

# NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION AGREEMENT

An agreement between

- the **Commonwealth of Australia** and
- the **States and Territories**, being:
  - ◆ New South Wales
  - ◆ Victoria
  - ◆ Queensland
  - ◆ Western Australia
  - ◆ South Australia
  - ◆ Tasmania
  - ◆ the Australian Capital Territory
  - ◆ the Northern Territory

This Agreement will contribute to building a better mental health and suicide prevention system for all Australians against a range of priority areas.

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# National Mental Health and Suicide Prevention Agreement

## OVERVIEW

1. This National Mental Health and Suicide Prevention Agreement (Agreement) sets out the shared intention of the Commonwealth, state and territory governments (the States) to work in partnership to improve the mental health of all Australians and ensure the sustainability and enhance the services of the Australian mental health and suicide prevention system.
2. The Parties recognise the need to improve Australia's mental health and suicide prevention system is amplified by the profound impact of the COVID-19 pandemic on mental health and wellbeing in Australia, as well as other recent challenges such as drought and bushfire.
3. The Parties will collaborate on systemic, whole-of-government reform to deliver a comprehensive, coordinated, consumer focused and compassionate mental health and suicide prevention system to benefit all Australians. This Agreement commences this collaboration.
4. This Agreement is created subject to the provisions of the Intergovernmental Agreement on Federal Financial Relations (IGA FFR). Bilateral agreements between the Commonwealth and the respective states will be developed as Schedules to this Agreement. Initiative level detail will be agreed through the Schedules with each of the States.
5. This Agreement builds on, and reaffirms, the policy and reform directions and outcomes, progress measures and outputs outlined in The Fifth National Mental Health and Suicide Prevention Plan. It also recognises the recommendations from the Productivity Commission's Inquiry Report on Mental Health and the National Suicide Prevention Adviser's Final Advice.
6. This Agreement complements the 2020-25 Addendum to the National Health Reform Agreement 2020-25 (NHRA) and the shared commitment of the Commonwealth and the States to improve mental health and suicide prevention outcomes.

### **Purpose**

7. The Commonwealth and the States agree to work together for the duration of this Agreement to support and implement a whole-of-government approach to mental health and suicide prevention, as referenced in Schedule A to this Agreement.
8. This Agreement and associated Schedules provide a platform to ensure all parties work together to build a better mental health and suicide prevention system for all Australians against a range of priority areas, including prevention and early intervention, suicide prevention, treatment and support, supporting the vulnerable, workforce and governance, and quality and safety.
9. Implementation of this Agreement and associated reform activities should be informed by the specific needs and experiences of those with lived experience of mental ill-health and suicide, and those who care for them.

### **Reporting Arrangements**

10. Reporting will be meaningful and assist public understanding of how the funding has delivered a benefit to the community.
11. Reporting arrangements for the duration of this Agreement are set out in Part 6 – Reporting.

### **Financial Arrangements**

12. Details of the Commonwealth's and States' financial contributions to the operation of the bilateral agreements are set out in Schedules to this Agreement.

## PRELIMINARIES

13. This Agreement will replace the Heads of Agreement on Mental Health and Suicide Prevention which will expire between parties when this Agreement commences between those Parties.
14. This Agreement is a key first step in the Mental Health and Suicide Prevention Reform agenda. It nominates areas identified as requiring immediate reform and highlights areas where further collaboration between Parties is required.
15. The activities within the NHRA and this Agreement will be reviewed, and this Agreement may be amended with the agreement of all Parties when either Agreement has completed a review as set out in the respective Agreements.
16. This Agreement sets out the national objectives, outcomes and outputs for mental health and suicide prevention as agreed by all Parties. Individual state bilateral agreements (Schedules to this Agreement) detail the specific Commonwealth and State objectives, outcomes and outputs that have been individualised as required to the local circumstances of that state. Additionally, the Schedules will detail the funding contributions for that state.
17. Mental health and suicide prevention reforms will consider each State's particular circumstances, and this Agreement will allow individual States flexibility to identify and deliver State reform directions for policy and service delivery, in line with the objectives of this Agreement.

## PART 1 – FORMALITIES

### Parties to this Agreement

18. This Agreement is between the Commonwealth of Australia (the Commonwealth) and the states and territories (the States).

### Term of this Agreement

19. This Agreement will commence as soon as the Commonwealth and one other Party sign it and will expire on 30 June 2026. This Agreement may be terminated earlier or extended as agreed in writing by the Parties.

## PART 2 – PRINCIPLES, OBJECTIVES, OUTCOMES AND OUTPUTS

### Principles

20. This Agreement will build upon the agreed principles as identified in the National Federation Reform Council in December 2020, and the NHRA and will underpin whole-of-governments efforts to transform and improve Australia's mental health and suicide prevention system. Parties commit to:
  - (a) Work together to build a better people-centred mental health and suicide prevention system for all Australians, with lived experience of mental ill health and/or suicide of consumers and their families and carers embedded in the design, planning, delivery and evaluation of services;

- (b) Facilitate an effective investment, policy and service mix that reduces gaps and overlaps in mental health and suicide prevention services to best support mental health outcomes;
- (c) Reduce system fragmentation, gaps and duplication across prevention, primary and secondary care specialist settings with an increased focus on prevention, early intervention and effective management of severe and enduring conditions in the community and tertiary settings;
- (d) Support and enhance the capability of the mental health, suicide prevention and broader health and related workforce to meet current and future needs, particularly in rural, regional and remote communities and priority populations;
- (e) Evaluate new models of care to drive improvement and ensure the best reforms are implemented, with consideration given to outcomes achieved and value for money;
- (f) Establish clear roles, responsibilities and accountabilities for the funding and delivery of mental health and suicide prevention services across the entire mental healthcare system;
- (g) Consider system design changes that are person-centred and evidence based to drive meaningful improvement in outcomes that matter to people, supported by innovative, efficient and flexible funding arrangements;
- (h) Recognise all governments are critical in policy and service delivery across the system;
- (i) Ensure the particular needs of Australia's rural, regional and remote communities are equitably addressed;
- (j) Review and establish structures and mechanisms as required to jointly drive planning and reform that: supports a stepped care model; supports effective early intervention and service provision across the entire spectrum of care; including addressing the group who are too unwell to have their needs met in primary care but not unwell enough (consistently, or sporadically) to access specialist mental health and suicide prevention services;
- (k) Enable effective regional and national cooperation between providers, systems and governments that facilitates local responses to address the unique needs of communities, particularly in rural, regional and remote areas;
- (l) Improve transparency and accountability of mental health and suicide prevention outcomes, including through clear roles and responsibilities for government, improving data collection, linkage and analysis that is shared publicly, and a commitment to develop an evaluation framework, to be formally agreed through this Agreement;
- (m) Recognise the role of social determinants of health on people's mental health and wellbeing, and facilitate a whole-of-system approach that draws together mental health and suicide prevention services and other services delivered by government outside of the health system; and
- (n) Work together to close the gap, improve mental health and wellbeing outcomes and reduce suicide for vulnerable cohorts, including Aboriginal and Torres Strait Islander peoples, CALD communities, LGBTQIA+SB communities, people impacted by

problematic substance use and people with a co-occurring disability, and deliver services to these cohorts in a culturally and locally appropriate manner.

## Objectives

21. The Commonwealth and the States recognise that this Agreement provides an opportunity to work together to lay the foundations for delivering landmark mental health and suicide prevention reform, with the aim of moving towards a unified and integrated mental health and suicide prevention system.
22. This Agreement acknowledges the significant, and often cumulative, challenges for people living in Australia including drought, bushfires and COVID-19. These challenges have amplified the need to improve our mental health and suicide prevention system to address the increased impact on mental health, increased levels of mental illness, and increased levels of suicidal risk, self-harm and distress.
23. The Parties agree on their shared objective to work collaboratively together to implement systemic, whole-of-government reforms that improve mental health outcomes for all people living in Australia, progress the goal of zero lives lost to suicide, and deliver a mental health and suicide prevention system that is comprehensive, coordinated, consumer-focussed and compassionate to benefit all Australians.
24. The Parties will work together in partnership to ensure that all people living in Australia have equitable access to the appropriate level of mental health and suicide prevention care they need, and are able to access this care when and where they need it.
25. As a priority in the first instance, the Parties agree to work together to address areas identified for immediate reform as informed by the Productivity Commission's Inquiry Report on Mental Health (PC Report), the National Suicide Prevention Adviser's Final Advice (NSPA Final Advice) and other relevant inquiries including to:
  - (a) reduce system fragmentation through improved integration between Commonwealth and State-funded services;
  - (b) address gaps in the system by ensuring community-based mental health and suicide prevention services, and in particular ambulatory services, are effective, accessible and affordable; and
  - (c) prioritise further investment in prevention, early intervention and effective management of severe and enduring mental health conditions.

## Outcomes

26. The Commonwealth and the States will work in partnership to implement arrangements for a unified and integrated mental health and suicide prevention system which will seek to:
  - (a) Improve the mental health and wellbeing of the Australian population, with a focus on improving outcomes for priority populations as per Clause 111 [refer Priority Populations list];
  - (b) Reduce suicide, suicidal distress and self-harm through a whole-of-government approach to coordinated prevention, early intervention, treatment, aftercare and postvention supports;



- (c) Provide a balanced and integrated mental health and suicide prevention system for all communities and groups;
- (d) Improve physical health and life expectancy for people living with mental health conditions and for those experiencing suicidal distress; and
- (e) Improve quality, safety and capacity in the Australian mental health and suicide prevention system.

## Outputs

27. The Parties commit to measure and report on the outputs of this Agreement and associated Schedules and will develop the Priority Data and Indicators for measurement as outlined in Annex B to this Agreement. High level outputs of this Agreement include:
- (a) The analysis of psychosocial support services outside of the NDIS completed as soon as possible within the first two years of this Agreement, to commence within the first 12 months of the Agreement being signed
  - (b) Commonwealth-State implementation plans and annual Jurisdiction Progress reports.
  - (c) An annual National Progress Report.
  - (d) A range of improvements to data collection, data sharing and data linkage.
  - (e) The development of a National Evaluation Framework within the first twelve months of signing this Agreement.
  - (f) Shared evaluation findings, in accordance with the National Evaluation Framework and associated guidelines.
  - (g) Consideration and implementation of relevant actions of the National Stigma and Discrimination Reduction Strategy once finalised.
  - (h) The establishment of the National Suicide Prevention Office.
  - (i) The development of national guidelines on regional commissioning and planning within the first twelve months of signing this Agreement.
  - (j) The development of the National Mental Health Workforce Strategy and identification of priority areas for action by mid-2022.
  - (k) Report on progress toward increasing the number of full-time equivalent (FTE) mental health professionals per 100,000 population to meet community need for the life of this Agreement.
  - (l) A submission to the mid-point NHRA review, due to be completed by December 2023.
  - (m) A final review of this Agreement provided to all Parties by June 2025.
28. Additional outputs described in the Schedules attached to this Agreement will be measured against the Priority Data and Indicators as outlined in Annex B.

