNs, can be used to contain this information.- Access to these platforms should be expanded beyond health, in particular to schools and psychosocial service providers. Each commissioning agency should also, either individually or collaboratively, fund a small dedicated team supporting the users of the online platform.In the medium term (over 2 – 5 years)- All online navigation platforms should incorporate the ability to book consultations with service providers directly from the platform.	6: integration and diversity	Further analysis required
DRAFT RECOMMENDATION 10.3 — SINGLE CARE PLANS FOR SOME CONSUMERS Governments should support the development of single care plans for consumers with moderate to severe mental illness who are receiving services across multiple clinical providers. In the medium term (over 2 – 5 years) The Department of Health should: - develop and promote protocols for sharing consumer information between service providers, and allocating responsibility for plan development, follow-through and updating the consumer's primary treating clinician (unless otherwise agreed by their treating team) - amend the MBS to include a specific item to compensate a clinician overseeing a single care plan for their time.	6: integration and diversity	Further analysis required
DRAFT RECOMMENDATION 10.4 — CARE COORDINATION SERVICES All people with severe and persistent mental illness who require care coordination services due to their complex health and social needs should be receiving them. Governments should set a national benchmark for all commissioning authorities, to ensure such services are available and any gaps are addressed. In the short term (in the next 2 years) All commissioning authorities 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 a severe and persistent mental illness and complex needs requiring support from multiple agencies have access to effective care coordination. In the medium term (over 2 – 5 years) All commissioning agencies should ensure that care coordination programs are available to match local needs, including 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 only for brief periods of time.	6: integration and diversity	Further analysis required
DRAFT RECOMMENDATION 12.1 — EXTEND THE CONTRACT LENGTH FOR PSYCHOSOCIAL SUPPORTS In the short term (in the next 2 years) 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.	7: community mental health	Support
DRAFT RECOMMENDATION 12.2 — GUARANTEE CONTINUITY OF PSYCHOSOCIAL SUPPORTS Requirements for continued access to psychosocial support should be changed so that anyone who requires it is able to access it, including former participants of Australian Government-funded psychosocial supports. In the short term (in the next 2 years) - Should someone choose to apply for the National Disability Insurance Scheme (NDIS), they should continue to be supported during the application process - Should someone choose not to apply for the NDIS, they should be allowed to continue to access support through the National Psychosocial Support Measure, should they require it, until it has been phased out In the medium term (over 2 – 5 years) - For those who did not apply for the NDIS, the psychosocial support commissioning agencies should conduct an evaluation of barriers and remove them as necessary - When the National Psychosocial Support Measure is phased out, participants should either be shifted onto the NDIS, if appropriate, or access the replacement psychosocial support.	7: community mental health	Further analysis required

DRAFT RECOMMENDATION 12.3 — NDIS SUPPORT FOR PEOPLE WITH PSYCHOSOCIAL DISABILITY The National Disability Insurance Agency (NDIA) should continue to improve its approach to people with psychosocial disability. In the short term (in the next 2 years) - The NDIA should complete the evaluations of the psychosocial disability stream trial sites in Tasmania and South Australia, and incorporate improvements into the stream, as soon as possible - The psychosocial disability stream should be fully rolled out across all National Disability Insurance Scheme sites by end-2020 - Incorporate the lessons learnt from the Independent Assessment Pilot into the National Disability Insurance Scheme access and planning processes by end-2020	7: community mental health	Support
DRAFT RECOMMENDATION 13.1 — REDUCE BARRIERS TO ACCESSING INCOME SUPPORT FOR MENTAL HEALTH CARERSIn the short term (in the next 2 years)The Australian Government Department of Social Services (DSS) should complete its review of the Adult Disability Assessment Tool used to assess eligibility for CarerPayment and Carer Allowance. DSS should:- publish its analysis and 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 social workers.In the medium term (over 2 – 5 years)DSS should amend eligibility criteria for Carer Payment (adult) and Carer Allowance (adult). Amendments should include:- replacing the requirements for 'constant care' and 'care and attention on a daily basis' with a requirement to provide 'regular care'- replacing the 25 hour per week restriction on work, study and volunteering with a 100 hour per month restriction on work and volunteering only- replacing the requirement that care must be provided in the home of the care recipient with a requirement that care must usually be provided in the home of the care recipient- removing the eligibility restriction for Carer Allowance that states that for carers who do not reside with their care recipient to be eligible, they must provide care that relates to the care recipient's bodily functions or to sustaining their life and for more than 20 hours per week.	2: Person-led	Further analysis required
DRAFT RECOMMENDATION 13.2 — EMPLOYMENT SUPPORT FOR MENTAL HEALTH CARERS In the short term (in the next 2 years) - The Australian Government Department of Social Services should evaluate its Carers and Work program to identify how to effectively support mental health carers to enter or maintain employment. - A working group consisting of both Department of Social Services and Department of Employment, Skills, Small and Family Business representatives should use the evaluation to inform the development of guidelines that jobactive providers can use to tailor their services to the needs of current and former mental health carers. In the medium term (over 2 – 5 years) The Australian Government should require designated staff who are delivering the mainstream jobactive program and the Career Transition Assistance, Mid-Career Checkpoint and Transition to Work programs to undertake training to apply these guidelines.	2: Person-led	Further analysis required
