MEMBER BRIEFING
NATIONAL AGREEMENT ON MENTAL HEALTH AND SUICIDE PREVETNION
MARCH 2022

OVERVIEW

A new National Agreement on Mental Health and Suicide Prevention has been announced. The Agreement outlines important principles, opportunities and priorities for reform. It has been signed by New South Wales, South Australia, Queensland, the Northern Territory and Tasmania. Western Australia, Victoria and the Australian Capital Territory are yet to agree to its terms.

The National Agreement is a positive step that makes some progress towards systemic reforms. Several aspects of our National Policy Platform are captured in the new Agreement including whole-of-government, lived experience, data and workforce priorities. This is a pragmatic and incremental reform, if fully delivered it will make progress in key areas. National support is however critical and requires support from outstanding jurisdictions and further bilateral agreements.

PURPOSE

Principles for reform

The Agreement commits jurisdictions to key principles for reform including:

- A better, people-centred mental health and suicide prevention system with lived experience embedded in design, planning, delivery and evaluation
- Effective investment, policy and services that reduce gaps and support better outcomes and reduces fragmentation across prevention, primary and secondary care settings
- Enhanced workforce capability to meet current and future needs
- New models of care to drive improvement and ensure outcomes
- Establish clear roles, responsibilities and accountability for planning and reform
- Recognising the role of the social determinants of health
- Collaboration to improve outcomes for vulnerable cohorts

Outcomes

The Agreement commits jurisdictions to work in partnership to improve outcomes including:

- Improved mental health and wellbeing of all Australians with a focus on priority cohorts
- Reduced suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention
- Provide a balanced and integrated mental health and suicide prevention system
- Improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress; and
- Improve quality, safety and capacity in the mental health and suicide prevention system

ROLES AND RESPONSIBILITIES

Commonwealth Government

Commonwealth responsibilities for mental health and suicide prevention:

- National leadership in suicide prevention including whole-of-population prevention activities
- Policy and funding for primary and specialist mental health care
- Ongoing commissioning of a range of services and activities to promote coordination
- Primary care reforms designed to improve patient outcomes and reduce hospitalisations
- Regulating private hospitals and private health insurance
- Ongoing responsibility for aged care and the National Disability Insurance Scheme
- Lead responsibility for Aboriginal Community Controlled Health Services (ACCHS)
- Services to veterans, defence force and people in immigration settings
- Some non-health sector supports including income and employment support
- Working with tertiary education sectors to address workforce needs
- National research and clinical trials
- Funding the Australian Institute of Health and Welfare
- National population mental health, suicide prevention and wellbeing surveys

State and Territory Governments

State and Territory responsibilities for mental health and suicide prevention:

- Health and emergency services through the public hospital system including mental health services and system management
- Community-based mental health services and responding to people in suicidal distress
- Regulatory and policy frameworks for service delivery
- Services in crisis and emergency department, mental-health liaison and in-patient settings
- Services to state-funded aged care residential settings and in custodial settings
- Overseeing treatment and care for those protected under state mental health legislation
- Funding for state-specific ACCHS programs
- Working with Registered Training Organisations on workforce issues
- State-specific mental health and suicide prevention research
- Collecting and managing state-based mental health and suicide prevention data

Shared roles and responsibilities

Governments commit to shared responsibilities for mental health and suicide prevention including:

- Provision of their share of funding for the National Health Reform Agreement
- Determine funding, policy and exploring innovative models of care in the funding model
- Establishing and maintaining nationally consistent standards
- Working together on policy decisions that impact each other's responsibilities
- Mental health promotion, prevention and wellbeing programs, suicide prevention stigma, digital information and clinical services
- Supporting better integrated services planning and care coordination
- Workforce planning
- Improving system capacity to respond to people at risk of suicide
- Suicide prevention, early intervention, aftercare and postvention programs

- Ongoing funding for programs beyond the health sector
- Psychosocial supports for people not supported through the NDIS
- Co-designing place-based approaches
- Measures to Close the Gap between Indigenous and non-Indigenous outcomes

NATIONAL PRIORITIES

Priority groups

Implementation of agreements will consider and support the following priority groups:

- Aboriginal and Torres Strait Islander peoples
- LGBTQIA+SB people
- Culturally and linguistically diverse communities and refugees
- People experiencing homelessness or housing instability
- Children and young people, including those in out-of-home care
- Older Australians (over 65, or over 50 for Aboriginal and Torres Strait Islander peoples)
- People living in regional, rural and remote areas of Australia
- People experiencing or at risk of abuse and violence, including sexual abuse, neglect and family and domestic violence
- People with a disability
- Australian Defence Force members and veterans
- People experiencing socioeconomic disadvantage
- People who are (or were previously) in contact with the criminal justice system
- People with complex mental health needs, including people with co-occurring mental health and cognitive disability and/or autism
- People with harmful use of alcohol or other drugs, or people with substance use disorders
- People who have made a previous suicide attempt or who have been bereaved by suicide

System-wide reforms

Sharing responsibility for addressing gaps in the system including:

- For people experiencing mild to moderate mental illness or psychological distress
- Better integration across services and systems
- Information sharing
- Provision of more seamless care including gaps between primary, community, specialist and acute care settings