## PART 3 – ROLES AND RESPONSIBILITIES OF EACH PARTY

29. There is widespread recognition that Australia's mental health and suicide prevention system requires significant reform to focus on better mental health and wellbeing outcomes. Achieving this requires collaboration from all governments, as critical players in policy and service delivery, as well as meaningful engagement with key stakeholders, particularly those with lived experience.
30. This Agreement sets out clear roles, responsibilities and accountabilities for the funding and delivery of mental health and suicide prevention services across the entire mental healthcare and suicide prevention system. All Parties recognise significant reform is required to effect whole of system change.
31. This Agreement builds on the roles and responsibilities agreed under the NHRA. All Parties are responsible for delivering improved health outcomes for all people living in Australia and ensure the sustainability of the Australian health system.
32. The Parties recognise the complexity and interrelationships between different parts of the mental health and suicide prevention system and broader health and other social services (including those outlined at Schedule A - Improving Mental Health and Preventing Suicide Across Systems), and that people frequently are referred to, and transition between different services within the system. This Agreement acknowledges that health outcomes are dependent on the availability of different services, how transitions between different parts of the system are managed, and how increasing or adjusting investment has flow-on impacts across the continuum of care.

## Role of the Commonwealth

33. The Commonwealth is responsible for system management, funding and policy direction for primary mental healthcare, as well as physical and mental health services subsidised by the Medicare Benefits Scheme (MBS) and commissioned through the Primary Health Networks (PHNs).
34. The Commonwealth also provides some clinical and non-clinical community based mental healthcare and subsidises private specialist mental healthcare via the MBS and the Pharmaceutical Benefits Scheme (PBS).
35. The Commonwealth has a national leadership role in suicide prevention. It is responsible for funding and delivering whole-of-population suicide prevention activities in a nationally consistent way.
36. In line with the NHRA, the Commonwealth is responsible for:
  - (a) Policy and funding for the delivery of primary and specialist mental health care provided through the MBS to ensure equitable and timely access to affordable primary health care and specialist medical services.
  - (b) Policy and funding of the PBS to ensure timely and affordable access to safe, cost-effective and high-quality medicines.
  - (c) National support and continued funding (including through PHNs) to commission a range of Commonwealth-funded activities, such as mental health and suicide prevention services and activities to promote coordinated service delivery, collaboration and integration, including for enhanced primary care activities.

- (d) Continuing to focus on reforms in primary care that are designed to improve patient outcomes and reduce avoidable hospital admissions.
- (e) Supporting and regulating private hospitals and the private health insurance sector to enable a viable, sustainable, and cost-effective private sector.

37. Under this Agreement, the Commonwealth agrees to be primarily responsible for:

- (a) Leading the provision of funding for Aboriginal Community Controlled Health Services (ACCHS) to deliver health and wellbeing services, including funding through direct grants, PHNs, and specific Medicare Benefits Scheme arrangements.
- (b) Continuing to administer the National Disability Insurance Scheme (NDIS), via the National Disability Insurance Agency (NDIA).
- (c) Primary responsibility for funding and provision of mental health and suicide prevention services to veterans, defence force personnel and people in immigration detention (noting that at times acute care might be required to be undertaken in state-based services).
- (d) Planning, funding, policy, management and delivery of the national aged care system, including mental health and suicide prevention services in Commonwealth-funded residential aged care facilities.
- (e) Supporting and regulating private hospitals and the private health insurance sector to enable a viable, sustainable and cost-effective private sector.
- (f) Funding and providing some non-health sector mental health and suicide prevention support services, including income and employment support.
- (g) Working with the higher education sector and post-graduate training bodies on the future workforce to address and support mental health and suicide prevention workforce planning, national workforce standards, training and accreditation requirements and supervision availability.
- (h) Collecting and reporting data relating to the use and delivery of MBS and PBS mental health-related services.
- (i) National research and clinical trials through national research bodies, such as the National Health and Medical Research Council and the Medical Research Future Fund.
- (j) Funding the Australian Institute of Health and Welfare (AIHW) to support relevant mental health and suicide prevention National Minimum Data Sets and other national data reporting.
- (k) National population mental health, suicide prevention and wellbeing, surveillance and surveys.

## **Role of the states and territories**

38. The States are generally responsible for providing health and emergency services through the public hospital system. This includes public hospital mental health services for people with severe and persistent mental illness, as well as specialist community-based mental health services and responding to people in suicidal distress. This also includes the system management of public

hospitals, taking a lead role in managing public health activities; and providing legislative and governance arrangements for Local Hospital Networks.

39. In line with the NHRA, states are primarily responsible for:
- (a) Providing health and emergency services through the public hospital system based on the Medicare principles. These services include:
    - i. all admitted services
    - ii. all emergency department services
    - iii. other outpatient, mental health, subacute and other services that could reasonably be considered a public hospital service.
  - (b) System management of public hospitals, including:
    - i. ensuring the legislative basis and governance arrangements for Local Hospital Networks and managing Local Hospital Network performance
    - ii. system-wide public hospital service planning and performance
    - iii. purchasing of public hospital services and monitoring delivery of services purchased
    - iv. taking a lead role in managing public health activities.
40. In addition to the NHRA, under this Agreement, the states agree to primarily be responsible for:
- (a) Developing and implementing legislative, regulatory and policy framework for mental health and suicide prevention service delivery within their jurisdiction.
  - (b) Providing mental health and suicide prevention services, including:
    - i. Mental health and suicide prevention services in crisis and Emergency Department settings.
    - ii. Mental health consultation-liaison and mental health and suicide prevention support in non-mental health and rehabilitation inpatient settings.
  - (c) Providing mental health and suicide prevention services to state funded aged care residential settings, where they exist, and specialist tertiary mental health services to older people with complex needs in residential aged care settings, including people with behavioural and psychosocial symptoms of dementia.
    - i. Mental health specific acute and long-term inpatient units able to provide treatment and care to those admitted under mental health legislation, or who require secure care.
  - (d) Providing specialist mental health community and bed-based services.
  - (e) Providing appropriate inpatient care for remanded and sentenced prisoners in custodial settings, including those in police custody and youth justice settings, and those given a verdict of not criminally responsible because of mental health impairment or cognitive impairment.

- (f) Legislation and overseeing treatment and care provided to those who need protection under state mental health legislation and in particular state-run settings, including:
  - i. Providing assessment, treatment and support in clinical services and related review and advocacy services to those with severe mental illness who need the rights and protections of mental health legislation, as well as related reporting requirements under safety and quality regarding restrictive interventions; and
  - ii. Managing the provision of mental health and suicide prevention care in youth and adult justice settings, for children in out of home care, and state funded education settings.
- (g) Providing funding to ACCHS for specific state programs and services.
- (h) Working with Registered Training Organisations on the mental health and suicide prevention trained by the vocational education sector, including workforce planning and student placements.
- (i) State specific mental health and suicide prevention research.
- (j) Collecting and managing state-based mental health and suicide prevention data, including surveys.

## Shared roles and responsibilities

- 41. All Australian governments have a shared responsibility to ensure equitable access to effective mental health and suicide prevention services for all people living in Australia. This responsibility falls across the mental health spectrum, spanning across sectors, jurisdictions and across government and non-government entities (as set out at Schedule A - Improving Mental Health and Preventing Suicide Across Systems).
- 42. Promoting the best possible mental health and wellbeing outcomes for all people living in Australia is a whole-of-government effort across the lifespan, commensurate with age and developmental needs. This includes the delivery of acute, recovery and rehabilitation health services, trauma informed care, preventative and early intervention programs, funding non-government organisations and privately delivered services.
- 43. The Parties affirm their shared responsibility to address existing gaps over time in the funding and delivery of new and additional community-based mental health services to support equitable access to treatment, care and support for people experiencing mental illness and psychological distress.
- 44. The Parties agree to work together across areas of established responsibility to integrate systems and services so that consumers, families and carers experience seamless treatment, care and support.
- 45. All governments have a responsibility to support priority populations (refer Clause 111 – Priority Populations) who are at higher risk of mental illness and/or suicide, due to experiencing vulnerability caused by social, economic, and/or environmental circumstances.
- 46. In line with the NHRA, the Commonwealth and the states are jointly responsible for:
  - (a) provision of their share of funding through the NHRA for eligible activities;

- (b) determining funding policy and exploring innovative models of care in the national funding model;
- (c) working together on policy decisions or areas of the system that impact on each other's responsibilities; and
- (d) establishing and maintaining nationally consistent standards for mental health and suicide prevention care, policy, planning and reporting. This includes the development of national standards and strategies in line with quality and safety standards.

47. Under this Agreement, the Commonwealth and the states agree to be jointly responsible for:

- (a) Undertaking mental health promotion, prevention, early intervention and social and emotional wellbeing programs, suicide prevention, stigma reduction and digital information and clinical services including help/crisis lines.
- (b) Supporting better integrated service planning and care coordination at a regional level, accompanied by accountability mechanisms and reporting.
- (c) Undertaking mental health workforce planning, including national workforce standards, training and accreditation requirements, student support and placement and supervision availability, noting there is a shared responsibility to ensure a sustainable, sufficient and appropriately skilled mental health workforce.
- (d) Improving system capacity to respond to people who are at risk of suicide, experiencing suicidal distress or crisis or following a suicide attempt. This includes working together to focus on prevention and early intervention, improving leadership to increase integration, prioritising lived experience knowledge, using data and evidence to drive outcomes and increasing the workforce and community capability.
- (e) Providing and/or funding of suicide prevention, early intervention, aftercare and postvention programs which reflect and respond to local needs and circumstances.
- (f) Continuing to fund and provide some mental health and suicide prevention services, and prevention, wellbeing, and early intervention services, beyond the health sector, including to and from health sector services (e.g. justice, education, disability services, housing and homelessness services etc).
- (g) Psychosocial support services for people who are not supported through the NDIS. including working together to develop and agree future psychosocial support arrangements (including roles and responsibilities).
- (h) Co-designing place-based approaches at a local level with affected communities ensuring:
  - i. The voices of people with lived experience are embedded in the planning, design and evaluation of services to enable person-centred care that addresses the needs of priority populations and rural, regional and remote communities.
  - ii. Rural, regional and remote areas where there is limited access to health and related services have new models of care, or refinement of existing models of care, developed to address equity of access and improve outcomes for that local community.

- (i) As per Clause 110 [refer clause for Aboriginal and Torres Strait Islander commitments under Priority Populations], a shared commitment for all Australian governments to contribute to the National Agreement on Closing the Gap. This includes:
  - i. contributing to closing the gap in Aboriginal and Torres Strait Islander peoples' disadvantage and life expectancy and achieving the Closing the Gap targets, including a significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander peoples towards zero (Target 14);
  - ii. empowering Aboriginal and Torres Strait Islander peoples to share decision-making authority with governments through formal partnership arrangements;
  - iii. building a strong, sustainable community-controlled sector to meet the needs of Aboriginal and Torres Strait Islander people across the country;
  - iv. ensuring all services funded by Australian governments are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander peoples';
  - v. ensuring Aboriginal and Torres Strait Islander peoples' have access to, and training and support to use, locally relevant data and information to set and monitor the implementation of efforts to close the gap, their priorities, and drive their own development.
- (ii) A commitment for all Australian governments to make the physical health of people living with mental illness a priority at all levels. The Parties reaffirm their commitment to the principles of Equally Well—The National Consensus Statement for improving the physical health and wellbeing of people living with mental illness in Australia.