DRAFT RECOMMENDATION 13.3 — FAMILY-FOCUSED AND CARER-INCLUSIVE PRACTICE Family-focused and carer-inclusive care requires mental health services to consider family members' and carers' needs and their role in contributing to the mental health of consumers. In the short term (in the next 2 years) - Where this is not already occurring, State and Territory Government mental health services should routinely collect responses to the Carer Experience Survey. The data collected should be sufficient for each Local Hospital Network to compare and assess the level of carer-inclusive practice across its services. - The Australian Institute of Health and Welfare should use the data to report publicly on survey take-up rates and survey results at the state and territory level. In the medium term (over 2 – 5 years) - To improve outcomes for children of parents with mental illness, the National Mental Health Commission should commission a trial and evaluation of the efficacy of employing dedicated staff to facilitate family-focused practice in State and Territory Government mental health services. - The Australian Government should amend the MBS so that psychologists and other allied health professionals are subsidised: – to provide family and couple therapy, where one or more members of the family/couple is experiencing mental illness. These sessions should count towards session limits for psychological therapy – for consultations with carers and family members without the care recipient present. Consistent with existing items that are available to psychiatrists, there should be a limit of four subsidised consultations with carers and family members per 12 month period.	2: Person-led	Further analysis required
DRAFT RECOMMENDATION 14.1 — EMPLOYMENT SUPPORT ASSESSMENT MEASURES Assessment tools for jobactive and Disability Employment Services participants should be more relevant to job seekers with mental illness. In the short term (in the next 2 years) The Departments of Social Services; Human Services; and Employment, Skills, Small and Family Business should review the jobactive and Disability Employment Services assessment tools to increase their relevance for job seekers with mental illness. The review should consider: - providing more specific guidance to job seekers answering the Job Seeker Classification Instrument about the types of medical illnesses or disabilities relevant to employability - adding a short-form mental health diagnostic instrument to the Job Seeker Classification Instrument - a new instrument for predicting employment likelihood based on a blend of administrative and self-reported data, and using more sophisticated analytical tools - supplementing the Employment Services Assessment with the Personal and Social Performance Scale or similar instrument.	3: SDOH	Further analysis required

DRAFT RECOMMENDATION 14.2 — TAILOR ONLINE EMPLOYMENT SERVICESOngoing development of the New Employment Services should consider the needs of participants with mental illness.In the short term (in the next 2 years)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 Employment, Skills, Small and Family Business should:- assess the potential for online peer group support for participants with mental illness as part of the Digital First software- consider adaptation of the use of the Job Seeker Classification Instrument so that anyone reporting a mental illness is referred for personal assessment before being allocated to Digital First- ensure participants with inadequate digital literacy and/or mental illness maintain access to face-to-face services- ensure scope for participants to inform service providers of relapse in mental illness in a timely manner.	3: SDOH	Further analysis required
DRAFT RECOMMENDATION 14.3 — STAGED ROLLOUT OF INDIVIDUAL PLACEMENT AND SUPPORT MODEL 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 State and Territory Government community mental health services, involving co-location of IPS employment support services. The Commission is seeking further feedback on whether this should occur through partnerships between dedicated IPS providers and community mental health services, or direct employment of IPS specialists by community mental health services. In the short term (in the next 2 years) - Governments should thoroughly trial and evaluate the IPS program to better establish the factors that influence its cost-effectiveness (for example, the impacts of local labour market conditions and participant characteristics). - The program should initially be open to all non-employed consumers of community mental health services who express a desire to participate and meet the other requirements of the IPS model. Participation in the program should fulfil mutual obligation requirements for income support recipients. In the medium term (over 2 – 5 years) Subject to these trials, the IPS program should be rolled out gradually with data shared across jurisdictions and a mechanism for diffusion of best practice. If the net benefits of the program apparent in the small scale trials are not replicated as the program is scaled up, its design (and if necessary, its desirability) should be re-appraised.	3: SDOH	Support
DRAFT RECOMMENDATION 14.4 — INCOME SUPPORT RECIPIENTS' MUTUAL OBLIGATION REQUIREMENTS In the short term (in the next 2 years) The Departments of Human Services; Social Services; and Employment, Skills, Small and Family Business should: - provide greater flexibility in the application of the Targeted Compliance Framework for jobseekers experiencing mental illness - assess more systematically whether employment service providers are meeting their obligations to provide personalised Job Plans that go beyond compliance, targeted at job seekers with complex needs - consider extending the period of time that job seekers with more complex needs have to consider and propose changes to their Job Plan beyond two business days.	3: SDOH	Support
DRAFT RECOMMENDATION 15.1 — HOUSING SECURITY FOR PEOPLE WITH MENTAL ILLNESS Housing services should increase their capacity to prevent people with mental illness from experiencing housing issues or losing their home. In the medium term (over 2 – 5 years) - Each State and Territory Government should offer and encourage the use of mental health training and resources for 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 poor mental health, such as connecting tenants to mental health services or care coordinators. - State and Territory social housing authorities should review their policies relating to anti-social behaviour, temporary absences and information sharing to provide consideration for people with mental illness, so as to reduce the risk of eviction. - 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 the unmet demand for these services. In the long term (over 5 – 10 years) - State and Territory Governments should monitor the impacts of forthcoming reforms to residential tenancy legislation, including no-grounds evictions, and assess the potential impacts for people with mental illness who rent in the private market.	3: SDOH	Support

