



Australian Government
Productivity Commission

PRODUCTIVITY COMMISSION
FINAL REPORT

Mental health and suicide prevention stocktake

April 2021



Key points

- The Australian, State and Territory Governments collectively reported spending around \$14.5 billion on mental health and suicide prevention programs in 2019-20. The Australian Government accounted for just under half of total program expenditure.
- Governments reported \$12.1 billion in program expenditure from health portfolios. Across the board, governments were not able to provide comprehensive program data on expenditures in key non-health areas such as justice, housing and community services. Consequently, the stocktake does not capture the entirety of funding for mental health and suicide prevention, and most likely overstates the relative role of health portfolio expenditures.
- Notwithstanding this, the stocktake's data show that State and Territory Governments:
 - directed most (54–88 per cent) of their reported program expenditure towards specialist mental health services and acute care (\$5.9 billion in total)
 - collectively spent \$388 million on mental health and suicide prevention programs in education portfolios (generally accounting for 5–8 per cent of total reported expenditure), which was primarily directed to prevention and early intervention.
- The Australian Government's reported program expenditure was relatively focused on primary mental health care (\$2.9 billion). 85 per cent (or \$6.0 billion) of Australian Government expenditure was absorbed by five programs — mental health-related funding for the Medicare Benefits Schedule (including Better Access), National Disability Insurance Scheme, Pharmaceutical Benefits Scheme, public hospitals and Primary Health Networks.
- Some groups — such as children and adolescents — received targeted funding; however, there was limited evidence of programs targeted towards many vulnerable cohorts (such as people experiencing homelessness and children in the child protection system).
- In developing the National Mental Health and Suicide Prevention Agreement, some observations from this stocktake are especially pertinent.
 - While the Australian, State and Territory Governments generally fund different types of programs, coordination between levels of government (including at the local level) is fundamental to achieving an integrated mental health and suicide prevention system.
 - The Commission estimates that \$7.9 billion of government expenditure is demand driven and incurred automatically, albeit generally as a result of 'bottom-up' decisions. However, given previously identified gaps in the system, these activity-based funding mechanisms will not result in the best consumer outcomes or value for money.
 - While expenditures on prevention and promotion, early intervention and suicide prevention programs are low (1–3 per cent of total reported expenditure), the types of programs being funded — particularly in education portfolios — are a solid basis to build on.
 - Many non-health portfolios that play a key role in improving mental health and suicide prevention outcomes — such as justice, housing and community services — do not see themselves as part of the system. There is considerable scope to harness *all* areas of government to work towards a shared aim of improving outcomes, and to design programs with the characteristics and needs of consumers front of mind.
- Future opportunities for data collection and research include compiling more comprehensive and granular information about mental health and suicide prevention expenditure, evaluating what works in improving outcomes — in most jurisdictions, less than 10 per cent of reported expenditure had been evaluated — and bringing together a fuller picture of the system. This could be progressed under a new National Agreement.

1 About this stocktake

This stocktake provides an overview of mental health and suicide prevention programs that are currently funded by the Australian and State and Territory Governments. It seeks to build a shared understanding of the landscape of existing government-funded programs, including ‘who funds what’ in the mental health and suicide prevention system (both in and outside the health portfolio). The consolidated expenditure information reported in this stocktake — based on data collected by governments and provided to the Productivity Commission for processing and analysis — provides a starting point for jurisdictions to assess gaps and duplications in mental health and suicide prevention programs, and to inform the development of the new National Mental Health and Suicide Prevention Agreement in 2021.

Background to the stocktake

There is widespread recognition that Australia’s mental health and suicide prevention system requires significant reform. A number of recent reports and studies have highlighted problems with the current system and identified opportunities for improvement (box 1.1). The toll on the community of the large-scale disruptive events of the last 12 months — bushfires, the COVID-19 pandemic and floods — adds to the case for reform.

Box 1.1 There has been a strong recent focus on the need to improve the mental health and suicide prevention system

A number of reports and studies that examine current issues in Australia’s mental health and suicide prevention system, and potential reform directions, have recently been published. These include (but are not limited to):

- the Productivity Commission’s 2020 Mental Health inquiry report
- the National Suicide Prevention Adviser’s Final Advice report to the Australian Government in 2021, and other work of the National Suicide Prevention Taskforce
- the Interim and Final Reports of the Royal Commission into Victoria’s Mental Health System, which was completed in early 2021.

Sources: DoH (2021); PC (2020); State of Victoria (2019, 2021).

Several common themes for mental health and suicide prevention system reform have been proposed in these reports.

- *The need for a person-centred mental health and suicide prevention system:* A system with evidence-based mental health assessment and referral processes that help people

find the services that are best for them, and which is inclusive of families and carers as part of mental health care. Outcomes for the consumer should be the predominant focus of every clinical and support service provider.

- *An increased focus on prevention and early intervention:* A system that better recognises the benefits of intervening early to promote good mental health, both early in life and early in people's experience of mental ill-health. This would include supporting the mental health of new parents, and making the social and emotional health of school children a national priority.
- *Improved accessibility of services:* Getting people the right services at the right time. This relates to improving both geographical and financial accessibility, but also ensuring the system caters for key target groups, with adequate provision of support services to enable better recovery within the community.
- *Improved integration and coordination of services:* Ensuring the range of services for people with mental ill-health are better integrated and coordinated. This includes better regional planning and national strategies to integrate health and other services, with greater clarity across different levels of government about roles, responsibilities and funding. Ultimately, the system should provide treatment and support that is seamless.
- *A better focus on workplaces:* A need to elevate the importance of psychological health and safety within workplaces, while viewing workplaces as an avenue to reach beyond the health system and into the broader community.
- *Better embedding of lived experience:* Ensuring that people with lived experience of mental ill-health are involved in future planning and service provision, including through consumer-focused evaluation and use of peer workers.
- *More emphasis on system outcomes:* Better collection and use of high quality outcomes data in service delivery and planning, and developing an evaluation culture focused on what matters to consumers.

What was the Productivity Commission asked to do?

The Productivity Commission was asked to undertake a stocktake of current government-funded mental health and suicide prevention programs, to assist in the development of the new National Mental Health and Suicide Prevention Agreement. The work was undertaken at the request of the National Federation Reform Council and in collaboration with the Australian and State and Territory Governments.

The stocktake seeks to improve the collective understanding of the landscape of government funding in this area, and provide a starting point for jurisdictions to better assess current gaps and duplication in mental health and suicide prevention programs. It collates data from governments on the programs they fund, but does not measure what is actually delivered 'on the ground' by service providers.

The Productivity Commission has not made findings or recommendations in this stocktake. Instead, the purpose of the stocktake is to provide a consolidated and consistent evidence base on the current state of play.