## PART 4 – GOVERNANCE ARRANGEMENTS

### Enforceability of this Agreement

- 48. The Parties do not intend any of the provisions of this Agreement to be legally enforceable. However, this does not lessen the Parties' commitment to this Agreement.
- 49. The Commonwealth Department of Health will be responsible for ongoing administration of this Agreement.

### Publication

- 50. This Agreement and any Schedules will be published on the Federal Financial Relations website and remain there for the life of this Agreement. Any subsequent changes to this Agreement will also be published on the website.

### Governance and Implementation

- 51. The Parties agree that governance mechanisms established for this Agreement will align with, and not duplicate, existing structures wherever possible and will clearly align with priorities identified by Health Ministers and Mental Health Ministers, and Health Chief Executives and Mental Health CEOs (where relevant).
- 52. This Agreement will be implemented through the following mechanisms:

- (a) Health Ministers and relevant Mental Health Ministers from all jurisdictions, through an appropriate existing mechanism such as the Health Ministers Meeting, will collectively maintain responsibility for this Agreement and provide a forum for resolution of issues as required, with oversight from First Ministers, including through the National Cabinet as requested. Health Ministers and/or Mental Health Ministers will provide implementation updates to the National Cabinet as required.
  - (b) Commonwealth and the State Health Chief Executives, and Mental Health CEOs where relevant, will have responsibility and accountability for the implementation of this Agreement including regular reporting to Health and Mental Health Ministers on implementation, key risks and issues. The Health Chief Executives and Mental Health CEOs where relevant can delegate implementation functions to Mental Health Senior Officials as required.
  - (c) A group of nominated Mental Health Senior Officials (HSO) will report to Health Chief Executives, and Mental Health CEOs where relevant, on:
    - i. key risks and implementation issues
    - ii. new and emerging mental health and suicide prevention policy developments
    - iii. any governance, policy or funding issues with this Agreement that should be brought to the attention of relevant Ministers for consideration and decision prior to the final review
    - iv. the benefits and lessons learned from implementation, and
    - v. escalate issues for resolution that cannot be resolved at the senior officials' level.
  - (d) The HSO membership will be nominated by each jurisdiction and will include senior officials with responsibility for mental health and suicide prevention policy, programs and other relevant clinical expertise as required to support implementation of this Agreement.
53. At the discretion of Health Chief Executives, and Mental Health CEOs where relevant, and in line with Clause 51 [first clause in Governance and Implementation], the HSO may establish time-limited Working Groups to assist with implementation of this Agreement, to progress key priority areas.
54. Where required to support implementation of reforms through this Agreement, the Parties will engage and collaborate with other relevant national and jurisdictional mental health and suicide prevention bodies who are accountable to Government, such as the National Mental Health Commission (NMHC), the AIHW, state or territory mental health commissions, national Aboriginal and Torres Strait Islander leadership bodies, and other relevant bodies. The Parties will also undertake targeted consultation with a range of experts and non-government organisations as required to support implementation of this Agreement.
55. To ensure a people-centred mental health and suicide prevention system for all people living in Australia the Parties commit to ensuring people with lived experience of mental ill health and/or suicide and their families and carers are consulted throughout implementation of this Agreement. The Parties will seek advice and provide opportunities for people with lived experience of mental health and/or suicide, other experts including representatives for the priority populations identified in Clause 111 [refer Priority populations list], and community



groups to influence matters of service design, planning, implementation, evaluation, data and governance.

## Delegations

56. The Parties may delegate monitoring and reporting of progress on reform activities under this Agreement to appropriate Commonwealth and state officials, such as the HSO.
57. Commonwealth and State Treasurers may authorise Ministers with responsibility for mental health and suicide prevention to amend this Agreement.

## Variation of this Agreement

58. This Agreement may be amended at any time by agreement in writing by all Commonwealth and State Ministers with portfolio responsibility for mental health and suicide prevention, and approval from the Council on Federal Financial Relations (CFFR). The National Cabinet may also require approval of amendments if they request. Prior to any amendment, the Parties agree to notify the Council on Federal Financial Relations and comply with any advice provided.
59. Schedules may be amended at any time by agreement in writing by all Commonwealth and State Ministers with portfolio responsibility for mental health and suicide prevention (or portfolio responsibility for other policy areas as relevant to each Schedule), including the Implementation Plans to this Agreement. If planned amendments may change the nature of the Schedule or involve significant changes to its associated funding, the Parties agree to notify CFFR prior to finalising these amendments and comply with any advice provided.
60. A Party to this Agreement may terminate their participation in this Agreement at any time by notifying all the other Parties in writing.

## Dispute resolution

61. Any Party may give notice to other Parties of a dispute under this Agreement.
62. Officials of relevant Parties will attempt to resolve any dispute in the first instance.
63. If a dispute cannot be resolved by officials, it may be escalated to the relevant Ministers.

## PART 5 – REVIEW OF THIS AGREEMENT

64. The Parties will jointly review the effectiveness of this Agreement in delivering its agreed objectives, outcomes and outputs. This Agreement will include a final review.
65. The final review of this Agreement will be conducted by an appropriately skilled and qualified independent third party and agreed by Health Chief Executives.
66. Terms of reference for the final review will be jointly developed by the Parties.
67. The cost of the final review will be shared by the parties, with 50 per cent of the cost to be covered by the Commonwealth and 50 per cent to be collectively covered by the States, upon mutual agreement of the scope and cost of the review.
68. The Parties will collectively develop a submission, for endorsement by Health Chief Executives, for the midpoint review of the NHRA, due to be completed by December 2023. In particular, the

submission will consider any impacts of the NHRA cap on jurisdictions' expenditure in mental health and suicide prevention, the benefits and lessons from implementation, and whether there are any gaps or duplication between the two agreements.

## Final Review

69. The final review will assess if this Agreement has met the stated objectives, outcomes and outputs it has set out to achieve. The report will be provided to all Parties by June 2025.
70. At a minimum, the final review should also consider:
  - (a) The effectiveness of the reforms to achieve the objectives and outcomes of this Agreement;
  - (b) Whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes;
  - (c) Effectiveness of the administration of this Agreement;
  - (d) Effectiveness of reporting and governance arrangements for this Agreement;
  - (e) Applicability of the roles and responsibilities established in this Agreement; and
  - (f) Other matters as agreed by Health Chief Executives, Health Ministers and/or Mental Health Ministers.
71. The report for the final review will be made publicly available by the Commonwealth within three months of completion, unless Parties agree it is not reasonable, appropriate or practical to do so at the time.
72. The final review will inform the development of a new National Mental Health and Suicide Prevention Agreement beyond 30 June 2026.

## PART 6 – REPORTING

73. Reporting requirements for this Agreement aim to minimise additional reporting burden wherever possible.
74. The Parties agree to jointly be accountable for reporting on the planning and implementation of this Agreement and relevant Schedules, and to coordinate and align reporting wherever possible.
75. The Parties agree to develop joint Commonwealth-State implementation plans within the first twelve months of signing this Agreement, with subsequent annual review and updates to monitor ongoing implementation and progress.
76. The Parties agree to produce Annual Jurisdiction Progress reports against the implementation plans by 31 August each year, commencing 31 August 2023, in consultation with key stakeholders involved in implementing the initiatives.
77. Consistent templates and guidance for the implementation plans and Jurisdiction Progress Reports will be developed and agreed by all Parties. The reports will include both qualitative and quantitative elements, incorporating priority key performance indicators as relevant and appropriate as identified in Annex B.

78. Annual Jurisdiction Progress Reports will be consolidated into a National Progress Report, which will be finalised and endorsed by Health Chief Executives, and Mental Health CEOs where relevant, and provided to Health Ministers and Mental Health Ministers by 30 November each year, commencing 30 November 2023.
79. The annual National Progress Report will be made publicly available by the Commonwealth within three months of completion, unless Parties agree it is not reasonable, appropriate or practical to do so at the time.

## PART 7 – DATA AND EVALUATION

80. The Parties recognise that comprehensive, accurate and accessible information is critical to mental health and suicide prevention system reform.
81. The Parties recognise the commitment made under the *Intergovernmental Agreement on Data Sharing between Commonwealth and State and Territory governments*, which commits all parties to share public sector data as a default position where it can be done securely, safely, lawfully and ethically. The Parties also recognise the role of whole of government data activities outlined in Schedule A [refer Schedule A - Improving Mental Health and Preventing Suicide Across Systems].
82. The Parties commit to continue collaborating to build the data and systems needed to understand and improve:
  - (a) Population mental health and wellbeing.
  - (b) The quality, safety and effectiveness of the mental health and suicide prevention system.
  - (c) Evaluation, transparency, reporting and accountability.
  - (d) Progress against the National Agreement on Closing the Gap commitments, including Outcome 14 (Aboriginal and Torres Strait Islander people enjoy high levels of social and emotional wellbeing), and Target 14 (significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander peoples towards zero).
  - (e) Mental health and suicide prevention workforce planning.
83. The Parties agree to:
  - (a) Monitor and evaluate the mental health and suicide prevention system, including activities in this Agreement and associated Schedules, against the National Mental Health Performance Framework 2020 and future editions or other nationally agreed frameworks.
  - (b) The principles and priorities outlined in the National Mental Health and Suicide Prevention Information Development Priorities, Third Edition and future editions.
84. To oversee this work, the Parties agree to establish an appropriate governance forum, reporting to the HSO, with input from people with lived experience of mental illness and/or suicide and Aboriginal and Torres Strait Islander peoples that will:
  - (a) Agree on authorising frameworks and systems for data sharing and linking.

- (b) Improve national consistency in Commonwealth, state and territory data collections, and agree minimum data specifications for jointly funded programs.
  - (c) Agree appropriate measurement and monitoring methodologies, including metrics for priority Key Performance Indicators (KPIs), that support evaluation of services and the mental health system against agreed objectives and outcomes.
  - (d) Provide technical advice on other data and outcomes activities, including data for the National Mental Health Service Planning Framework.
85. The Parties acknowledge the strong alignment between the activities outlined in this Agreement and those reforms agreed to within the NHRA (including but not limited to *Enhanced Health Data*), and commit to collaborate and share learnings between these reforms to support and strengthen common activities and products.
86. The Parties agree the priority areas for action are to:
- (a) Improve data collection and data sharing, balanced with a focus on reducing burdensome and duplicative data collection, sharing and reporting.
  - (b) Support national data linkage and sharing of linked data, for use in policy, planning, commissioning, system management, evaluation and performance reporting.
  - (c) Improve reporting and transparency and drive system improvement.
  - (d) Build an evidence base that sustains ongoing system improvement.
87. The Parties seek to maximise the value of using data to improve outcomes for the Australian community in a manner that maintains public trust and adheres to the *Privacy Act 1988*, Australian Privacy Principles and other relevant Commonwealth, State and Territory legislation.