DRAFT RECOMMENDATION 15.2 — SUPPORT PEOPLE TO FIND AND MAINTAIN HOUSINGHousing and homelessness services should have the capacity to support people with severe mental illness to find and maintain housing in the community.In the short term (in the next 2 years)- 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 institutional care, including hospitals and prisons.- Governments should ensure that people with mental illness who exit institutional care (particularly hospitals or prisons) receive a comprehensive mental health discharge plan, and services have the capacity to meet their needs. These programs should integrate care coordination and access to accommodation.- The National Disability Insurance Agency should review its Specialist Disability Accommodation strategy and policies with a view to encouraging development oflong-term supported accommodation for National Disability Insurance Scheme recipients with severe and persistent mental illness.- Each State and Territory Government, with support from the Australian Government, should work towards meeting the gap in the number of 'supported housing' places for those individuals with severe mental illness who are in need of integrated housing and mental health supports.– Governments should provide (either themselves or outsourced to non-government organisations) a combination of long-term housing options for this cohort to support the diverse needs for mental health support and tenancy security.- Each State and Territory Government, with support from the Australian Government, should work towards meeting the gap for homelessness services among people with mental illness in their jurisdiction. This could include increasing existing homelessness services as well as scaling up longer-term housing options such asHousing 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.	3: SDOH	Support
DRAFT RECOMMENDATION 16.1 — SUPPORT FOR POLICE A systematic approach should be implemented to support police respond to mental health crisis situations. In the short term (in the next 2 years) All State and Territory Governments should implement initiatives that enable police, health and ambulance services to collectively respond to mental health crisis situations. The approach undertaken in Queensland 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 (draft recommendation 8.1) are able to co-respond to mental health crisis situations if necessary - roles and responsibilities of all service providers are clearly defined - approaches are tailored to meet the needs of particular groups, such as Aboriginal and Torres Strait Islander people.	3: SDOH	Support
DRAFT RECOMMENDATION 16.2 — MENTAL HEALTHCARE STANDARDS IN CORRECTIONAL FACILITIES National mental health service standards should apply to mental healthcare service provision in correctional facilities to the same level as that upheld in the community. In the short term (in the next 2 years) The Australian Commission on Safety and Quality in Health Care should review the National Safety and Quality Health Service Standards to ensure that it applies to mental health service provision in correctional facilities.	3: SDOH	Support
DRAFT RECOMMENDATION 16.3 — MENTAL HEALTHCARE IN CORRECTIONAL FACILITIES AND ON RELEASE Mental health screening and assessment of individuals in correctional facilities should be undertaken to inform resourcing, care and planning for release. In the medium term (over 2 – 5 years) - All State and Territory Governments should undertake mental health screening and assessment of all individuals (sentenced or unsentenced) on admission to correctional facilities, and on an ongoing basis where mental ill-health is identified. - The mental health information obtained from the screening and assessment needs to be comprehensive enough to inform resourcing of mental health services in correctional facilities. Where appropriate, authorities should share this information with community-based mental health services to enable individuals with mental illness to receive continuity of care on release.	3: SDOH	Support
DRAFT RECOMMENDATION 16.4 — INCARCERATED ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE In the short term (in the next 2 years) - 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 appropriate. 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 the skills on release to reintegrate. - State and Territory Governments should work with Aboriginal and Torres Strait Islander organisations to ensure Aboriginal and Torres Strait Islander people with mental illness are connected to culturally appropriate mental healthcare in the community upon release from correctional facilities.	3: SDOH	Support
DRAFT RECOMMENDATION 16.5 — DISABILITY JUSTICE STRATEGIESIn the medium term (over 2 – 5 years)All State and Territory Governments should continue to develop 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.In the long term (over 5 – 10 years)All State and Territory Governments should implement their disability justice strategies.	3: SDOH	Support

DRAFT RECOMMENDATION 16.6 — LEGAL REPRESENTATION AT MENTAL HEALTH TRIBUNALS In the medium term (over 2 – 5 years) State and Territory Governments should adequately resource legal aid services to assist people appearing before mental health tribunals and other tribunals that hear matters arising from mental health legislation. This could be addressed through broader legal aid funding or providing a specific legal aid grant.	3: SDOH	Support
DRAFT RECOMMENDATION 16.7 — NON-LEGAL INDIVIDUAL ADVOCACY SERVICES In the medium term (over 2 – 5 years) State and Territory Governments should ensure that non-legal individual advocacy services are available for all individuals subject to involuntary treatment under mental health legislation. In particular, services should: - focus on facilitating supported decision-making by individuals subject to orders - be resourced to provide assistance to all individuals who require it - integrate with rather than replace legal advocacy services.	3: SDOH	Support