By necessity, the stocktake was undertaken relatively quickly — commencing in February 2021 and ending April 2021. The Australian and State and Territory Governments intend to finalise the National Mental Health and Suicide Prevention Agreement by November 2021.

The data collection for the stocktake was undertaken by the Australian and State and Territory Governments under the guidance of the Productivity Commission to ensure consistency in approach and scope. The subsequent data processing, compilation and analysis was undertaken by the Commission.

The Productivity Commission's approach

The stocktake captures government-funded programs and services that have mental health and/or suicide prevention as a *primary* objective. This includes programs that support mental health or wellbeing, and those that respond to mental illness in different ways — such as through prevention of mental ill-health, early intervention, treatment, suicide prevention and research.

The mental health and suicide prevention system extends beyond health care. A range of other programs and services — including psychosocial supports, housing and education programs — can be critical for improving mental health outcomes. Wherever possible, relevant programs and services funded from *outside* the health portfolio have been included in the stocktake. Programs that have a broad focus but include a dedicated mental health or suicide prevention component have been captured within the scope of the stocktake — in these instances, only the portion of expenditure that specifically relates to supporting and/or improving mental health outcomes has been included.

The stocktake does not include programs where improved mental health or suicide prevention may be a potential by-product, but is not a specific focus or objective. This means programs designed to improve physical health or broader wellbeing, or to prevent dangerous or risky behaviour, are not in scope. For example, general alcohol and other drug-related services are not included. Similarly, government services and programs designed to promote social inclusion more generally, such as public transport, are excluded from this stocktake.

The Productivity Commission sought a range of information from jurisdictions about the size (in terms of actual expenditure in 2018-19 and 2019-20, and budgeted spend in 2020-21), purpose and coverage of the mental health and suicide prevention programs they fund. In addition to classifying programs according to a taxonomy of service categories (discussed below), jurisdictions were asked to identify various program characteristics. These included:

- whether program funding was ongoing or terminating

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- whether programs were targeted towards particular groups — such as specific age cohorts, localities and vulnerable groups, or based on the mental health care needs of the recipient (by severity)
 - whether funding was provided to an Aboriginal or Torres Strait Islander-owned or controlled service provider
 - whether an evaluation had been undertaken for the program
 - for State and Territory Government expenditure, whether the program was fully or partly funded by a transfer from the Australian Government
 - for transfers from the Australian Government to State and Territory Governments and Primary Health Networks (PHNs), the amount transferred to each jurisdiction.

To promote data consistency and completeness, the Productivity Commission provided guidance to jurisdictions throughout their data collection. Where appropriate, the Commission also made adjustments to the information provided as part of its data processing, to ensure that in-scope expenditures were consistently captured and that the stocktake’s coverage was as complete as possible.¹

The Productivity Commission acknowledges the considerable effort and goodwill demonstrated by the Australian and State and Territory Governments in collecting the data to make the stocktake possible, especially given the short timeframes. That said, the ability of jurisdictions to provide information varied based on their systems and available program data, as well as their capacity to dedicate resources to participating in the stocktake. The expenditure data provided to the Commission therefore differed in terms of coverage, completeness and consistency, and not all of the reported program information was as granular as requested. For example, program expenditure on specialist mental health services (including hospital- and community-based services) was often presented in a highly aggregated way, constraining the types of analysis possible (chapter 2).

In addition, the stocktake’s focus on government-funded mental health and suicide prevention *programs* is limited in its ability to measure broader government funding for services that are related to mental health but are not direct ‘programs’. It therefore does not capture the entirety of government funding for mental health and suicide prevention. Previous estimates from the Productivity Commission’s 2020 inquiry can provide a useful reference point for understanding broader government expenditures in some of these areas where governments have not been able to provide comprehensive program-level information, such as justice and community services including psychosocial supports (box 1.2).

¹ For example, this included reclassifying misallocated expenditures and — where jurisdictions were unable to separately report dedicated spend on the mental health component of broader programs — applying an assumption that 8 per cent of the broader program’s overall expenditure was dedicated to mental health. This proxy for the mental health-related share of overall program spend was based on the Australian Institute of Health and Welfare’s estimate that in the decade to 2018-19, government mental health-related expenditure as a share of total government health expenditure varied between 7.48 and 7.82 per cent (AIHW 2021a, table EXP.35).

Box 1.2 **The stocktake focuses on mental health and suicide prevention program-level expenditure**

This stocktake collected expenditure data for programs that have mental health or suicide prevention as a primary objective. It follows a ‘bottom-up’ approach to reporting government expenditure on individual programs. While this has enabled the Productivity Commission to capture what is actually spent on in-scope programs, such an approach is limited in its ability to measure broader government funding for services that are related to mental health but are not direct ‘programs’ — for example, costs relating to mentally unwell people who are in prison.

As part of its 2020 Mental Health inquiry, the Productivity Commission sought to estimate the total economic cost of mental ill-health and suicide in Australia, via a top-down approach. It took a broad approach to developing these estimates, and assumptions were necessary to attribute non-health care expenditure. For instance, the cost of people being imprisoned that is attributable to mental illness was estimated by applying the prevalence of mental illness in the population and prisons to total government expenditure on prisons.

Given the different approaches taken between the data collated for this stocktake and the estimates prepared in the inquiry, the numbers provided in each report are not directly comparable. Notwithstanding this, estimates from the Commission’s inquiry can provide a useful reference point for areas where governments have not been able to provide comprehensive program-level information for this stocktake. It is in these areas that the stocktake will likely underrepresent overall funding for mental health and suicide prevention.

The programs reported for this stocktake provide reasonably good coverage of governments’ mental health-related expenditure in the health and education portfolios (chapter 2) — indeed, the reported education programs are an example of how a bottom-up approach can capture expenditure in areas that are hard to estimate top-down (broader education sector costs were unable to be estimated at the time of the inquiry). However, jurisdictions were not able to report comprehensive program data in other areas such as justice, housing and community services including psychosocial supports. In these areas, estimates from the inquiry provide a sense of the scale of mental health-related government expenditure, noting that the inquiry focused on 2018-19 and the stocktake on 2019-20 (table below).

<i>Area of government</i>	<i>Inquiry estimate of expenditure on services attributable to mental illness</i>	<i>Expenditure on mental health-related programs reported to this stocktake</i>
	2018-19, \$m	2019-20, \$m
Justice	1 120	98
Education	na	461
Psychosocial supports — Australian Government (non-National Disability Insurance Scheme)	403	229
Psychosocial supports — State and Territory Governments	452	226

Sources: Data provided by Australian, State and Territory Governments; PC (2020).