## Improve data collection and data sharing

88. The Parties, through the governance forum, agree to:
- (a) Maintain and improve measurement of individual, at-risk cohorts, and population mental health status and the prevalence of mental disorders.
  - (b) Develop and maintain national datasets and resources (see Annex A) to enable monitoring and evaluation of mental health and suicide prevention services, including jointly funded programs delivered through this Agreement.
  - (c) Prioritise the collection of data required for monitoring and evaluating progress against the objectives of this Agreement and associated Schedules, including jointly funded services, and determining performance against KPIs.
  - (d) Streamline the collection and management of existing datasets to minimise collection burden, reduce duplication and improve national consistency. Policies will minimise service delivery organisations having to report the same information multiple times.
  - (e) Share agreed up-to-date data items, between governments and with commissioning organisations and mental health and suicide prevention service providers, including non-government providers. Data items to be shared, and frequency of sharing, will be agreed through the governance forum.

- (f) Share data with as much geographic and demographic detail as possible according to the “Five Safes <sup>1</sup>” principles.
  - (g) Establish a governance framework and technical systems to enable data sharing, and commence agreed routine data sharing, by the end of the second year of this Agreement.
  - (h) Once data sharing is enabled in accordance with Clause 88(g), share agreed data items quarterly, and agree to more frequent sharing where required.
89. The States will continue to collect and share state and territory delivered mental health service data, including hospital, specialised mental health services and other mental health program data, and consumer outcome data, and continue to develop and refine those collections to improve system coverage and national consistency where not over-burdensome or duplicative.
90. The Commonwealth will collect and share data on Commonwealth funded mental health and suicide prevention services, including Primary Health Network (PHN) services and consumer outcome data, Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) data, and continue to develop and refine those collections to improve system coverage and national consistency.
91. The Commonwealth will provide funding to maintain national data infrastructure for national data collections, including but not limited to the Mental Health National Minimum Datasets (NMDS). States will fund the development, collection, and supply of data from their jurisdictions referred to in Clause 89 [two clauses above] into the NMDS.

## **Support national data linkage and sharing of linked data, for use in policy, planning system management, evaluation and performance reporting**

92. The Parties agree to:
- (a) Establish processes that enable the routine linking of national data, including mental health data linked with data from other health, human services (including education, housing and justice), government and survey datasets, to the maximum extent allowable by relevant national and state legislation.
  - (b) Establish a governance framework and technical systems to enable data linkage by a suitably accredited linkage authority or authorities.
  - (c) Consider emerging developments in national data sharing or linkage solutions that may assist in facilitating a national data asset.
  - (d) Ensure that any data linkage preserves privacy and confidentiality and abides by relevant Commonwealth and state and territory legislation.
  - (e) Consider the amendment of legislation to enable data linkage where regulatory or legislative barriers to data sharing and/or linkage are identified as soon as possible following commencement of this Agreement.
  - (f) Develop a strategy for safe storage and approved use of linked data. The strategy will explore the best combination of a national data asset, to support a truly national view,

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<sup>1</sup> Safe People; Safe Projects; Safe Settings; Safe Data; Safe Outputs.

with local storage of linked data to support responsive local analysis by states and territories.

- (g) Develop frameworks and procedures for researchers and other organisations not party to this Agreement to seek access to linked data for approved purposes.
93. The Commonwealth will provide funding to conduct national data linkage and facilitate safe access to national linked data assets by authorised analysts, where held by the Commonwealth.
94. The Commonwealth will ensure:
- (a) A subset of data for agreed priority items is supplied, linked and available to the Parties for analysis within the first 18 months of this Agreement, subject to the Parties supplying the required data within the first twelve months of this Agreement.
  - (b) Broader linked data will be available to the Parties within 30 months of this Agreement.
95. The States will provide funding in their own jurisdiction to ensure the agreed priority items are supplied, and available to the Parties for analysis within the first twelve months of this Agreement.

## **Increase reporting and transparency, and drive system improvement**

96. The Parties agree to:
- (a) Develop and report on a range of indicators, outcomes measures and KPIs which reflect the objectives and goals of this Agreement (Annex B) including having a whole-of-government focus where relevant.
  - (b) Develop specific KPIs for vulnerable cohorts and regional, rural and remote areas to ensure that outcomes for these groups are a priority focus.
  - (c) Work together to develop data collection requirements, indicator specifications, and analysis processes to enable reporting on the KPIs.
  - (d) Develop a detailed technical implementation plan for the agreed KPIs within the first twelve months of this Agreement and commence reporting against KPIs in the second year of this Agreement.
  - (e) Develop processes for reporting of detailed, locally relevant, and timely data to service funders, service providers, and the public. Wherever possible, data should be reported quarterly, with detail provided for local regions (Statistical Area Level 3 or equivalent) and provider organisations.

## **Strengthening evaluation culture to measure the impact of programs**

97. The Parties will work together to evaluate jointly funded programs implemented under the associated Schedules as per the clauses outlined in the Schedules.
98. The Parties agree that a robust information and evidence base is needed to improve programs, policies, and outcomes for people with mental health issues, including those at risk of or experiencing suicidal distress, and their families and carers. The Parties will support improvements across the whole mental health and suicide prevention system by:

- (a) Supporting use of available data for evaluations, including linked datasets, national priority KPIs (Annex B) and where possible, work towards consistent outcome measures appropriate to the program.
  - (b) Collaborating to conduct system evaluation to assess the effectiveness of the mental health and suicide prevention system.
  - (c) Making investment decisions that are appropriately informed by evaluation, while supporting new and innovative initiatives to be trialled and tested.
  - (d) Considering the approach to evaluation outlined in Annex C when assessing government investment in mental health and suicide prevention where appropriate and possible, including nationally consistent approaches to measuring effectiveness and efficiency and using evaluation to inform investment decisions.
99. The Parties agree to share evaluation findings:
- (a) Between government and with commissioning organisations, service providers and the public where appropriate.
  - (b) According to guideline to be developed and agreed by HSO within six months of this Agreement.
100. The Parties agree to contribute funding to engage an external consultant to undertake a costings exercise for the development of a national evaluation framework. The evaluation framework must ensure nationally consistent evaluation methodologies and be supported by an inter-jurisdictional working group.
101. Subject to all Parties agreeing to co-contribute to the cost of its development, the national evaluation framework will be developed within the first twelve months of this Agreement.
102. The Parties, through the governance forum, will:
- (a) Develop a national evaluation framework including nationally consistent evaluation methodologies within the first twelve months of this Agreement.
  - (b) Develop national guidance on domains and measures to assess effectiveness and efficiency of programs within the second year of this Agreement and support the use of these domains and measures (Annex C).
  - (c) Provide coordination of national mental health and suicide prevention program evaluation, and advocate for a more robust and consistent evaluation methodology.
  - (d) Ensure that all Parties meet their program evaluation commitments as outlined in the Schedules.
  - (e) Provide advice to Health Chief Executives and the HSO on priority aspects of the mental health and suicide prevention system requiring evaluation.
  - (f) Facilitate the sharing and publication of evaluation findings according to the guidelines agreed by HSO.
  - (g) Facilitate progress reporting for this Agreement [see Part 6 - Reporting]
  - (h) Consider a role for the National Mental Health Commission in monitoring and enabling the evaluation activities in this Agreement.

103. Health Chief Executives and Mental Health CEOs will consider proposals put forward by the Parties for national evaluations of the mental health and suicide prevention system or programs of national significance and determine appropriate cost sharing mechanisms for any supported proposals.

## **PART 8 – FINANCIAL ARRANGEMENTS**

### **Financial contributions**

104. Financial contributions will give effect to initiatives as set out in Schedules to this Agreement.

### **Maintenance and Duplication of effort**

105. All Parties will maintain or increase their existing levels of investment in mental health and suicide prevention over the life of this Agreement.
  - (a) All Parties will ensure minimum annual funding in their jurisdictional equivalent to 2018-19 recurrent expenditure on mental health and suicide prevention services. reporting by the AIHW.
  - (b) The Commonwealth funding contribution to mental health services in the National Health Reform Agreement (NHRA) will be attributed to the Commonwealth, and not the state or territory that expended the NHRA funding when accounting for maintenance of effort in this Agreement.
106. Investment information as described in Clause 105 [Maintenance of effort] will be captured by both the Commonwealth and states from the commencement of this Agreement and reported in annual Jurisdiction Progress reports and National Progress Report. The purpose of collecting this information is to identify any gaps or duplication in mental health and suicide prevention expenditure.
107. In line with the provisions at A9 and A10 of the NHRA, the Commonwealth will not fund patient services through the NHRA if the same service, or any part of the same service, is funded through this Agreement or any other Commonwealth program except as specifically exempt.
108. Similarly, the Commonwealth will not fund through other Commonwealth programs any services that are funded through this Agreement.

## **PART 9 – NATIONAL PRIORITIES**

### **Priority Populations**

109. The mental health and wellbeing needs of individuals are different across life stages and dependent on a range of personal and social factors. This Agreement recognises that collaboration is required across sectors, jurisdictions and governments to deliver responses that effectively meet the mental health and suicide prevention needs of different population groups, appropriate to age and development needs.
110. The Parties commit to work in partnership with Aboriginal and Torres Strait Islander peoples, their communities, organisations and businesses to improve Aboriginal and Torres Strait Islander



mental health, social and emotional wellbeing, and access to, and experience with, mental health and wellbeing services. In the implementation of this Agreement, the Parties will:

- (a) Support the implementation of the Gayaa Dhuwi (Proud Spirit) Declaration.
- (b) Ensure alignment with the National Agreement on Closing the Gap and associated Implementation Plans. This includes the reforms outlined at Clause 49(i) [refer to the clause re: commitment to Closing the Gap reforms]:
- (c) Ensure alignment with other relevant national commitments and agreements for Aboriginal and Torres Strait Islander mental health and suicide prevention including the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, and the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing.
- (d) Recognise and enable leadership of Aboriginal and Torres Strait Islander peoples throughout the mental health, wellbeing and suicide prevention system.
- (e) Collaborate with ACCHS, organisations and other service providers wherever possible to improve Aboriginal and Torres Strait Islander access to mental health, wellbeing and suicide prevention services and deliver services in a culturally and locally appropriate manner.

111. Implementation of initiatives under this Agreement or associated Schedules will consider and support the mental health and wellbeing of the following priority populations groups, at a minimum, noting that a person may fall into one or more of the below groups:

- (a) Aboriginal and Torres Strait Islander peoples (refer Clause 110 relating to Aboriginal and Torres Strait Islander people above)
- (b) LGBTQIA+SB people
- (c) Culturally and linguistically diverse communities and refugees
- (d) People experiencing homelessness or housing instability
- (e) Children and young people, including those in out-of-home care
- (f) Older Australians (over 65, or over 50 for Aboriginal and Torres Strait Islander peoples)
- (g) People living in regional, rural and remote areas of Australia
- (h) People experiencing or at risk of abuse and violence, including sexual abuse, neglect and family and domestic violence
- (i) People with a disability
- (j) Australian Defence Force members and veterans
- (k) People experiencing socioeconomic disadvantage
- (l) People who are (or were previously) in contact with the criminal justice system

- (m) People with complex mental health needs, including people with co-occurring mental health and cognitive disability and/or autism.
  - (n) People with harmful use of alcohol or other drugs, or people with substance use disorders
  - (o) People who have made a previous suicide attempt or who have been bereaved by suicide.
112. It is also recognised that not everyone who dies by suicide has lived experience of mental health issues. Broad suicide prevention policy response is needed to promote the protective factors, address the economic, environmental and social drivers of distress, and support social, emotional and cultural wellbeing.