DRAFT RECOMMENDATION 17.1 — PERINATAL MENTAL HEALTH Governments should take coordinated action to achieve universal screening for perinatal mental illness. In the short term (in the next 2 years) - The Australian Institute of Health and Welfare should expand the Perinatal National Minimum Data Set, to include indicators of mental health screening, outcomes and referrals. This data should be reported by State and Territory Governments. - State and Territory Governments should use the data to evaluate the effectiveness of health checks for infants and new parents, and adjust practice guidelines in accordance with outcomes. In the long term (over 5 – 10 years) - The National Mental Health Commission should monitor and report on progress towards universal screening. - State and Territory Governments should put in place strategies to reach universal levels of screening for perinatal mental illness for 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.	4: PPEI	Support
DRAFT RECOMMENDATION 17.2 — 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. In the short term (in the next 2 years) - State and Territory governments should use existing guidelines to expand early childhood health checks, such that they assess children's social and emotional development before they enter preschool. - State and Territory departments of education should ensure that all early childhood education and care services have ready access to support and advice from qualified mental health professionals. - The Australian Children's Education and Care Quality Authority should review the pre service training programs for early childhood educators and teachers to ensure qualifications include specific learning on children's social and emotional development. In the medium term (over 2 – 5 years) - State and Territory departments of education, as the regulators responsible for early childhood education and care, should review the quality improvement plans of all services to ensure they include professional learning for staff on child social and emotional development. - Where this is not already occurring, funding for backfilling should be made available to enable early childhood education and care staff to attend accredited professional development, to support their knowledge of child social and emotional development and mental health. - State and Territory Governments should expand the provision of parent education programs through child and family health centres.	4: PPEI	Support
DRAFT RECOMMENDATION 17.3 — SOCIAL AND EMOTIONAL LEARNING PROGRAMS IN THE EDUCATION SYSTEMGovernments 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.In the short term (in the next 2 years)- The COAG Education Council should develop a national strategic policy on social and emotional learning in the Australian education system. This policy should include:– a clear statement on the role of the education system in supporting mental health and wellbeing, and the role of schools in interacting with the mental health system– a commitment to cooperate with the COAG Health Council in the implementation of mental illness prevention policy, and a clear delineation of responsibility, to prevent overlap and confusion in policy development– guidelines for the accreditation of initial teacher education and professional development courses for teachers, which will include social and emotional learning. These guidelines should be developed by the Australian Institute of Teaching and School Leadership– guidelines for the accreditation of external social and emotional learning programs offered to schools. These guidelines could be developed by an expert advisory panel.In the medium term (over 2 – 5 years)- State and Territory departments of education should use the national guidelines to accredit social and emotional learning programs delivered in schools.- State and Territory teacher regulatory authorities should use the national guidelines to accredit initial teacher education programs and professional development programs for teachers. 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.	4: PPEI	Support

DRAFT RECOMMENDATION 17.4 — EDUCATIONAL SUPPORT FOR CHILDREN WITH MENTAL ILLNESS The education system should review the support offered to children with mental illness and make necessary improvements. In the short term (in the next 2 years) - The Disability Standards for Education are due to be reviewed in 2020. The upcoming review should: – include specific consideration of the way the standards affect students with mental illness and their educational outcomes. – examine application processes for adjustments and consider any necessary improvements. - MBS-rebated health professionals treating children should be required to include recommendations for parents/carers and teachers in their report to the referring medical practitioner. In the medium term (over 2 – 5 years) - The Australian Government should use data collected by schools as part of the National 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 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 referred to them, once the student's attendance declines below a determined level, and monitor their implementation.	4: PPEI	Support
DRAFT RECOMMENDATION 17.5 — WELLBEING LEADERS IN SCHOOLS All schools should employ a dedicated school wellbeing leader, who will oversee school wellbeing policies, coordinate with other service providers and assist teachers and students to access support. In the short term (in the next 2 years) - State and Territory Governments should review existing programs that support school wellbeing initiatives, and establish which funding could be redirected towards the employment of school wellbeing leaders in government schools. In the medium term (over 2 – 5 years) - All schools should have a dedicated wellbeing leader. In larger schools, this should be a full-time position. - Where government schools can demonstrate that they already employ a staff member in an equivalent position, and are delivering effective mental health and wellbeing programs, they should be able to access the equivalent funding to be used for additional investment in social and emotional wellbeing.	4: PPEI	Further analysis required
DRAFT RECOMMENDATION 17.6 — DATA ON CHILD SOCIAL AND EMOTIONAL WELLBEING Governments should expand the collection of data on child social and emotional wellbeing, and ensure data is used (and used consistently) in policy development and evaluation. In the short term (in the next 2 years) - the Australian Government should fund the AIHW'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 AIHW should work with Departments of Health to implement data collection. Data should be collected and reported annually. - State and Territory departments of education should use existing school surveys to monitor the outcomes of wellbeing programs implemented in schools. These should be used to identify schools that require additional support to implement effective wellbeing programs. In the long term (over 5 – 10 years) - The Australian Government should fund the creation of an education evidence base, including an evidence base on mental health and wellbeing. This should include funding networks of schools to trial and evaluate innovative approaches. - The Australian Government should fund the Australian Institute of Family Studies to establish new cohorts of the Longitudinal Study of Australian Children at regular intervals.	4: PPEI	Support