More generally, neither the stocktake’s program data nor the inquiry’s estimated costs of mental illness and suicide included the \$10.9 billion (in 2018-19) of income support payments for those with mental illness and carers, which represent a transfer between different parts of

the community. Notwithstanding, all of these aspects of government funding are relevant to the development of a National Mental Health and Suicide Prevention Agreement.

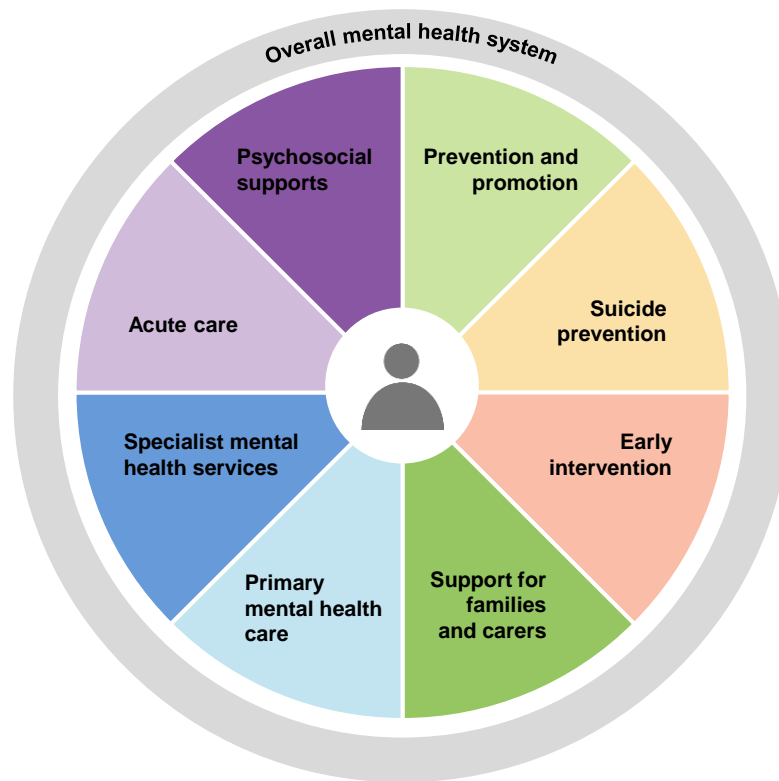
A taxonomy of mental health and suicide prevention programs

Mental health and suicide prevention programs and services in Australia are diverse in nature and complex in the way they are funded and delivered. Perhaps not surprisingly then, there are various approaches to collecting and categorising funding, expenditure and activity data. For example:

- Mental health care expenditure and activity data are captured in the Australian Institute of Health and Welfare’s (AIHW’s) Mental Health Establishments and Community Mental Health Care datasets (AIHW 2021a). These classifications tend to focus on resources (for example, beds) rather than on the purpose of the activity (for example, to prevent mental ill-health).
- The National Mental Health Service Planning Framework provides nationally consistent language to describe mental health services and considers the service functions required to meet the needs of people with mental illness, rather than the location, format or provider of that service (UQ 2019). However, the classification system does not extend beyond the health sector.
- Each state and territory has their own data system to capture mental health service information. For example, Victoria has the Client Management Interface/Operational Data Store. This system focuses on selected clinical client-level information including admissions, contacts, outcomes measurement and diagnosis (Vic DHHS 2021).

Given the breadth and nature of this stocktake exercise, existing approaches to reporting mental health programs and expenditures are not entirely fit for purpose. Instead, the Productivity Commission has developed and applied a program taxonomy based on the *type* of service being provided (figure 1.1 and table 1.1). While all jurisdictions configure and manage mental health and suicide prevention programs in different ways, a consistent taxonomy is required to better understand how — and for what purpose — funding is allocated.

Figure 1.1 Taxonomy of mental health and suicide prevention programs



It should be noted that in some instances, the categories in the Productivity Commission’s taxonomy are somewhat different to similarly worded definitions used in other contexts or by other organisations. For example, the stocktake captures expenditure on acute hospital beds in ‘specialist mental health services’, not in ‘acute care’. Where this has resulted in inconsistencies in the data reported by jurisdictions, the Commission has re-categorised program expenditures according to the taxonomy as part of the stocktake’s data processing stage (if possible based on the information provided).

Table 1.1 Summary of taxonomy categories and program examples

<i>Service category and taxonomy description</i>	<i>Examples of programs and services</i>
<i>Prevention and promotion</i> — prevention occurs before the initial onset of a condition to prevent its development (for example, to reduce risk factors); promotion is about increasing awareness and understanding of mental health issues.	<ul style="list-style-type: none"> • Programs that reduce discrimination and stigma, or encourage help-seeking behaviour. • Providing teachers, parents and carers the information, training and tools to understand mental ill-health and promote mental wellbeing, such as school nurse and chaplaincy programs.
<i>Suicide prevention</i> — interrupting an individual's movement towards suicide and to reduce suicidal thoughts, plans, attempts and deaths.	<ul style="list-style-type: none"> • Telephone support, counselling and referral services. • Aftercare and follow-up services for those who have attempted suicide (to prevent further attempts).
<i>Early intervention</i> — preventing the early signs and symptoms of a mental health condition from escalating to a diagnosable condition, including treatment and support that is offered early in life, early in illness and early in episode.	<ul style="list-style-type: none"> • Programs targeted to people showing early signs of mental ill-health, such as employee assistance programs. • Programs targeted to people who have recently experienced a crisis, such as incident response programs including peer support.
<i>Support for families and carers</i> — improving the wellbeing of families and those caring for people with mental illness.	<ul style="list-style-type: none"> • Trauma care services and other integrated supports, including programs for first responders and emergency services.
<i>Primary mental health care</i> — the diagnosis and treatment of individuals with mild and moderate mental illnesses; often the first touchpoint with mental health-related practitioners in the system.	<ul style="list-style-type: none"> • A range of front-line health services, including the prescription of medication and services delivered by general practitioners. • Diagnosis and treatment delivered in a community setting, and in settings such as schools, prisons and youth justice centres (such as psychologists in schools).
<i>Specialist mental health services</i> — providing treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability.	<ul style="list-style-type: none"> • Admitted patient care in public hospitals relating to mental illnesses. • Community-based public mental health care services, including those provided by hospital based ambulatory care services, outpatient clinics, outreach services into homes and aged care facilities.
<i>Acute care</i> — immediate care for people experiencing acute mental illness or a crisis.	<ul style="list-style-type: none"> • Ambulance (first responder) services, emergency departments and joined-up mental health responses with police and ambulance.
<i>Psychosocial supports</i> — non-clinical supports that help people experiencing mental ill-health or recovering from mental illness to build skills to manage their condition.	<ul style="list-style-type: none"> • Non-clinical programs to promote social and economic participation in the community, including rehabilitation programs, home-based services and supported accommodation. • Includes the National Disability Insurance Scheme (NDIS) and other Australian, State and Territory Government programs targeted at people who are ineligible for the NDIS.
<i>Overall mental health system</i> — broader system activities; where any of these activities were focused primarily on one of the above categories of mental health or suicide prevention services, the activity was allocated to that specific category.	<ul style="list-style-type: none"> • Coordination. • Infrastructure investment. • Workforce development. • Research.