## Stigma Reduction

113. The Parties commit to reducing stigma and discrimination for those affected by mental ill-health by:
- (a) responding proactively and providing leadership when stigma or discrimination is seen
  - (b) empowering consumers and carers to speak about the impacts of stigma and discrimination; and
  - (c) contributing to promotion and normalisation of help seeking.
114. Parties will work in partnership to develop the National Stigma and Discrimination Reduction Strategy, agreed by the National Cabinet. Parties will work together to consider and implement relevant actions of the National Stigma and Discrimination Reduction Strategy once finalised.

## Safety and Quality

115. The Parties reaffirm their joint commitment to making safety and quality central to mental health and suicide prevention service delivery and will collaborate to establish and maintain nationally consistent standards for mental health and suicide prevention care, policy, planning and reporting. This includes the development of national standards and strategies in line with quality and safety standards.
116. The Parties agree to implement and monitor the *National Guidelines to improve the co-ordination and treatment of people with severe and complex mental illness* to improve the co-ordination and treatment of people with severe and complex mental illness.
117. The Parties agree to work collaboratively with the Australian Commission on Safety and Quality in Health Care to uphold and promote existing safety and quality standards for mental health and suicide prevention, and to undertake continuous review of existing standards and/or development of new safety and quality standards to continually improve quality, safety and capacity in the Australian mental health and suicide prevention system.

## Gaps in the System of Care

118. This Agreement recognises that the Parties have shared responsibility for addressing gaps in the system of care and that all Governments are committed to improving the experience of mental health and suicide prevention care for all people living in Australia. The Parties will collaborate to give this effect by:

- (a) Exploring appropriate policy solutions, develop new models of care and/or review existing models of care, and jointly plan agreed reform activities where appropriate and as relevant, in relation to people experiencing mild to moderate mental illness or psychological distress.
  - (b) Partnering to deliver accessible and affordable community-based treatment and care for people experiencing mild to moderate and severe and enduring mental illness or psychological distress.
  - (c) Working together to support better integration across disciplines, services and the mental health and suicide prevention system, including improved:
    - i. vertical integration between tertiary, community and primary care services in a geographical region,
    - ii. accessibility of secondary consultation and review by tertiary services to those presenting to local or community mental health and suicide prevention services; and
    - iii. engagement and coordination by primary care services.
  - (d) Better information sharing.
  - (e) Provision of more seamless care, including embedding:
    - i. mechanisms to bridge the gap between primary, community, specialist and acute care settings; and
    - ii. more appropriate interventions across the spectrum of presentations and need.
  - (f) Prioritising and delivering whole of person, mental health-focused prevention and early intervention services. These services should be easily accessible and responsive so they can be accessed in a timely manner. This will reduce future presentations at emergency departments and acute services and will likely reduce overarching health system costs and generate economy-wide benefits.
119. The Parties recognise that variation and flexibility is required across jurisdictions to address funding and service gaps for consumers due to local and geographical factors. Specific reform activities that allow for jurisdictional variation are described in the bilateral agreements as Schedules to this Agreement.
120. To improve effectiveness, access and equity of care, the Parties agree that reform activities implemented under this Agreement will:
- (a) be easy to identify and access.
  - (b) be culturally appropriate and accessible.
  - (c) focus on the consumer and be transparent on process, wait times and out of pocket costs.
  - (d) be available in varied geographic locations, including rural, regional remote areas.
  - (e) be accessible to priority cohorts (refer Clause 111 for priority populations).

121. Parties agree that assessing outcomes are required to measure the effectiveness of reform (refer to Annex B).

## Suicide Prevention and Response

122. This Agreement recognises that the Parties have a shared responsibility for suicide prevention and that collaboration is required to provide a more effective system-based approach to meet the needs of people at risk of suicide.
123. The Parties recognise that suicide prevention is complex as there are many contributing factors which can increase an individual's risk of suicide including behaviours, environmental characteristics and psychosocial factors such as a history of self-harm, relationship problems, legal issues, financial pressures, unemployment or homelessness. The Parties recognise that a whole-of-government approach is required, and that many enablers of suicide prevention reform are beyond the influence of the health system alone and span all aspects of where people live, work, learn and socialise (Refer to the Whole of Government priorities attached as a Schedule to this Agreement).
124. The Parties agree, in collaboration, to:
- (a) Seek to reduce suicide deaths, suicide attempts, and self-harm towards zero.
  - (b) Progressively meet the different needs of identified priority population groups and increase accessibility to services through evidence informed care and targeted approaches, such as dedicated services or enhancements to existing services.
  - (c) Develop suicide prevention services and programs in collaboration with communities and people with lived experience to identify gaps in service provision and to gain insights into individual experiences.
  - (d) Improve joint regional planning for suicide prevention to drive development of evidence-based services in areas of identified need to address gaps in service provision.
  - (e) Improve the quality of suicide prevention services by establishing standards either developed specifically for the program or by an external organisation to improve outcomes of service provision nationally.
  - (f) Incorporate suicide prevention training into service modelling to develop skills for building capacity and fostering suitably skilled workers that are empathetic to the needs of people in suicidal distress.
  - (g) Build competency within the suicide prevention workforce, including the peer workforce, through evidence informed training.
  - (h) Seek to avoid or minimise service gaps, fragmentation, duplication, and inefficiencies in joint suicide prevention activities.
125. The Commonwealth will establish the National Suicide Prevention Office (NSPO) to lead a national whole-of-government approach to suicide prevention. The role of the NSPO will be determined in collaboration with the States. The Parties agree to avoid duplication of effort with existing State suicide prevention organisational structures and work in partnership to improve suicide prevention.

## Psychosocial Supports Outside of the NDIS

126. The Parties recognise that psychosocial supports for people with mental illness and associated functional impairment are an important part of a well-equipped mental health service system. Supports provided through the NDIS are out of scope for this Agreement.
127. The Parties will work together to develop and agree future psychosocial support arrangements (including roles and responsibilities) for people who are not supported through the NDIS.
128. To inform future arrangements, the Parties agree to undertake further analysis of psychosocial supports outside of the NDIS, to commence within the first twelve months from the commencement of this Agreement and be completed as soon as possible within the first two years of this Agreement. This work will include:
  - (a) Developing and agreeing a common definition for psychosocial support that builds on the work already being undertaken through the National Mental Health Service Planning Framework, or other nationally agreed frameworks.
  - (b) Estimating demand for, compared to current availability of, psychosocial supports outside of the NDIS according to the agreed common definition. This will be achieved by:
    - i. Comprehensive state-based mapping of all current psychosocial support services outside of the NDIS, led by the States and supported by the Commonwealth;
    - ii. Sharing of appropriate and relevant data, including from the NDIS (subject to applicable NDIS legislation and associated definition of 'psychosocial disability'); and
    - iii. State-based analysis of the target cohort and demand for psychosocial supports outside of the NDIS, compared to current availability, to be jointly undertaken by the Parties through information sharing about funding, commissioning, services and clients.
129. The Parties agree that further clauses relating to future arrangements for psychosocial supports outside of the NDIS will be developed after the analysis work has been completed and attached to this Agreement as a Schedule.
130. To ensure continuity of psychosocial support services for Australians with severe mental illness and enable the sector to retain a skilled workforce, the Commonwealth and the States will maintain investments in current psychosocial support programs outside the National Disability Insurance Scheme while the further analysis work is undertaken.

## Regional Planning and Commissioning

131. The Parties agree to work together to strengthen regional planning and commissioning of mental health and suicide prevention and psychosocial services to provide person-centred care and place-based care.
132. The Parties recognise that strengthened regional planning and commissioning aims to drive better outcomes for communities by improving system integration and coordination; addressing gaps, duplication and fragmentation in services; and evidence-based decision making to inform future policy and planning strategies.

133. The Parties will work together within the first twelve months of this Agreement to develop national guidelines on regional planning and commissioning to provide enhanced direction that includes minimum national standards whilst recognising the unique requirements and needs in each jurisdiction and region.
134. The Parties acknowledge the unique strengths and challenges in each jurisdiction and region, and agree to support Primary Health Network (PHNs), Local Health Networks (LHNs) and other commissioning bodies to develop and/or strengthen Joint Regional Plans with an agreed terms of reference agreed by the Parties to improve how they work together to:
  - (a) Determine the needs of local communities, including identifying gaps, duplication and inefficiency, within their region based on evidence and data and consultation within their communities, including consumers and carers with lived experience representative of local communities;
  - (b) Plan, design and fund mental health care, suicide prevention and psychosocial supports to respond to the needs of local communities;
  - (c) Coordinate and integrate care across the stepped care model and support transition between mental health and non-health services; and
  - (d) Implement an agreed framework for ongoing monitoring, reporting and evaluation of regional plans.
135. The Parties acknowledge that models of regional planning and commissioning range from complementary service delivery and integration activities through to pooled funding and shared accountability arrangements. The Parties will determine planning and commissioning arrangements on a case by case basis to ensure that they are suited to local needs and will drive improved outcomes for consumers. These arrangements will align with planning cycles and build on existing arrangements.
136. The Parties will work together to assess and share evidence about the effectiveness of different models through testing and evaluating innovative planning and commissioning arrangements.
137. The Parties acknowledge the diversity of service delivery in local communities and regions, and that other organisations will be included in regional planning and commissioning arrangements as required. This includes non-government organisations (NGOs), Aboriginal Medical Services (AMSs), ACCHSs, and where appropriate, organisations delivering services that support the social and cultural determinants of mental health.
138. The Parties agree to support PHNs, LHNs and other state-based commissioning bodies to engage in regional planning and commissioning activities by:
  - (a) Allowing commissioning bodies to use mental health and suicide prevention funding with appropriate flexibility to respond to local needs, where aligned with joint regional plans;
  - (b) Ensuring funding is distributed based on patient and population need, and funding cycles provide for continuity of service, planning and alignment;
  - (c) Improving the transparency of mental health and suicide prevention services spending and outcomes delivered by:

- i. Establishing shared reporting through development of Joint Regional Plans and reported on through regional commissioning arrangements and annual Jurisdiction Progress reports outlined in Reporting arrangements for this Agreement;
    - ii. Establishing shared accountability across levels of Government under the governance structures of this Agreement
  - (d) Streamlining reporting and accountability requirements for service delivery organisations;
  - (e) Ensuring integrated governance and planning mechanisms at the regional level that have genuine representation from the communities they serve and enable appropriate oversight and accountability to governments, including cross representation on PHN and LHN (or other State commissioning bodies) governance and decision-making structure(s) wherever possible. This would include regular meetings (but no less than twice per year) between PHN/LHN (or other State commissioning bodies) groupings to discuss development and implementation of joint regional plans.
139. The Parties agree to use the National Mental Health Service Planning Framework (NMHSPF), and/or other tools appropriate for their local population, to support regional planning and commissioning.
140. The Parties acknowledge the strong alignment with reforms and agreed actions within the NHRA (including but not limited to *Joint Planning and Funding* and *Paying for value and Outcomes*) and commit to collaborate and share learnings between these reforms to support and strengthen common activities and products. This includes planned efforts to support bilateral state-wide planning between PHNs and state and territory organisations.
141. The Parties acknowledge that reform activities outlined under this Agreement will not limit Parties' ability to pursue other reforms or activities related to commissioning outside of the mental health system.