DRAFT RECOMMENDATION 18.1 — TRAINING FOR EDUCATORS IN TERTIARY EDUCATION INSTITUTIONSIn the short term (in the next 2 years)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 teaching staff to undertake training on student mental health and wellbeing- all tertiary education providers to make available guidance for teaching staff on what they should do if a student approaches them with a mental health concern and how they can support student mental health.	4: PPEI	Support

DRAFT RECOMMENDATION 18.2 — STUDENT MENTAL HEALTH AND WELLBEING STRATEGY IN TERTIARY EDUCATION INSTITUTIONS In the short term (in the next 2 years) 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, including information on their internal and external support and the partnerships with providers of external supports - ensuring on-site 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. In the medium term (over 2 – 5 years) 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 then disseminate this information to tertiary education providers.	4: PPEI	Support
DRAFT RECOMMENDATION 18.3 — GUIDANCE FOR TERTIARY EDUCATION PROVIDERS In the short term (in the next 2 years) 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.	4: PPEI	Support
DRAFT RECOMMENDATION 19.1 — PSYCHOLOGICAL HEALTH AND SAFETY IN WORKPLACE HEALTH AND SAFETY LAWS Psychological health and safety should be given the same importance as physical health and safety in workplace health and safety (WHS) laws. In the short term (in the next 2 years) The model WHS laws (and the WHS laws in those jurisdictions not currently using the model laws) should be amended to ensure psychological health and safety in the workplace is given similar consideration to physical health and safety. - 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 similarly to physical health and safety.	3: SDOH	Support
DRAFT RECOMMENDATION 19.2 — CODES OF PRACTICE ON EMPLOYER DUTY OF CARE In the short term (in the next 2 years) Codes of practice should be developed by Workplace Health and Safety authorities in conjunction with Safe Work Australia to assist employers meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Codes of practices should be developed to reflect the different risk profiles of different industries and occupations.	3: SDOH	Support
DRAFT RECOMMENDATION 19.3 — LOWER PREMIUMS AND WORKPLACE INITIATIVES In the medium term (over 2 – 5 years) Workers compensation schemes should provide lower 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.	3: SDOH	Support
DRAFT RECOMMENDATION 19.4 — NO-LIABILITY TREATMENT FOR MENTAL HEALTH RELATED WORKERS COMPENSATION CLAIMS In the short term (in the next 2 years) Workers compensation schemes should be amended to provide clinical treatment 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 self-insurers.	3: SDOH	Support
DRAFT RECOMMENDATION 19.5 — DISSEMINATING INFORMATION ON WORKPLACE INTERVENTIONS In the medium term (over 2 – 5 years) 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. They should then advise employers of effective interventions that would be appropriate for their workplace.	3: SDOH	Support

DRAFT RECOMMENDATION 20.1 — NATIONAL STIGMA REDUCTION STRATEGYA national stigma reduction strategy can direct efforts to reduce stigma towards people with mental illness that is poorly understood in the community.In the short term (in the next 2 years)The National Mental Health Commission should develop and drive the implementation of a national stigma reduction strategy that focuses on the experiences of people with mental illness that is poorly understood in the community. The 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 distance, 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. Australian Governments should recognise their commitments to reducing stigma and discrimination made under the Fifth National Mental Health and Suicide Prevention Plan, and should support the National Mental Health Commission in developing and implementing this strategy.In the medium term (over 2 – 5 years)Stigma reduction programs should be incorporated in the initial training and continuing professional development requirements of all mental health professionals, subject to periodic evaluation as to their appropriateness and effectiveness.	3: SDOH	Support
DRAFT RECOMMENDATION 20.2 — AWARENESS OF MENTAL ILLNESS IN THE INSURANCE SECTOR In the short term (in the next 2 years) - The Financial Services Council should update the mental health training requirements for insurers in Life Insurance Industry Standard 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 Life Industry Standard 21 to include all employees of covered insurers so as to ensure the industry as a whole has a better understanding of mental illness - publish data they receive on industry compliance with the Standard - rollout the Standard to superannuation funds and financial advisory group members. - The Australian Securities and Investments Commission should evaluate 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 evaluation 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 - has implemented standardised definitions of diagnosed mental illnesses that are used to assess risk - 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 these changes have not been achieved, regulatory changes to ensure these changes are put in place should be recommended. This review should occur within two years. - The Office of the Australian Information Commissioner 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. This review should be conducted in 2022 after the protocols have been operating for two years.	3: SDOH	Support
DRAFT RECOMMENDATION 20.3 — TRADITIONAL HEALERS Traditional healers have the potential to help improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. In the medium term (over 2 – 5 years) - 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.	5: ATSI	Support
DRAFT RECOMMENDATION 21.1 — UNIVERSAL ACCESS TO AFTERCARE In the short term (in the next 2 years) Australian, State and Territory Governments should offer effective aftercare to anyone who presents to a hospital, GP or other government service following a suicide attempt. Aftercare should be directly provided or referred, and include support prior to discharge or leaving the service, as well as proactive follow-up support within the first day, week and three months of discharge, when the individual is most vulnerable.	6: integration and diversity	Support