2 Data analysis and insights

Who funds mental health and suicide prevention programs?

The Australian Government and State and Territory Governments share funding responsibilities

In 2019-20, total reported government expenditure on mental health and suicide prevention programs (across all portfolios) was \$14.5 billion.² The Australian Government funded about 49 per cent of total program expenditure (\$7.1 billion) and the State and Territory Governments funded the remainder (\$7.4 billion) (table 2.1).³

Expenditure on mental health and suicide prevention programs varied across jurisdictions, largely aligning with differences in population (figure 2.1). That said, there are some deviations — for example, Western Australia’s reported expenditure was relatively high compared to its population.⁴

² The Productivity Commission made an adjustment to expenditures for programs that were funded by the Australian Government but also reported by State and Territory Governments, to remove double counting. However, many State and Territory Governments reported public hospital expenditure at a relatively aggregated level — and in combination with other specialist mental health and acute services — so the Commission was unable to identify how much of this was funding provided by the Australian Government. High-level comparisons between the Australian Government’s reported transfers to State and Territory Governments for public hospitals, the expenditure reported by jurisdictions in specialist mental health and acute services, and AIHW data on public hospital expenditure related to mental health suggest that the magnitude of any double counting in the stocktake’s estimates of total expenditure is likely to be small.

³ The total spend on mental health and suicide prevention programs captured in this stocktake was higher than the \$10.6 billion of expenditure on mental health services reported by the AIHW in 2018-19 (AIHW 2021a, p. 2). The AIHW data also showed slightly different shares of funding between Australian, State and Territory Governments. These discrepancies reflect both the broader scope of this stocktake (chapter 1), and the likelihood that jurisdictions took varying approaches in providing data for the stocktake.

⁴ This is likely to be partly attributable to different geographic and population characteristics across jurisdictions, and partly due to variations in the approach each jurisdiction has taken to capturing relevant expenditures for the stocktake.

Table 2.1 Program expenditure by jurisdiction, 2018-19 to 2020-21^a

Government spend on mental health and suicide prevention programs across all portfolios

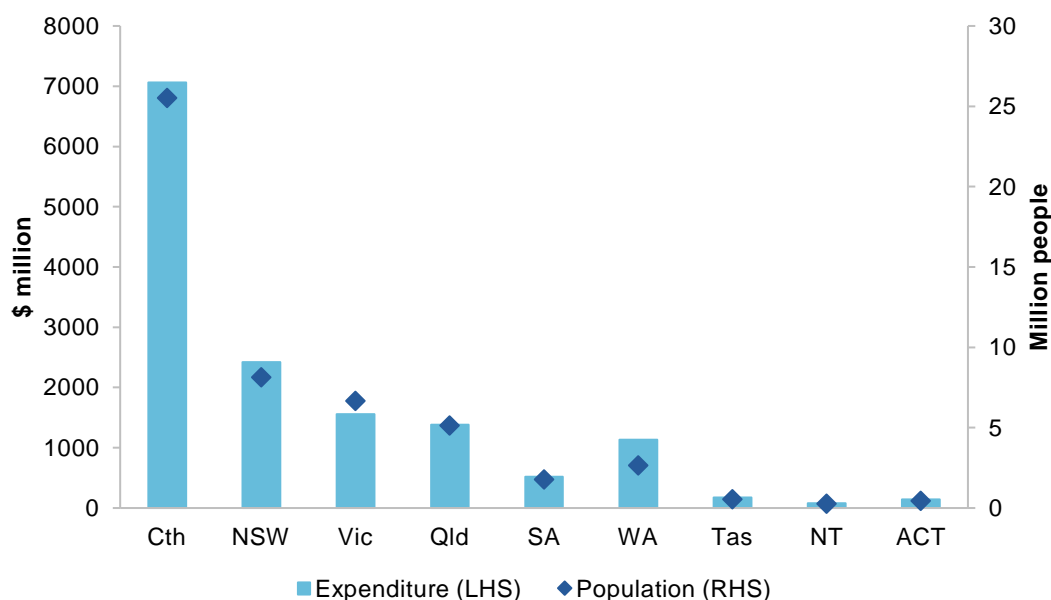
	2018-19	2019-20	2020-21
	\$m	\$m	\$m
Cth	5 770	7 065	8 728
NSW	2 036	2 419	2 478
Vic	1 433	1 555	1 729
Qld	1 314	1 382	1 463
SA	494	520	530
WA	1 079	1 134	1 226
Tas	163	173	173
NT	39	78	97
ACT	123	139	153
Total	12 450	14 465	16 576

^a Data reported for 2018-19 and 2019-20 are actual expenditure; data for 2020-21 are budgeted funding.

Source: Data provided by Australian, State and Territory Governments.

Figure 2.1 Government spend varied by jurisdiction, largely in line with population differences

Expenditure on mental health and suicide prevention programs and population by jurisdiction, 2019-20



Data sources: ABS (National, state and territory population, Dec 2019, Cat. no. 3101.0); data provided by Australian, State and Territory Governments.