## National Consistency of Initial Assessment and Referral

142. The Parties commit to work toward national consistency of initial assessment and referral to:
- (a) Improve integration of mental health and suicide prevention services so that consumers experience a consistent and seamless service system regardless of which level of government is funding and delivering services;
  - (b) Promote consistent, evidence-based clinical decision making across the mental health and suicide prevention system;
  - (c) Minimise the assessment burden on individuals;
  - (d) Provide treatment and care appropriate to individual needs and circumstances,
  - (e) Promote consumer choice; and
  - (f) Promote optimal use of available mental health and suicide prevention services and workforce.
143. The Parties agree to work together to determine the suitability of the Commonwealth Initial Assessment and Referral (IAR) Tool as a mechanism for improving consumer experiences and

outcomes, and to improve integration in and between services. The IAR Tool will be considered for use in both Commonwealth-funded and state-funded clinical settings, including interoperability with state-based intake and referral systems.

## Workforce

144. Workforce is a key enabler for the generational reforms being undertaken in Australia's mental health and suicide prevention system. Governments need to work together to build a mental health and suicide prevention workforce that is culturally safe and responsive to changing needs while ensuring that current shortages and maldistribution are addressed.
145. The Parties acknowledge that an appropriately skilled workforce, working collaboratively with consumers and carers across occupations, organisations and service settings is continually required to enhance mental health and suicide prevention service provision.
146. The Parties acknowledge that all Governments have a role in ensuring a skilled workforce is available across the health, education, skills and employment sectors to meet the mental health and suicide prevention needs of people living in Australia and that public-private partnerships across sectors are required to achieve this.
147. The Parties agree that there is a requirement for all Australian governments to collaborate at a regional level to jointly determine community needs and plan the response to those needs, including assessment of the required mental health and suicide prevention workforce.
148. The Parties agree that over time, additional resources will be required to support the attraction and retention of an appropriately skilled workforce, including overseas trained staff.
149. The Parties commit to support workforce development and sustainability across sectors, including those sharing the mental health and suicide prevention workforce (i.e. aged care, disability, alcohol and other drugs) and seek opportunities to address areas of thin markets (including rural, regional and remote settings).
150. In line with efforts already underway, the Parties will collaborate to develop the National Mental Health Workforce Strategy (Workforce Strategy) as a ten-year plan to grow, strengthen and support an appropriately skilled, flexible mental health and suicide prevention workforce, working within a recovery-oriented, integrated mental health system. The Workforce Strategy will consider the skills, supply and demand, distribution and structure of a broadly-defined mental health and suicide prevention workforce.
151. As part of development of the Workforce Strategy, Parties will work together to identify priority areas for action, by mid-2022 and work together to agree on the Workforce Strategy's implementation, including an annual review of priorities.
  - (a) The Workforce Strategy will be complementary to existing national workforce reforms and policies, such as the National Medical Workforce Strategy 2021-2031 and the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031.
152. The Parties agree to work together and in partnership with professional peak bodies, colleges and the education and training sector to address issues related to the mental health workforce and suicide prevention pipeline. Noting, roles and responsibilities may vary by profession and service setting.



153. Parties will support the governance and use of the NMHSPF and share program level and other data to achieve optimal workforce planning at the regional level.
154. All Parties will agree to work together to take action to increase the number of full-time equivalent (FTE) mental health professionals per 100,000 population (FTE rate) over the life of this Agreement for professional groups identified at Clause 159 [refer list of groups] and any other professions agreed upon by the Mental Health Workforce Senior's Officials group.

### **Workforce Attraction, Training, Retention, Optimisation and Distribution**

155. All Parties will jointly plan and implement workforce initiatives to attract, upskill, retain and optimally distribute and utilise mental health and suicide prevention workforce, guided by the Workforce Strategy, and in consultation with professional bodies, specialist colleges, and education and training institutions.
156. Parties will support the development of the new National Suicide Prevention Workforce Strategy to be developed by the NSPO, in accordance with the NSPA final advice.<sup>2</sup>
  - (a) The Suicide Prevention Workforce Strategy will include (but is not limited to) personnel from across government departments, social services, educators, employer groups, miscellaneous service providers, community-based organisations and other settings where individuals a risk of suicide may present.
157. The Parties agree that there will be an increase in effort to support the expansion of vocational undergraduate and post graduate scholarships, specialist training posts, and clinical placements across all settings (private and public, and acute and primary care) for mental health and suicide prevention professions with identified shortages, with a particular focus on sub-specialities in shortages, and on regional, rural and remote locations.
158. Parties will promote multidisciplinary care and the optimal utilisation and distribution of the mental health and suicide prevention workforce in accordance with agreed scopes of practices.
159. Parties agree that the following professions require immediate action by all governments to respond to the PC Report, address critical shortages and promote multidisciplinary care; or as specified in the Mental Health Workforce Strategy when finalised:
  - (a) Psychiatry
  - (b) Psychology
  - (c) Mental health Nursing
  - (d) Aboriginal and Torres Strait Islander mental health and suicide prevention workers
  - (e) Lived experience (peer) workforce
  - (f) Other relevant allied health professions

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<sup>2</sup> National Suicide Prevention Adviser – Connected and Compassionate. 4. Workforce and community capability <https://www.health.gov.au/sites/default/files/documents/2021/05/national-suicide-prevention-adviser-final-advice-connected-and-compassionate.pdf>

160. Detailed workforce planning in each jurisdiction will take into account the local context and regional variation.
161. Parties will collaborate to build the capacity of (including through education and training) the mental health and suicide prevention workforce to improve the experience of and outcome for priority populations as per Clause 111 [refer list of priority populations]. Parties will seek opportunities to grow and support the representation of Aboriginal and Torres Strait Islander peoples in the mental health and suicide prevention workforce, in effort to achieve population parity, through training, recruitment and retention strategies, and through supporting culturally safe workplaces.
  - (a) Parties agree to allocate a minimum number of scholarships, traineeships, clinical placements and employment placements that reflect the Aboriginal and Torres Strait Islander population in each jurisdiction for allocation, to Aboriginal and Torres Strait Islander peoples as first priority, over the life of this Agreement.
162. Parties will maintain their investment in the Mental Health Professional Online Development (MHPOD) platform over the life of this Agreement. The MHPOD platform will be enhanced by the lead jurisdiction, in partnership with the Parties, to ensure content aligns with best available evidence and is suitable for the full range of the mental health workforce. Victoria will continue to be lead jurisdiction.
163. Parties will work together to reduce stigma associated with working in the mental health and suicide prevention sector and promote the system as an attractive career option.
164. Parties will jointly commit to developing the broader human services workforce, who may have contact with clients experiencing mental or suicidal distress and/or ill health, suicidal ideation or crisis including by:
  - (a) Developing national guidelines for appropriate mental health and suicide prevention training of the broader human services workforce. Consultation should ensure the design, scope and content of guidelines builds on, rather than duplicates, existing material.
  - (b) Providing mental health and suicide prevention training and resources to the broader human services workforce.

## **PART 10 – WHOLE-OF-GOVERNMENT ACTION TO IMPROVE MENTAL HEALTH AND PREVENT SUICIDE**

165. The Parties recognise that improving mental health and preventing suicide requires a whole-of-government approach across and beyond the health portfolios, and that the enablers of mental health and suicide prevention reform are beyond the influence of the health system alone and span all aspects of where people live, work, learn and socialise.
166. The Parties acknowledge that mental health and suicide prevention reform requires:
  - (a) Whole-of-government recognition of the influence of social, economic, cultural and environmental factors on mental health and suicide prevention;
  - (b) Action across other government portfolios to enable a whole of system approach; and

(c) Investment in prevention and early intervention.

167. The Parties acknowledge that a whole-of-government approach:

- (a) Aims to address factors that impact mental ill-health and suicide risk across and beyond the health portfolio;
- (b) Will lead to improvement for individuals and communities that are not possible through delivery within the health portfolio alone;
- (c) Supports coordinated action on mental health and suicide prevention and represents potential cost savings and efficiency gains across service systems; and
- (d) Represents good public value, where return on investment is strong and there are broad economic benefits including enabling economic participation and enhancing productivity and economic growth.

168. The Parties agree to work together on the whole-of-government approach outlined in Schedule A.

The Parties have confirmed their commitment to this Agreement as follows:

*Signed for and on behalf of the Commonwealth of Australia by*



**The Honourable Josh Frydenberg MP**  
Treasurer of the Commonwealth of Australia

8 / 3 / 22

*Signed for and on behalf of the State of New South Wales by*

**The Honourable Matt Kean MP**  
Treasurer of the state of New South Wales

/ /

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Treasurer of the state of Victoria

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*Signed for and on behalf of the State of Queensland by*

**The Honourable Cameron Dick MP**  
Treasurer of the state of Queensland

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**The Honourable Mark McGowan MLA**  
Treasurer of the state of Western Australia

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*Signed for and on behalf of the State of South Australia by*

**The Honourable Rob Lucas MLC**  
Treasurer of the state of South Australia

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*Signed for and on behalf of the State of Tasmania by*

**The Honourable Peter Gutwein MP**  
Treasurer of the state of Tasmania

/ /

*Signed for and on behalf of the Australian Capital Territory by*

**Andrew Barr MLA**  
Treasurer of the Australian Capital Territory

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*Signed for and on behalf of the Northern Territory by*

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Treasurer of the Northern Territory of Australia

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11 / 04 / 2022

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24/02/2022

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Treasurer of the state of Western Australia

/ /

**Signed for and on behalf of the State of South Australia by**

*Rob Lucas*

\_\_\_\_\_  
**The Honourable Rob Lucas MLC**  
Treasurer of the state of South Australia

18 / 2 / 22

**Signed for and on behalf of the State of Tasmania by**

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Treasurer of the state of Tasmania

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Treasurer of the Northern Territory of Australia

/ /

**24 FEB 2022**

## SCHEDULE A: IMPROVING MENTAL HEALTH AND PREVENTING SUICIDE ACROSS SYSTEMS

*To have the greatest impact, mental health supports and suicide prevention must reach beyond the mental health system, and into the lives of people through their work, education, training, and engagement with government and support services. A proactive approach focused on prevention and early intervention – both early in life and early in the development of illness – can see improved outcomes for individuals and communities. A focus on mental health and suicide prevention across systems also provides an opportunity to support those who may not have otherwise presented to traditional mental health and suicide prevention services by providing additional pathways for early intervention and prevention.*

*As part of the National Agreement, Parties agree to work together to promote positive mental health, provide early intervention and prevention supports, and ensure that a focus on improving mental health and preventing suicide is embedded across all levels of government, areas of responsibility, and portfolios, during service design and policy development.*

*A focus on improving mental health and preventing suicide across systems will be particularly important as we manage both the immediate and long-term impacts of COVID-19. Responding to the COVID-19 pandemic represents a unique opportunity to strengthen mental health and suicide prevention efforts across government, with Commonwealth, State and Territory governments already prioritising investment in the sector. The Parties acknowledge the impact of COVID-19 on mental health and the risk of suicide, and commit to continue collective efforts to improve mental health and suicide prevention during and beyond the pandemic.*

*To focus efforts under this Agreement, the below priority areas have been identified, drawing on the final report of the Productivity Commission's Inquiry Report on Mental Health and the National Suicide Prevention Adviser Final Advice.*

### PART 1 – Mental health and suicide prevention across systems

1. The Parties commit to working together to pursue whole-of-government approaches to mental health and suicide prevention 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<sup>3</sup>, and justice** with a focus on the priority groups outlined in Clause 111 of the National Agreement.
  - a. As per Clause 55, the Parties commit to working with people with lived experience of mental illness or suicide and those who care for them to ensure their participation in the design, delivery and evaluation of services and programs.
  - b. As per Clause 110<sup>4</sup>, the Parties commit to working with Aboriginal and Torres Strait Islander peoples, their communities, organisations and businesses to improve access to and experiences of social and emotional wellbeing, and mental health and suicide prevention services, and to address Closing the Gap targets.