DRAFT RECOMMENDATION 21.2 — EMPOWER INDIGENOUS COMMUNITIES TO PREVENT SUICIDE In the short term (in the next 2 years)- The Council of Australian Governments Health Council should develop a renewed National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and associated Implementation Plan to guide suicide prevention activities in Indigenous communities.- Indigenous organisations should be the preferred providers of local suicide prevention activities for Aboriginal and Torres Strait Islander people. For all organisations providing programs or activities into Indigenous communities, the requirements of performance monitoring, reporting and evaluation should be adapted to ensure they are appropriate and reflective of the cultural context.	5: ATSI	Support
DRAFT RECOMMENDATION 21.3 — APPROACH TO SUICIDE PREVENTION Australia's approach to suicide prevention holds promise, but there are opportunities to improve going forward. In the short term (in the next 2 years) - The proposed National Mental Health and Suicide Prevention Agreement (draft recommendation 22.1) 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. In the medium term (over 2 – 5 years) - The National Mental Health Commission should assess evaluations of current trials that follow a systems approach to suicide prevention. It should consider whether the evidence shows if these approaches are likely to be successful at reducing suicide rates and behaviours in Australia. If so, this approach should be implemented across all Australian regions.	Other - suicide prevention	Support
DRAFT RECOMMENDATION 22.1 — A NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT All stakeholder groups, including government, should know which tier of government is responsible for funding particular services and is accountable for mental health outcomes that are attributable to the provision of those services. In the short term (in the next 2 years) COAG should develop a National Mental Health and Suicide Prevention Agreement between the Australian, States and Territory Governments 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 - recognises the importance of separating funding and governance arrangements of mental health from those of physical health to strengthen the accountability of individual jurisdictions for mental health outcomes - specifies the responsibility of each tier of government to fund and deliver particular mental health services and supports, and suicide prevention activities to ensure maximum separation in responsibilities and maximum coverage of consumer and carer needs - introduces new funding and governance arrangements between both tiers of government for mental health services and supports, including the mechanism for establishing funding allocations - includes consumers and carers as key partners in developing the agreement - recognises the role of non-health supports in meeting consumer and carer needs, particularly psychosocial supports - sets out clear and transparent performance reporting requirements - sets out the governance arrangements for the proposed Regional Commissioning Authorities, if recommended and accepted by all governments. The COAG Health Council should be responsible for developing and implementing the proposed National Mental Health and Suicide Prevention Agreement.	1: National Agreement	Support
DRAFT RECOMMENDATION 22.2 — A NEW WHOLE-OF-GOVERNMENT MENTAL HEALTH STRATEGY A national strategy that integrates services and supports 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. In the short term (in the next 2 years) The Council of Australian Governments (COAG) should amend the terms of reference of the COAG Health Council to enable it to include other COAG Councils in policy discussions and decisions, or ministers responsible for portfolios that do not have a relevant COAG council, where this is necessary to cement cross-portfolio commitment to reforms directed at the social determinants of mental health and suicide prevention. 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. The COAG Health Council should develop a new whole-of-government National Mental Health Strategy to improve population mental health over a generational time frame. In developing the new strategy, the COAG Health Council should: - collaborate with relevant health and non-health portfolios of Australian, State and Territory Governments, consumers and carers, and the private sector - redraft its mental health vision statement to better balance the outcomes desired by consumers and carers with the level of ambition it has for mental health reforms - ensure that it is a single document that has the demonstrable support of consumers and carers, for whom it exists. The National Mental Health Commission should be responsible for monitoring and reporting on the strategy's implementation annually. The COAG Health Council should ensure that progress in implementing the strategy is independently reviewed and improvements recommended every five years. The COAG councils should ensure that all national, and State and Territory agreements and strategies that affect mental health outcomes explicitly articulate how they contribute to meeting the aims of the National Mental Health Strategy and how they will demonstrate progress in meeting these aims. Similarly, the new National Mental Health Strategy should include corresponding links to other strategies that support it.	1: National Agreement	Support

DRAFT RECOMMENDATION 22.3 — ENHANCING CONSUMER AND CARER PARTICIPATIONConsumers and carers should have the opportunity to participate in the design of government policies and programs that affect their lives.In the short term (in the next 2 years)- The Australian, State and Territory Governments should ensure that they collaborate with consumers and carers in all aspects of mental healthcare system planning, design, monitoring and evaluation.- COAG should instruct the National Mental Health Commission to monitor and report on total expenditure by individual jurisdictions on systemic advocacy in mental health that is provided by peak representative bodies.In the medium term (over 2–5 years)The Australian, State and Territory Governments should strengthen systemic advocacy by:- extending the funding cycle length for peak bodies to a minimum five years to improve business planning and capability development- concluding contract renewals at least one year before expiry- reporting their total funding to peak bodies that represent mental health consumers and carers through the annual Report on Government Services.	2: Person-led	Support