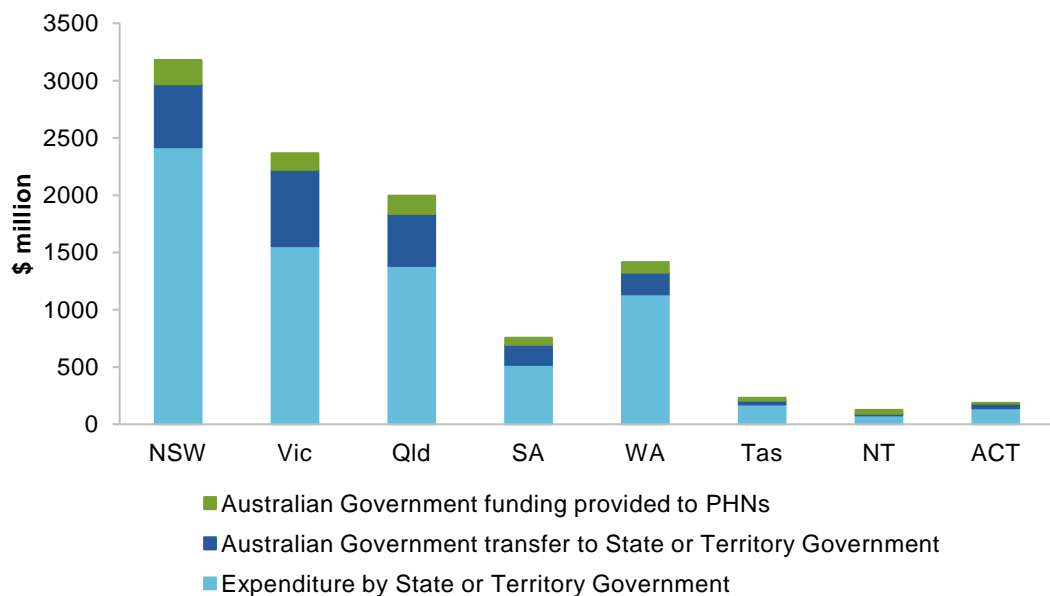
Some of the Australian Government’s expenditure on mental health and suicide prevention programs represented funding transfers to states and territories. Specifically, about 41 per cent (\$2.9 billion) of Australian Government expenditure was provided to State and Territory Governments and PHNs in 2019-20 (figure 2.2). This included:

- intergovernmental transfers to State and Territory Governments — which predominantly related to mental health care services in public hospitals (about \$2 billion), consistent with funding arrangements under the National Health Reform Agreement (Administrator NHFP 2020), but also included other mental health-related programs such as the National School Chaplaincy Program and veterans’ services
- funding provided to PHNs to commission mental health and suicide prevention services (about \$734 million) — box 2.1.

Accounting for these transfers enables a better understanding of the amount of funding actually spent on mental health and suicide prevention programs in each state and territory.

Figure 2.2 The Australian Government transferred \$2.9 billion to states and territories in 2019-20

Program expenditure in states and territories including funding transfers from the Australian Government, 2019-20



Data source: Data provided by Australian, State and Territory Governments.

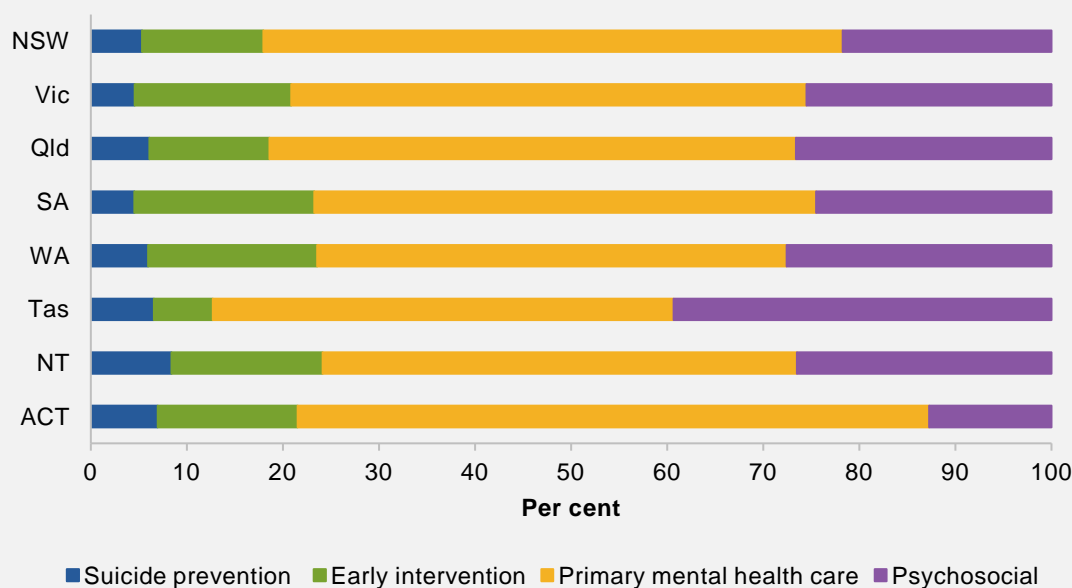
Box 2.1 Mental health funding provided to Primary Health Networks

The 31 Primary Health Networks (PHNs) across Australia are independent organisations funded by the Australian Government to commission health services, of which mental health is one area of focus. PHN funding for mental health services is provided via the Mental Health Care Flexible Funding Pool (the funding pool). Some decisions about the use of these funds have been devolved to PHNs, while others are made centrally by the Department of Health.

- About one third of the funding pool is committed to headspace services (including the headspace early psychosis youth service).
- A further (approximately) 8 per cent of the funding pool is hypothecated to mental health services for Aboriginal and Torres Strait Islander people.
- PHNs have discretion over how the remainder (approximately 60 per cent) of the funding pool is spent — though the Department of Health issues guidance documents that outline the various priority areas for PHN commissioning.

Data provided to this stocktake suggest that in 2019-20:

- over half of Australian Government funding provided to PHNs to commission mental health services was spent on primary care (which includes low-intensity services, psychological therapies for people in underserved and/or hard to reach populations and primary mental health care for people with severe mental illness); headspace falls in this category
- about a quarter of the funding provided to PHNs was spent on psychosocial supports. Early intervention services (such as support for young people with, or at risk of, severe mental illness managed in the primary care setting, including those presenting with early psychosis) and suicide prevention accounted for the remainder
- PHN funding was allocated differently across jurisdictions — for example, primary health care accounted for between 48 and 66 per cent of total PHN funding depending on the jurisdiction, while early intervention programs absorbed between 6 and 19 per cent (figure below).