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<sup>3</sup> Child maltreatment refers to physical abuse, emotional abuse, sexual abuse, exposure to domestic and family violence and neglect.

- c. Whole-of-government data activities in this schedule will leverage existing efforts, will be done securely, safely and legally, and will be conducted in line with the principles of Part 7 – Data and Evaluation and the *Intergovernmental Agreement on data sharing between Commonwealth and State and Territory governments*. Existing data-sharing efforts will not be duplicated.
2. **Education** settings, including early childhood, primary, secondary and tertiary settings, provide a critical opportunity for prevention and early intervention. In line with existing work, where applicable, parties will work together, and with Education Ministers, to:
  - a. Identify and share best practice examples of mental health supports and suicide prevention across all education settings to encourage implementation of evidence-based approaches across jurisdictions.
  - b. Consider approaches to improve school aged children’s social and emotional wellbeing to align with work under the current National Schools Reform Agreement and to inform the next agreement. This could include developing guidelines to help inform jurisdictions’ selection of wellbeing programs in schools, and further work on wellbeing measurement data.
3. As **workplaces** provide a critical opportunity for prevention, early intervention and the provision of social and emotional wellbeing supports, Parties will work together to:
  - a. Implement approaches to improve the mental health and suicide prevention literacy and capability of public sector workforces, both to encourage Parties’ own workplaces to embed tools that support mental health capability, and to support frontline workers to identify and appropriately respond to distress.
  - b. Support and promote legislative reform for work-related psychological health to ensure psychological health and safety is as important in the workplace as physical health and safety. This includes:
    - i. Leveraging existing work on amending model Work Health and Safety Regulations as agreed by Work Health and Safety Ministers in May 2021 in response to the Model Law Review.
    - ii. Leveraging the model Code of Practice in Managing Psychosocial Hazards at Work being developed by Safe Work Australia.
    - iii. Working with the relevant intergovernmental forums (e.g. Safe Work Australia) to ensure consistency between employer education tools and guidance materials on creating mentally healthy workplaces and psychological health risk prevention and early intervention, that is adaptable for all business sizes.
    - iv. Collaborating to support the implementation of the Australian Government’s long-term strategy to improve workplaces outlined in the Roadmap for Respect, in response to the *Respect@Work: Sexual Harassment National Inquiry Report*, with parties collaborating to drive the implementation of measures in each

jurisdiction, in accordance with state and territory government responses to the report.

- v. Leveraging the work of the inter-jurisdictional First Responder Mental Health Working Group which is developing a national approach to workers' compensation arrangements for first responders with post-traumatic stress disorder to support early access to treatment.

4. Acknowledging the complex relationship between **homelessness** and mental health and suicide prevention, the Parties will work together to:

- a. Improve referral pathways and integrate responses between mental health and suicide prevention supports and specialist homelessness services.
- b. Develop a nationally consistent approach to the collection, linkage, and sharing of data and reporting on people discharged with mental illness or suicidality from hospitals, correctional facilities, and other institutional care settings (e.g. out-of-home care, youth justice, ) into a situation of homelessness, to support decreasing instances of discharge into homelessness. This work should be conducted in line with Part 7 – Data and Evaluation of the National Agreement and should not duplicate existing data sharing but address any identified gaps.
- c. Share best practice examples of programs that reduce incidence of discharge into homelessness to encourage consideration of new, evidence-based approaches across jurisdictions, to move towards zero discharge into homelessness.
- d. Develop approaches related to mental health and suicide prevention to align with work outlined in state and territory homelessness strategies as required under the National Housing and Homelessness Agreement (NHHA).

5. Acknowledging that many people who access government-funded **financial counselling** services may be experiencing heightened distress, the Parties agree to work together to:

- a. Improve integration and coordination between mental health and suicide prevention supports and services and financial counselling services, including for small businesses.

6. Acknowledging the intersections between mental health and **family, domestic and sexual violence, including sexual harassment, and child maltreatment** (including experiences when accessing support), Parties agree to work together to deliver an integrated approach with the family and domestic violence sector, including by:

- a. Improving referral pathways and integrating responses between mental health and suicide prevention supports and: family, domestic and sexual violence services; services that support people who have experienced (or are experiencing) child maltreatment; family support services; the child protection system; behaviour change services for people who use violence; and services for children and young people with harmful sexual behaviours.
  - i. Develop education and training materials for use by relevant services to enhance understanding of trauma related mental health and suicide prevention risk and

available services.

- b. Develop education and reference materials to enhance the mental health and suicide prevention workforce's understanding of family, domestic and sexual violence, including sexual harassment, and child maltreatment, including:
  - i. Enhancing capability to assess and address the safety needs of people (including for children, young people, families, carers and others) who have experienced family, domestic and/or sexual violence, including sexual harassment, or child maltreatment, and provide support which promotes recovery from trauma.
  - ii. Enhancing capability to identify and respond to the safety risks to children and young people, families, carers and others where people accessing mental health and suicide prevention are using or are at risk of using violence.
  - iii. Promoting integrated service responses to meet the mental health and wellbeing needs of child, youth, and adult survivors of child maltreatment, including providing appropriate treatment and support to victims and survivors with co-occurring alcohol and other drug use.
7. Acknowledging the high prevalence of mental ill-health among people in contact with the **justice system**, including children and young people in contact with the youth justice system, the Parties agree to improve mental health and suicide prevention outcomes for those who interact with the justice system and law enforcement, by:
  - a. Implementing and sharing best practice examples of services and programs supporting those with mental ill-health, particularly those people who frequently interact with various parts of the justice system.
  - b. Considering current data on people with mental illness within and transitioning from the justice system, and develop approaches for further data collection to inform best-practice services.
    - i. This will not duplicate, but may consider, the reporting requirements for the Commonwealth funding provided to the states and territories through the National Legal Assistance Partnership 2020-25 for supporting people with mental health conditions to access the justice system.
8. As **drug use and other substance use disorders** and mental illness or suicidal distress can co-occur frequently, Parties agree to:
  - a. Improve communication, collaboration and coordination between Commonwealth, state and territory government-funded health services, including through trialling and evaluating joint planning and regional commissioning of alcohol and other drug services, in line with the *National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-29*.
  - b. Implement clear and consistent care pathways for people with co-occurring alcohol and other drug use and mental illness, and ensure warm referrals across alcohol and other drug services, and mental health and suicide prevention services irrespective of funding

source.

- c. Integrate (and trial where appropriate) alcohol and other drug services and mental health and suicide prevention services, regardless of the level of government delivering the service, with co-location being one option to facilitate integration.
  - d. Develop a nationally consistent approach to data collection to understand the prevalence of co-occurring alcohol and other drug use and mental illness and suicide.
  - e. All levels of government will work collaboratively to appropriately share findings from research and data analysis with relevant stakeholders, to assist in identifying gaps, improving supports provided.
  - f. Build on and leverage existing efforts to build the capability of the mental health and suicide prevention workforce, including the peer and Aboriginal and Torres Strait Islander workforces, to provide support and appropriate clinical treatment to people with co-occurring alcohol and other drug use and mental health and suicidality.
9. The Parties acknowledge that the implementation of some of the actions may require resourcing with any resourcing or financial implications subject to governments consideration via budget processes.

## PART 2 – GOVERNANCE

10. In line with Clause 52(a) of the National Agreement, and noting the importance of working collaboratively across government to promote mental health and reduce suicide, the Health Ministers and relevant Mental Health Ministers from all jurisdictions will collectively maintain responsibility for the Schedule, while relevant portfolio ministers will have responsibility for elements of the Schedule that lie in their portfolios, in partnership with First Ministers on cross-portfolio issues where required. Health Ministers and/or Mental Health Ministers will provide implementation updates to the National Cabinet as required, in consultation with relevant portfolio ministers and First Ministers.
11. This Schedule will be implemented through a working group established under Clause 53 of the National Agreement, for the life of the current Agreement.
12. Membership will be nominated by each jurisdiction and must include senior officials with responsibility for mental health and suicide prevention policy beyond the mental health and suicide prevention system. Where escalation of issues is required, officials may elect to elevate through to First Deputies Group as appropriate, in addition to Health Senior Officials.
13. Parties agree to develop a work plan to guide implementation of the actions in the Schedule by 31 August 2022.
  - a. The work plan will also consider linkages between the National Agreement and other cross-jurisdictional Agreements, strategies and activities, and leverage existing forums to consult and work with sectors beyond the health portfolio.



- b. To ensure whole-of-government oversight of progress against the work plan, progress updates will be provided to First Deputies Group and the Health Senior Officials Group every six months.
  - c. Parties may separately prepare their own, detailed implementation plans to support their contributions to the actions under the Schedule and work plan if they wish.
14. Parties will include information on progress against this Schedule as part of the National Agreement's annual National Progress Report (Refer Part 6 - Reporting).