DRAFT RECOMMENDATION 22.4 — ESTABLISHING TARGETS FOR OUTCOMES Accountability for mental health outcomes should include measurement against predetermined performance targets. In the medium term (over 2 – 5 years) The COAG Health Council 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 reflect an appropriate balance of ambition and reality, it should develop a process for setting them that, among other things, involves collaboration with consumers and carers. Following this collaborative process, the COAG Health Council should publish the targets and an explanation of how they were set.	9: evidence and accountability	Support
DRAFT RECOMMENDATION 22.5 — 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 most efficiently and effectively. In the medium term (over 2 – 5 years) The National Mental Health Commission (NMHC) should have statutory authority to 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. The COAG Health Council should communicate its support to the NMHC in taking on the proposed broad-ranging evaluation role. - The NMHC should be governed by a skills-based Board of multiple persons. 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 continue to work closely with the Australian Bureau of Statistics, the Australian Institute of Health and Welfare, and the Australian Commission on Safety and Quality in Health Care to minimise duplication in monitoring and reporting. - 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. To this end, the NMHC should: - develop a consultation process and consult with, at a minimum, State and Territory Government health/mental health departments, the Australian Government's Department of Health, the Department of Social Services, the National Indigenous Australians Agency, and consumer and carer peak bodies - in consultation with key stakeholders, develop and publish a process for prioritising policy and program evaluations, including decision-making criteria.	9: evidence and accountability	Further analysis required
DRAFT RECOMMENDATION 23.1 — REVIEW PROPOSED ACTIVITY-BASED FUNDING CLASSIFICATION FOR MENTAL HEALTHCARE In the short term (in the next 2 years) The Independent Hospital Pricing Authority should review the Australian Mental Health Care Classification to determine: - whether the structure of the Australian Mental Health Care Classification and the variables within it should be refined or changed (especially the 'phase of care' variable) - if the 'phase of care' variable is retained, how the variable 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, the Independent Hospital Pricing Authority should consider developing a classification system for community ambulatory mental healthcare services based on hours of care provided.	Other - activity based funding	Further analysis required
DRAFT RECOMMENDATION 23.2 — RESPONSIBILITY FOR PSYCHOSOCIAL AND CARER SUPPORT SERVICES In the medium term (over 2 – 5 years) State and Territory Governments should take on sole responsibility for commissioning psychosocial and mental health carer support services outside of the National Disability Insurance Scheme. The Australian Government should provide funding to support the new and expanded roles that State and Territory Governments are taking on, and continue to administer the Carer Gateway's service navigation and information services for all carers.	7: community mental health	Further analysis required
DRAFT RECOMMENDATION 23.3 — STRUCTURAL REFORM IS NECESSARY The Australian Government and State and Territory Governments should work together to reform the architecture of Australia's mental health system to clarify federal roles and responsibilities and incentivise governments to invest in those services that best meet the needs of people with mental illness and their carers. There should be greater regional control and responsibility for mental health funding	1: National Agreement	Support

DRAFT RECOMMENDATION 24.1 — FLEXIBLE AND POOLED FUNDING ARRANGEMENTSMBS-rebated and regionally commissioned allied mental healthcare should be funded from a single pool, and commissioning agencies should be able to co-fund MBS-rebated allied mental health professionals. State and Territory Government agencies should be permitted to co-fund MBS-rebated out-of-hours GP services where this will reduce mental health-related emergency department presentationsIn the short term (in the next 2 years)The Australian Government Minister for Health should issue a direction in relation to section 19.2 of the Health Insurance Act 1973 (Cth) that allows State and Territory Government agencies to provide additional funding to MBS-rebated out-of-hours GP services, with the agreement of PHNs. 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.In the medium term (over 2 – 5 years)MBS rebates for allied mental healthcare should be explicitly linked to commissioning agencies' (PHNs or RCAs) mental health funding pools, so as to create a single budget from which all primary allied mental healthcare would be funded.Once this linkage has been established, the Minister for Health should issue a direction in relation to section 19.2 of the Health Insurance Act 1973 (Cth) that:- allows commissioning agencies (PHNs or RCAs) to provide additional funding to allied mental health professionals whose services receive MBS rebates- allows other Australian, State and Territory Government agencies to provide additional funding to MBS-rebated allied mental health professionals with the agreement of commissioning agencies (PHNs or RCAs).	6: integration and diversity	Further analysis required
DRAFT RECOMMENDATION 24.2 — REGIONAL AUTONOMY OVER SERVICE PROVIDER FUNDING In the short term (in the next 2 years) The Department of Health should cease directing PHNs to fund headspace centres, including the headspace Youth Early Psychosis Program, and other specific service providers. PHNs should be able to continue funding headspace services or redirect this funding to better meet the needs of their local areas as they see fit. In the medium term (over 2–5 years) There should be no requirements that commissioning agencies (RCAs or PHNs) have to fund particular service providers.	6: integration and diversity	Further analysis required
DRAFT RECOMMENDATION 24.3 — THE NATIONAL HOUSING AND HOMELESSNESS AGREEMENT In the medium term (over 2 - 5 years) As part of the next negotiation of the National Housing and Homelessness Agreement, the Council of Australian Governments should increase the quantum of Australian Government funding for State and Territory Government-provided housing and homelessness services. State and Territory Governments should use this additional funding to expand their provision of housing and homelessness services for people with mental illness.	3: SDOH	Support