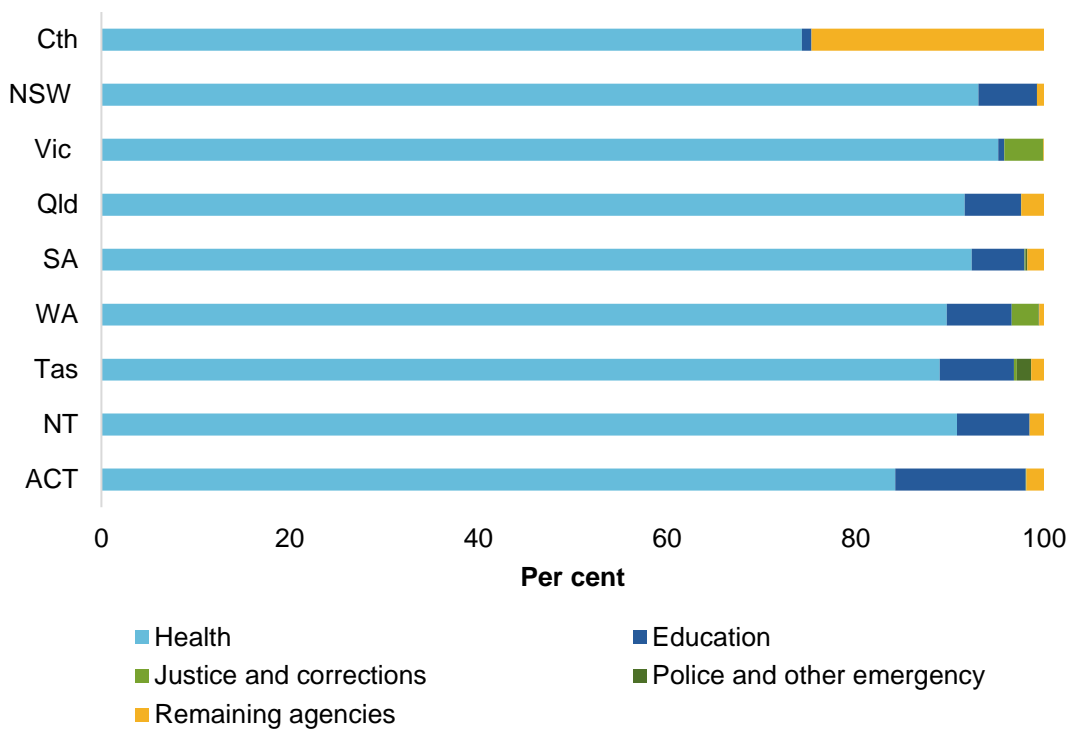
Sources: Data provided by Australian, State and Territory Governments; DoH (2019); Health Direct (2021); PC (2020).

Almost all of the government funding reported for this stocktake — 96 per cent of total expenditure in 2019-20 — was identified as recurrent and ongoing spend that was not expected to terminate. There has been a slight rise in recurrent and terminating expenditure since 2018-19, as governments provided additional short-term funding for mental health support programs in response to the COVID-19 pandemic and the 2019-20 bushfires.

Most program expenditure is from the health portfolio

Across the Australian, State and Territory Governments, the majority of reported expenditure on mental health and suicide prevention programs came from health portfolios, which reported \$12.1 billion in funding in 2019-20. Program expenditure by health portfolios across State and Territory Governments was generally about 90 per cent of total reported spend (figure 2.3). At the Commonwealth level, health program expenditure represented a lower 74 per cent of total reported spend. This reflects the significant funding (\$1.2 billion) provided by the Australian Government for mental health supports under the National Disability Insurance Scheme (NDIS), which sits outside the health portfolio.

Figure 2.3 The health portfolio funded the majority of reported mental health and suicide prevention program expenditure
Distribution of each jurisdiction's spend by portfolio, 2019-20



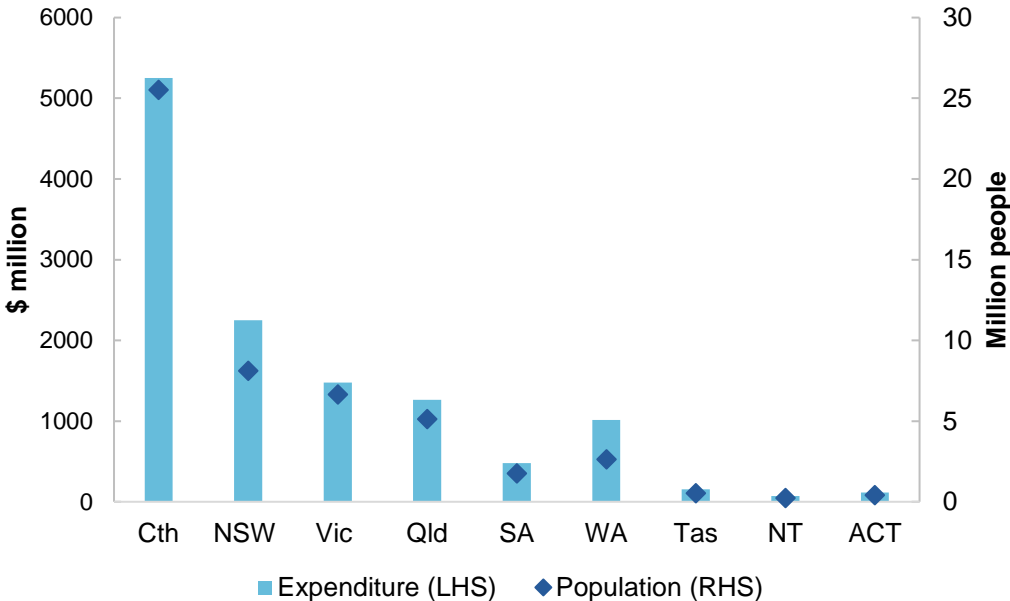
Data source: Data provided by Australian, State and Territory Governments.

Agencies in education portfolios across all governments reported \$461 million in funding for mental health and suicide prevention programs in 2019-20, of which \$388 million was provided by State and Territory Governments. The education portfolio represented the second largest source of program expenditure — around 5–8 per cent of total reported spend — for most State and Territory Governments (figure 2.3). Examples of programs funded from education portfolios included employing mental health practitioners in schools, teacher training on prevention and promotion, and programs that support students’ emotional wellbeing.

While health portfolio expenditure on mental health and suicide prevention programs varied across jurisdictions in a pattern consistent with population differences (figure 2.4), education portfolio funding fluctuated in a more unpredictable manner (figure 2.5).⁵

Figure 2.4 Health portfolio spend by jurisdiction varied largely in line with population ...