## ANNEX A: EXISTING NATIONAL INFORMATION AND DATA FRAMEWORKS, TOOLS AND MEASURES

Title	Description
National MH and Suicide Prevention Information Development Priorities, Third Edition	Ten year strategic direction for Australian national information priorities. Endorsed by Australian Health Ministers Advisory Committee MH Principal Committee, 2019, following national consultation with peak consumer and professional bodies.  Includes any amendments or future editions.
National Mental Health Service Planning Framework (NMHSPF)	The NMHSPF project commenced in 2011 as a commitment under the Fourth National Mental Health Plan to develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services. The Commonwealth, states and territories further developed the NMHSPF under the Fifth National Mental Health and Suicide Prevention Plan, with updates in 2012 and 2016.
National Mental Health Performance Framework 2020	The revised NMHPF was developed based on the Australian Health Performance Framework and was endorsed by the Mental Health Principal Committee in March 2019. Key domains are: Determinants of health, Health status and Health system performance.
Key Performance Indicators for Australian Public Mental Health Services	The Third edition of the Key Performance Indicators for Australian Public Mental Health Services (MHS KPIs) was published by the National Mental Health Performance Subcommittee in 2014. The 15 MHS KPIs were developed to improve accountability and transparency and to address the Health System Performance tier (Tier 3) of the National Mental Health Performance Framework.
<b>National Minimum Datasets</b>	
Community Mental Health Care	Specialised public mental health services that are classified as 'ambulatory'.
Mental Health Establishments	Annual collection summarizing expenditure, workforce and activity by specialised mental health services managed by, or in receipt of funds from, State or Territory health authorities.
Admitted Patient Care	Detailed data on same-day and overnight admitted care in Australian public hospitals, including care for people in specialised mental health units and/or for care of mental health conditions.
Residential Mental Health Care	Episodes of residential care for residents in all government-funded mental health services. Excludes residential aged care services in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements.
<b>Minimum Data Set</b>	

Primary Mental Health Care	Data collection of Commonwealth funded mental health services delivered through Primary Health Networks.
MBS (Mental Health Items)	Data on Medicare-funded mental health activities, defined by item numbers specific to mental healthcare, including GP, Psychiatrist, Psychologist, Allied Health and Nursing item numbers.
PBS (Psychotropic medications)	PBS prescription data on psychotropic medications
Headspace Dataset	Minimum dataset for national headspace initiatives
<b>National Dataset Specifications</b>	
Mental Health National Outcomes and Casemix Collection (NOCC)	Clinician and consumer-rated measures of symptoms and functioning at key points of care within public specialised clinical mental health services. (Implemented by all States and Territories)
Seclusion and Restraint (SECREST)	Annual collection of summary/aggregate data on seclusion and restraint for identified hospitals and service types, from State and Territory public hospitals. (Implemented by all States and Territories)
Activity Based Funding Mental Health Care Classification (ABF MHC) NBEDS	Quarterly submission of detailed hospital and community clinical data and, activity, to Independent Hospital Pricing Authority (IHPA)
<b>National consumer and carer experience tools</b>	
Your Experience of Service (YES)	Consumer-rated experience of care and support. A suite of related tools has been validated for State/Territory services (YES), community managed organisations (CMO YES) and Primary Health Networks (PHN YES).
Carer Experience of Service (CES)	A nationally consistent tool for measuring carer experiences of mental health service provision.

## ANNEX B: PRIORITY DATA AND INDICATORS FOR DEVELOPMENT

Priority data items and indicators requiring development during this Agreement have been identified and are outlined in the table below. These are not a comprehensive set of indicators and aim to supplement existing KPIs which remain relevant for health system management.

Shared work will need to be undertaken as a partnership between the Parties to develop these items. That work should prioritise indicators which are:

- **Relevant** to the shared strategic goals of this Agreement;
- **Efficient**, minimizing collection burden;
- **System-wide**, including all government funded services and sectors where possible;
- **Localisable**, having sufficient resolution to support local planning, commissioning and monitoring;
- **Feasible**, able to be developed and reported within this current Agreement, and;
- **Building on investments**, making use of existing data collections and recent data and indicator development work.

FOCUS AREA	PRIORITY DATA AND INDICATORS FOR DEVELOPMENT
<b>Goal: Improving the mental health and wellbeing of the population</b>	
Improving health and wellbeing for Aboriginal and Torres Strait Islander Australians	Specific prevalence estimates for Aboriginal and Torres Strait Islander health status Growth in Aboriginal and Torres Strait Islander mental health workforce Social and emotional wellbeing (SEWB) measures for Aboriginal and Torres Strait Islander Australians
Addressing social and economic determinants	Stratification of all key socioeconomic and general health indicators by mental health status
<b>Goal: Reducing suicide and self-harm through coordinated care and follow up</b>	
Improving identification and measurement	Rate of Emergency Department Self-harm presentations Suspected or confirmed suicide deaths (from State/Territory registers)
Improved service integration and continuity after self-harm	Integrated measures of community care (State and Commonwealth) before and after hospital care or self-harm presentations
<b>Goal: Providing a balanced and integrated mental health system for all communities and groups</b>	
Shared planning, commissioning and service delivery	Joint commissioning arrangements: number and proportion of regions, in-scope, services, population or budget covered Progress in implementation of NGOE dataset
Monitoring progress and outcomes through detailed regional data	Integrated regional profiles of resource distribution (expenditure, workforce, facilities) and service access (MBS, PHN, headspace, State/Territory, NGOs)
Services are accessed by those who need them	The distribution of service use per population across MBS, services delivered in the community (e.g. Adult Mental Health Centres), state and territory specialised community services, and hospitals
<b>Goal: Improving physical health and life expectancy for people living with mental health conditions</b>	

Closing the mortality gap for people living with mental health conditions	Life expectancy gap Potentially Preventable Hospitalisations (PPH) for physical health conditions.
<b>Goal: Improving quality, safety, and capacity in the Australian mental health system</b>	
Responsive services	Consumer and carer/family experience of care and consumer-rated assessment of service effectiveness, appropriateness (including culturally, developmentally and with respect to needs) and impact in all service sectors Service availability and timeliness
Safe services	Suicide in mental health care settings Seclusion and restraint in all health care settings (including Emergency Departments) Adverse medication effects Consumer experiences of feeling safe whilst being supported by services.
Efficient services	Cost per unit of clinical care (For example: AMHCC phase, hospital episode, bed day, community care hour) Efficiency (eg cost per client outcome improvement)
A capable, sustainable workforce	Growth and distribution of the mental health workforce Satisfaction and wellbeing of the workforce

## ANNEX C: NATIONALLY CONSISTENT EVALUATION PRINCIPLES

All government funded mental health and suicide prevention services should be able to demonstrate they are delivering evidence-based interventions safely, effectively and efficiently, to the people and communities who need them. Evaluation is essential for understanding the effectiveness of existing services and systems, and for supporting development and comparison of new service models.

### **Nationally consistent approaches to measuring effectiveness and efficiency**

- The Parties to this Agreement will work in partnership to develop and implement common measures and domains to allow comparison of similar services and to support policy, planning and purchasing decisions across the spectrum of services and needs.
- Wherever possible, measures and domains will be applied consistently across the system, with the methodologies adapted to program priorities, target groups and models of care.
- An evaluation framework should define a small number of measurable priority domains which provide a common language for comparison. These may include specific agreed measures of accessibility, safety, acceptability, outcomes and cost effectiveness. Wherever possible these should be based on validated or widely accepted measures. Examples could include:
  - Increased uptake of mental health and suicide prevention services
  - Improved mental health outcomes
  - Targeted outcomes to measure impact for priority populations
  - Consumer experience reports of service quality/acceptability
  - Cost per disability- or quality-adjusted life year.
- The evaluation of specific programs and services is likely to also require program- or population-specific measures. Wherever possible these should be drawn from common suites of tools to allow comparisons between like programs and benchmarking with other relevant national or international programs.
- Program evaluations should seek to minimise assessment burden on health service users.

### **Using evaluation to inform investment decisions**

A coordinated national approach to formal evaluation will support improvements in planning, purchasing and program management of the mental health and suicide prevention system. Evaluations should be made available for multiple users, where appropriate and as agreed by relevant Parties:

- The public: to understand the effectiveness, efficiency and safety of mental health care and support as a priority government program
- By health service users: to allow informed choice of care and full and equal participation in system planning and design
- By providers: to guide service management and continuous improvement and better meet the needs of priority groups
- By health service planners, funders and commissioners: to guide planning, performance monitoring research priorities and decisions on investment and disinvestment.

The overall cost of evaluations should be managed by building evaluation into program design, collecting and monitoring data during the program and ensuring evaluations are proportionate to the cost, risk and complexity of the program.

## ANNEX D: GLOSSARY

Term	Definition
Aboriginal Community Controlled Health Services (ACCHS)	A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health service to the community that controls it, through a locally elected Board of Management
Accessible	The ability of people to obtain required or available services when needed within an appropriate time. Factors include providing appropriate cultural, disability, affordability, socio economic status, and location accessibility.
Aftercare	Aftercare services provide support for people who have attempted suicide to reduce the likelihood of further suicide attempts or deaths.
Commissioning	Commissioning is an evidence-based, cyclical approach to planning and purchasing services that involves assessing community needs to inform planning and designing services; selecting, overseeing and engaging with providers; managing contracts and undertaking ongoing monitoring and evaluation of delivery and outcomes (also see 'Regional Commissioning').
Community-based mental health services	Mental illness is often treated in community and hospital-based outpatient care services provided by state and territory governments. Collectively, these services are referred to as community mental health care (CMHC) services.
Community managed sector	The community managed sector is predominantly made up of not-for-profit organisations providing community-based support services that help keep people well in the community.
Comorbidity	The presence of one or more diseases or disorders in a person, in addition to a primary disease or disorder.
Consumer	A person living with mental illness who uses, has used or may use a mental health service.
Continuity of care	The provision of barrier-free access to the necessary range of health care services, across hospital, community and other support services, over any given period of time with the level of support and care varying according to individual needs.
Early intervention	The early identification of risk factors and provision of timely treatment, care or support for people experiencing early signs and symptoms of mental illness. It aims to prevent the incidence, severity and impact of mental illness
Health literacy	The ability of people to access, understand and apply information about health and the health care system so as to make decisions that relate to their health.

Horizontal integration	Horizontal integration refers to the bringing together of a range of professions, service types and organisations that operate at similar levels in the provision of care. For mental health services, horizontal integration would see clinical care provided alongside disability support services, vocational assistance services, housing services, social care services, legal services, and others (also see Vertical Integration).
Lived experience	<p>Mental illness - People with lived experience are people who identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness. People with lived experience are sometimes referred to as consumers and carers.</p> <p>Suicide - People who think about suicide, people who have attempted suicide, people who care for someone with suicidal behaviour, people who are bereaved by suicide, and people who are impacted by suicide in some other way, such as a workplace incident.</p>
Mental health	The World Health Organization defines mental health as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.
Mental health workforce	Distinguishes between people who work exclusively in the mental health sector (for example Aboriginal and Torres Strait Islander mental health workers, mental health nurses, psychologists and psychiatrists) and those working in other health settings who frequently treat, interact with, care and support people experiencing suicidality, mental distress and/or ill-health (for example allied health, general practitioners and nurses). Particularly for suicide prevention, this also extends to people working in other settings who are likely to have regular contact with people experiencing suicidality, mental distress and/or ill-health as part of their role (for example aged care workers, educators, drug and alcohol workers, housing and justice services workers). Peer workers with a lived experience of mental health and suicide are also included in this definition.
Mental health and suicide prevention investment	Investment as outlined in <i>Expenditure on mental health-related services</i> reported by the Australian Institute of Health and Welfare, noting that health expenditure is reported in terms of who incurs the expenditure rather than who ultimately provides the funding, and health funding is reported in terms of who provides the funds that are used to pay for health expenditure.
Person centred	Treatment, care and support that places the person at the centre of their own care and considers the needs of the person's carers.
Postvention	Postvention services aim to support individuals and communities bereaved or impacted by suicide through the grieving process, and to reduce the possibility of imitative suicidal behaviour.



Prevention	Action taken to prevent the development of mental illness, including action to promote mental health and wellbeing and action to reduce the risk factors for mental illness
Regional commissioning	Regional commissioning (sometime referred to as collaborative commissioning or joint commissioning) refers to the ways in which organisations work together to commission services, to make the best use of limited resources to avoid duplication of effort and achieve better outcomes for the local community.
Self-harm	Deliberately hurting oneself without conscious suicidal intent.