DRAFT RECOMMENDATION 24.4 — TOWARD MORE INNOVATIVE PAYMENT MODELS In the long term (over 5 – 10 years) The Australian Government should establish a Mental Health Innovation Fund to trial innovative system organisation and payment models. Commissioning agencies (PHNs or RCAs) could apply for additional funding to trial new models under the proviso that they have them independently evaluated and share the findings. As part of these trials, and with appropriate governance arrangements in place, commissioning agencies (PHNs or RCAs) should be permitted to cash-out Medicare Benefits Schedule rebates for allied mental health professionals in their regions and administer this funding through a means of their choosing.	Other - innovation	Support
DRAFT RECOMMENDATION 24.5 — PRIVATE HEALTH INSURANCE AND FUNDING OFCOMMUNITY-BASED HEALTHCARE In the short term (in the next 2 years) 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.	7: community mental health	Further analysis required
DRAFT RECOMMENDATION 24.6 — LIFE INSURERS AND FUNDING OF MENTAL HEALTHCARE In the short term (in the next 2 years) The Australian Government should permit life insurers to fund mental health treatments for their income protections 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.	6: integration and diversity	Further analysis required
DRAFT RECOMMENDATION 25.1 — A DATA LINKAGE STRATEGY FOR MENTAL HEALTH DATA In the medium term (over 2 – 5 years) The Australian, State and Territory Governments should task the Mental Health Information Strategy Steering Committee with developing a strategy to improve data linkage in mental health including: - identifying high-priority data linkage projects - assessing the barriers to implementing such projects - advising on solutions to address them.	9: evidence and accountability	Support
DRAFT RECOMMENDATION 25.2 — ROUTINE NATIONAL SURVEYS OF MENTAL HEALTHIn the long term (over 5 – 10 years)The Australian Government should support the ABS to conduct a National Survey of Mental Health and Wellbeing no less frequently than every 10 years. The survey design should enable consistent comparisons across time, and aim to routinely collect information on:- prevalence of mental illness- service use by people with mental illness, and- outcomes of people with mental illness and their carers.The survey design should ensure that it adequately represents vulnerable population sub-groups who may have diverse needs. Opportunities for linking the survey data with other datasets should be considered.	9: evidence and accountability	Support

DRAFT RECOMMENDATION 25.3 — STRATEGIES TO FILL DATA GAPS High-quality and fit-for-purpose data should be collected to drive improved outcomes for consumers and carers. In the medium term (over 2 – 5 years) - 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. The priorities should consider data gaps identified in this inquiry, in particular for mental health services provided by general practitioners, private providers and non-government organisations, and vulnerable population sub-groups. In the long term (over 5 – 10 years) - The Australian, State and Territory Governments should develop and adequately fund strategies to address identified data gaps and information priorities. 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 consumers.	9: evidence and accountability	Support
DRAFT RECOMMENDATION 25.4 — STRENGTHENED MONITORING AND REPORTING Monitoring and reporting should be more focused on outcomes for consumers and carers and broadened beyond health portfolios. In the short term (in the next 2 years) - The National Mental Health Commission (NMHC) should conduct monitoring and reporting on mental health and suicide prevention outcomes, activity and reforms across portfolios. This should include monitoring and reporting on: – outcome areas derived from the Contributing Life Framework for people living with mental illness, their carers and suicidal behaviour annually – mental health and suicide prevention expenditure (including in non-health sectors), with the frequency of reporting to be determined by the NMHC – 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 representatives and sector experts in finalising the set of indicators to monitor progress against outcomes. - The NMHC should consult with stakeholders and sector experts to identify what expenditure across which sectors should be reported on. - The NMHC should continue to monitor and report on progress against mental health reforms under the National Mental Health Strategy.	9: evidence and accountability	Support
DRAFT RECOMMENDATION 25.5 — REPORTING SERVICE PERFORMANCE DATA BY REGION In the short term (in the next 2 years) - The Australian, State and Territory Governments should authorise the Australian Institute of Health and Welfare (AIHW) to report all data relating to the performance of mental health and suicide prevention services at a regional level, as defined by commissioning agencies (PHNs or RCAs), 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 their 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 more accessible.	9: evidence and accountability	Support
DRAFT RECOMMENDATION 25.6 — STANDARDISED REGIONAL REPORTING REQUIREMENTS In the short term (in the next 2 years) The Australian, State and Territory Governments should provide commissioning agencies (PHNs or RCAs) with guidance and support to enable them to implement standardised monitoring and reporting requirements for commissioned services, with minimal undue regulatory burden.	9: evidence and accountability	Support
DRAFT RECOMMENDATION 25.7 — PRINCIPLES FOR CONDUCTING PROGRAM EVALUATIONS In the short term (in the next 2 years) The COAG Health Council should agree to a set of principles by which the National Mental Health Commission would undertake its evaluation function, as set out in draft recommendation 22.5. These principles should be set in consultation with relevant stakeholders.	9: evidence and accountability	Support
DRAFT RECOMMENDATION 25.8 — REQUIRING COST-EFFECTIVENESS CONSIDERATION In the medium term (over 2 – 5 years) The Australian Government should consider the expected cost-effectiveness of all mental health programs or interventions before funding is provided. 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.	9: evidence and accountability	Further analysis required
DRAFT RECOMMENDATION 25.9 — A CLINICAL TRIALS NETWORK SHOULD BE ESTABLISHEDIn the short term (in the next 2 years)The Australian Government should fund the establishment of a national clinical trial network in mental health and suicide prevention. In developing this network, the Australian Government should consult with bodies that work in this area including the National Medical and Health Research Centre and the Australian Clinical Trials Alliance.	9: evidence and accountability	Further analysis required