Health portfolio expenditure on mental health and suicide prevention programs and population by jurisdiction, 2019-20

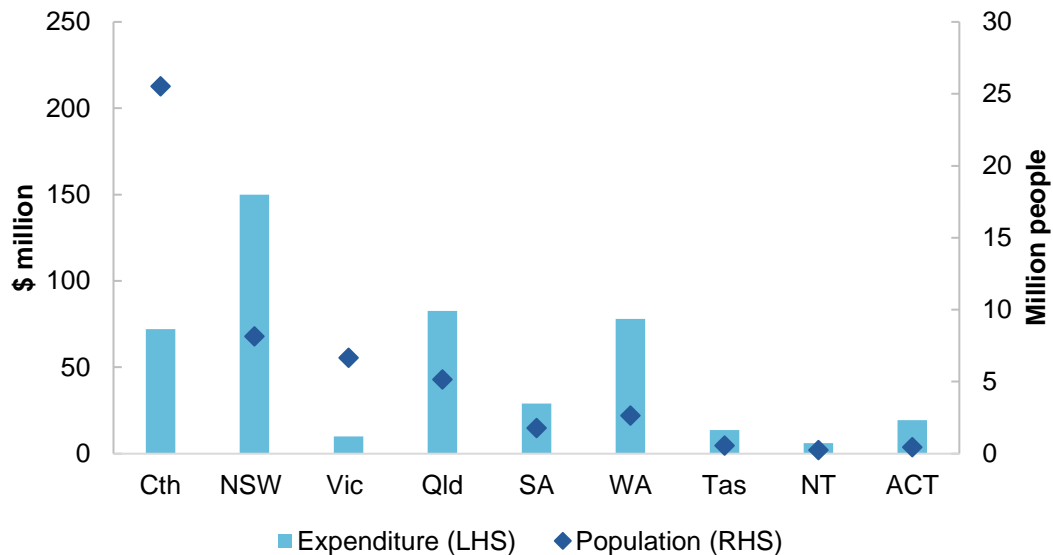


Data sources: ABS (National, state and territory population, Dec 2019, Cat. no. 3101.0); data provided by Australian, State and Territory Governments.

⁵ While this could partly reflect the different configurations of jurisdictions’ mental health and suicide prevention systems, it is also likely to have been influenced by the varying extent to which jurisdictions were able to report on programs outside of the health portfolio for the stocktake.

Figure 2.5 ... while education portfolio expenditure was more variable

Education portfolio expenditure on mental health and suicide prevention programs and population by jurisdiction, 2019-20



Data sources: ABS (National, state and territory population, Dec 2019, Cat. no. 3101.0); data provided by Australian, State and Territory Governments.

Outside of the health and education portfolios, governments reported relatively little expenditure on mental health and suicide prevention programs (figure 2.3). This gap in data completeness suggests that some areas of government — including those with responsibility for delivering broader government services (in social housing and justice, for example) — do not necessarily see themselves as part of the mental health and suicide prevention system. The National Mental Health and Suicide Prevention Agreement presents an opportunity to identify and bring together all parts of government that have a role in improving mental health and suicide prevention outcomes (chapter 3).

Notwithstanding this, the expenditure that was reported outside of health and education portfolios spanned a range of programs and services. For example:

- agencies in justice and corrections portfolios funded mental health services in prisons and other corrective services, suicide and self-harm training for custodial and community corrections staff, and social workers offering counselling support
- agencies in police and other emergency services portfolios funded programs such as mental health leadership training for emergency services staff, peer support and the implementation of mental health co-response models
- remaining agencies reported funding for a variety of other programs, including some community services (such as counselling for family violence victims and supports to assist people with mental ill-health in finding secure housing) and workplace supports (such as employee assistance programs and employing mental health consultants in workplaces).

There are some broad classes of programs that are important for improving mental health and suicide prevention outcomes, which receive funding from multiple portfolios. Examining such programs across portfolios can provide useful takeaways and learnings for a whole-of-government approach to investing in these areas, such as mental health-related workforce development and training (box 2.2).

Box 2.2 Expenditure on workforce development programs: what did the stocktake find?

The effective functioning of the mental health system depends on the availability of workers with the right skills, who are allocated to tasks that use their skills efficiently.

Across the Australian, State and Territory Governments, around \$60 million of expenditure on workforce development programs was reported in this stocktake for 2019-20. The most common type of workforce development program reported was mental health-related training provided by government agencies for their employees. These programs were offered to workers across a range of agencies, from first-response training for police and other emergency services staff who may be expected to respond to traumatic incidents, to general mental health awareness training for staff in large government departments (such as Treasuries and First Ministers' Departments).

In addition, the Australian Government reported that the psychology and social work professional pathway in its Job-ready Graduates Package will seek to improve the pipeline of mental health professionals across the country (with funding budgeted to commence in 2020-21). There were also several smaller programs reported by some jurisdictions, such as funding to assist organisations in developing peer workforces and for education and training activities in community service providers.

Jurisdictions are likely to be funding other workforce development programs that have not been captured in the stocktake. Developing a better understanding of these programs across all levels of government and portfolios would help inform future initiatives to improve Australia's mental health workforce.

Sources: Data provided by Australian, State and Territory Governments.

How is funding spread across different mental health and suicide prevention programs?

Governments' program expenditures are concentrated in specialist services and primary care

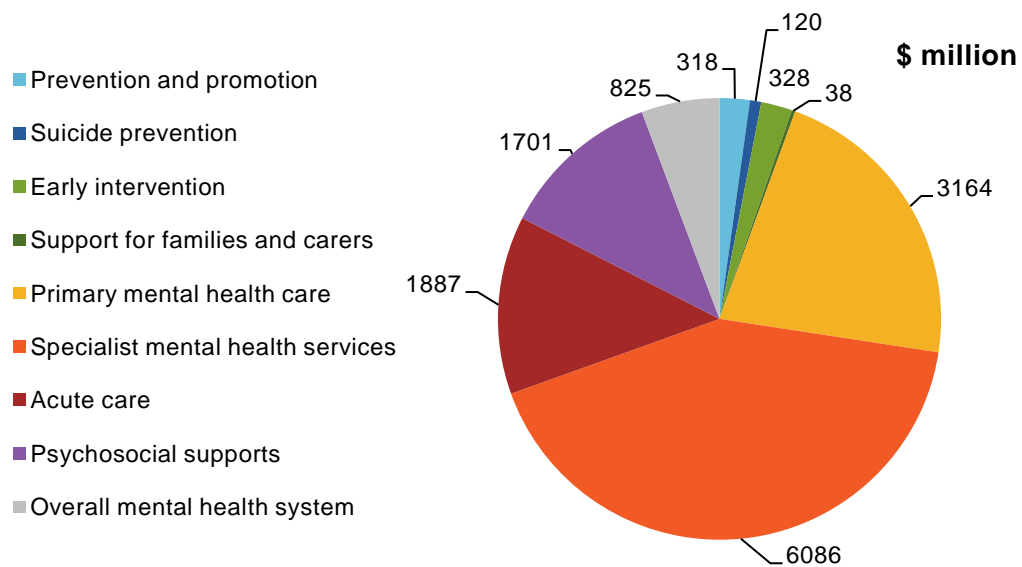
Across the Australian, State and Territory Governments, specialist mental health services⁶ accounted for the largest share of total reported government expenditure on mental health and suicide prevention programs (about 42 per cent, or \$6.1 billion) in 2019-20 (figure 2.6). This

⁶ As outlined in chapter 1, this category includes admitted patient care in public hospitals and community-based care (provided by ambulatory care services, outpatient clinics and outreach services into homes and aged care facilities).

was followed by primary mental health care (22 per cent, or \$3.2 billion), acute care (13 per cent) and psychosocial support services (12 per cent). A much smaller share of program expenditure was allocated to prevention and promotion (2 per cent), early intervention (2 per cent), suicide prevention (1 per cent) and support for families and carers (0.3 per cent). Expenditure on the overall mental health system made up the remaining 6 per cent.