Shared commitments to address:

- Stigma reduction including through the National Strategy for Stigma Reduction
- Safety and quality in service delivery and consistent standards
- Strengthening regional planning and commissioning
- National consistency of initial assessment and referral
- Workforce planning and development including a Suicide Prevention Workforce Strategy
- Psycho-social supports outside of the NDIS

Suicide prevention

Seek to reduce suicide deaths, suicide attempts, and self-harm towards zero including to:

- Meet the different needs of priority groups and increase accessibility to services
- Develop suicide prevention services and programs in collaboration with communities and people with lived experience
- Improve joint regional planning for suicide prevention
- Improve the quality of suicide prevention services through national standards
- Incorporate suicide prevention training into service modelling
- Build competency within the suicide prevention workforce, including the peer workforce
- Seek to avoid or minimise service gaps, fragmentation, duplication, and inefficiencies
- Establish the National Suicide Prevention Office

Social determinants

Agreement to pursue whole-of-government approaches in the priority areas of education, work environments, homelessness, alcohol and other drugs, financial counselling, family, domestic and sexual violence, including sexual harassment, child maltreatment, and justice with a focus on the priority groups.

Specific commitments to share best practice examples in these areas is agreed. There are also agreed priorities to progress, including:

- Approaches to improve school aged children's social and emotional wellbeing
- Implement approaches to inmove mental health literacy and suicide prevention capability of public sector workforces and legislative reform for work-related psychological health
- Improve referral pathways and data for mental health, suicide prevention and homelessness
- Develop suicide prevention training materials for use by family and domestic violence services
- Priorities for co-occurring alcohol and other drug use and mental illness

Governance and reporting

The Agreement will be monitored through meetings of Health and Mental Health Ministers and their senior officials.

Reporting outputs include:

- Commonwealth-State implementation plans and annual jurisdiction reports
- An annual National Progress Report
- Development of a National Evaluation Framework
- A final review

The Agreement commits to improved data collection and sharing, supporting national data linkage, improved reporting and transparency and building the evidence-base.

The Agreement commits to ensuring people with lived experience are consulted throughout implementation and to seek advice on matters of design, planning, evaluation and governance.

Funding

All parties commit to maintaining or increasing existing levels of funding. Minimum annual funding is tied to equivalent recurrent expenditure as reported in 2018-19.

Bilateral agreements with each jurisdiction will outline the quantum of additional funding.

IMPLICATIONS AND ANALYSIS

The National Agreement is a positive step that makes some progress towards systemic reforms

The Agreement generally progresses much-needed national, systemic and whole-of-government reform. It agrees important objectives, principles, and outcomes in line with recent reviews and long-standing sector priorities. This includes addressing whole-of-government, data, workforce and system-wide issues.

The Agreement outlines roles and responsibilities for jurisdictions. Yet, this largely clarifies existing functions and commits to addressing fragmentation and duplication rather than the challenging work of shifting or streamlining responsibilities.

Annual reporting requirements, progress updates and additional performance indicators are welcome steps towards a more transparent and accountable system.

The Agreement makes a consistent commitment to lived experience in all aspects of suicide prevention. Yet, lived experience involvement in the development of this critical document was very limited and will need to be significantly improved upon implementation.

The importance of the social determinants is repeated throughout the Agreement. While specific commitments in the agreement are health and mental health focused, there are several practical undertakings to work across other human services and progress specific whole-of-government priorities.

Several aspects of our National Policy Platform are captured in the new National Agreement

Key parts of the National Agreement reflect our new National Policy Platform and long-standing SPA priorities. At a systemic level, this includes the commitment to a whole-of-government approach and putting lived experience knowledge and insight at the centre of all that we do. It is also reflected in commitments to quality standards and increase data reporting and linkage.

The repeated focus on workforce development is a much-needed inclusion in the new National Agreement. Commitments to workforce planning, development and sustainability are key priorities. In particular, capability in suicide prevention across workforces and the need for a specific Suicide Prevention Workforce Strategy is acknowledged.

The Agreement recognises a number of priority cohorts for which SPA has been a longstanding advocate. This includes Aboriginal and Torres Strait Islanders, culturally and linguistically diverse communities and LGBTQIA+ groups. Importantly, it includes those who have attempted or are bereaved by suicide. The Agreement lacks a specific priority around male suicide prevention.

National support is critical for the delivery of this Agreement

As of March 2022, the Agreement has been signed by the Commonwealth, New South Wales, Queensland, the Northern Territory and Tasmania. It has not been signed by Victoria, Western Australia and the Australian Capital Territory. As the Agreement was first promised for November 2021, this is a disappointing outcome and without national coverage the impact of this Agreement will be severely limited.

Only two States have currently entered into bilateral agreements that unlock additional funds. While the New South Wales agreement is comprehensive, the South Australian agreement makes no firm commitments to aftercare, postvention or distress intervention programs. This is a disappointing outcome and will need to be resolved as soon as practicable after the South Australian state election.

Overall, this is fairly pragmatic and reasonably incremental reform. While it does not outline revolutionary whole-sale changes, it makes good progress in a systemic way. In the context of several State and a Commonwealth election in 2022, it is a positive outcome.