Figure 2.6 Specialist mental health services accounted for the largest amount of program expenditure

Total government spend on mental health and suicide prevention programs, 2019-20



Data source: Data provided by Australian, State and Territory Governments.

The concentration of spending on specialist mental health services is largely driven by the significant amount of funding provided to public hospitals. The Australian Government transferred around \$2 billion to State and Territory Governments in 2019-20 for mental health care in public hospitals.

Collectively, State and Territory Governments reported spending around \$4 billion on specialist mental health services in 2019-20. However, issues with the granularity of reported data made it difficult to identify how much of this expenditure was directed to public hospital-based services versus community-based services across most jurisdictions. In the couple of jurisdictions for which this funding breakdown could be separately identified, around 40–50 per cent of specialist mental health service expenditures were allocated to hospital-based programs. This is broadly consistent with AIHW estimates (based on 2018-19 data), which suggest that State and Territory Government expenditure on specialised mental

health services⁷ is relatively evenly split between public hospitals and community-based services, though this balance varies across jurisdictions (AIHW 2021a).

The data reported for this stocktake on community-based specialist services were relatively opaque, so the Productivity Commission has been unable to provide detailed insights on the specific community-based services that are funded by State and Territory Governments, and on whom they are focused. Despite this lack of reported information, community-based mental health services — including both health care services and supports beyond the health sector — play a critical role in facilitating an individual’s mental wellbeing and recovery from mental ill-health, as was highlighted in the Commission’s 2020 Mental Health inquiry (PC 2020, p. 24).

For each State and Territory Government, the largest category of reported program expenditure in 2019-20 was specialist mental health services or acute care.⁸ Expenditure on these two categories combined was \$5.9 billion across all State and Territory Governments, and ranged from 54 to 88 per cent of total spend across the jurisdictions (figure 2.7).

Based on the stocktake data, the Productivity Commission estimates that around \$5.9 billion was spent by the Australian, State and Territory Governments on mental health-related services in public hospitals and acute care.⁹ This represented a significant share of funding that is being spent on providing a relatively intense response to the range of mental health-related issues that are currently presented across the system.

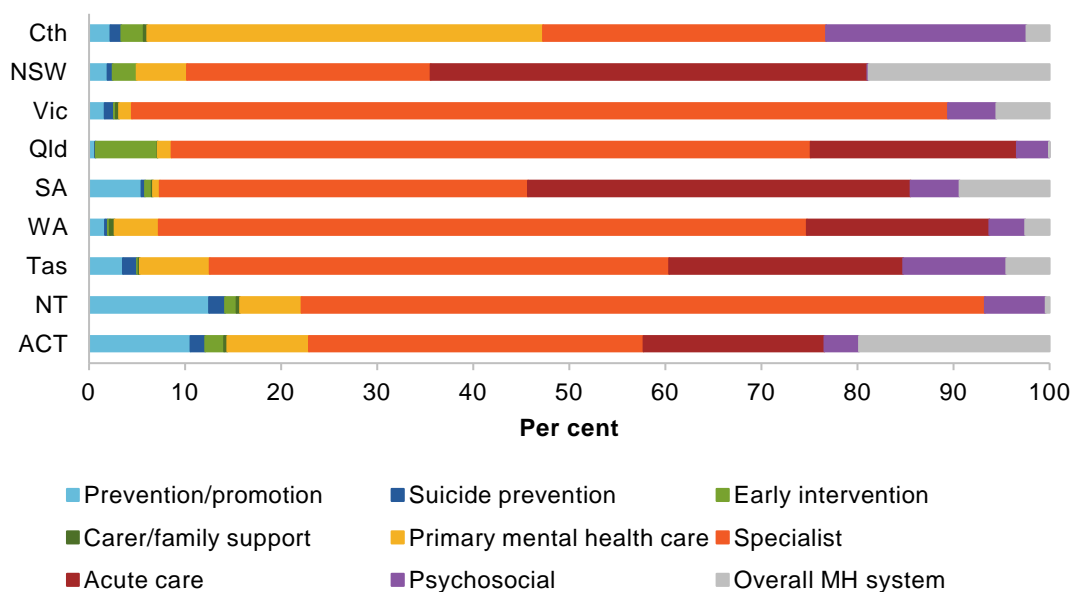
⁷ The AIHW’s specialised mental health services category represents a reasonable proxy for the specialist mental health service category used in the stocktake.

⁸ While the breakdown of expenditure by service category varied considerably across jurisdictions, it is important not to over-interpret these results. In particular, much of this variation can likely be explained by the different approaches taken by jurisdictions in providing data for the stocktake — for example, some jurisdictions categorised virtually all hospital-related mental health spending as specialist mental health services, while others allocated the bulk of this type of spending to acute care. Because the data were sometimes reported at an aggregated level (for instance, a single item on specialist mental health services and/or acute care), it was difficult for the Productivity Commission to identify and alter how reported expenditures are allocated.

⁹ This estimate includes all expenditure reported as acute care, the Australian Government’s transfers for public hospitals and half of State and Territory Governments’ reported expenditure on specialist mental health services (using the rough assumption that State and Territory Governments’ expenditures on specialist mental health services are about evenly split between hospital- and community-based services).

Figure 2.7 Jurisdictions reported different patterns of spending across service categories

Distribution of each jurisdiction's spend by service categories, 2019-20



Data source: Data provided by Australian, State and Territory Governments.

On psychosocial supports, State and Territory Governments reported spending \$226 million on programs in 2019-20. However, this likely represents an understatement, given jurisdictions provided little program data from community services portfolios (discussed above) — the Productivity Commission’s 2020 Mental Health inquiry estimated this area of expenditure was approximately \$452 million in 2018-19 (box 1.2).

In contrast to State and Territory Governments, the Australian Government’s reported program expenditure was more heavily weighted towards primary mental health care (41 per cent or \$2.9 billion in 2019-20), with specialist mental health services accounting for around 30 per cent (figure 2.7). This divergence in focus reflects the specific funding responsibilities of different levels of government.¹⁰

Within primary care, the Australian Government’s largest spending items were for mental health services provided through the Medicare Benefits Schedule (MBS)¹¹ (including the Better Access program) and subsidised mental health-related prescriptions via the

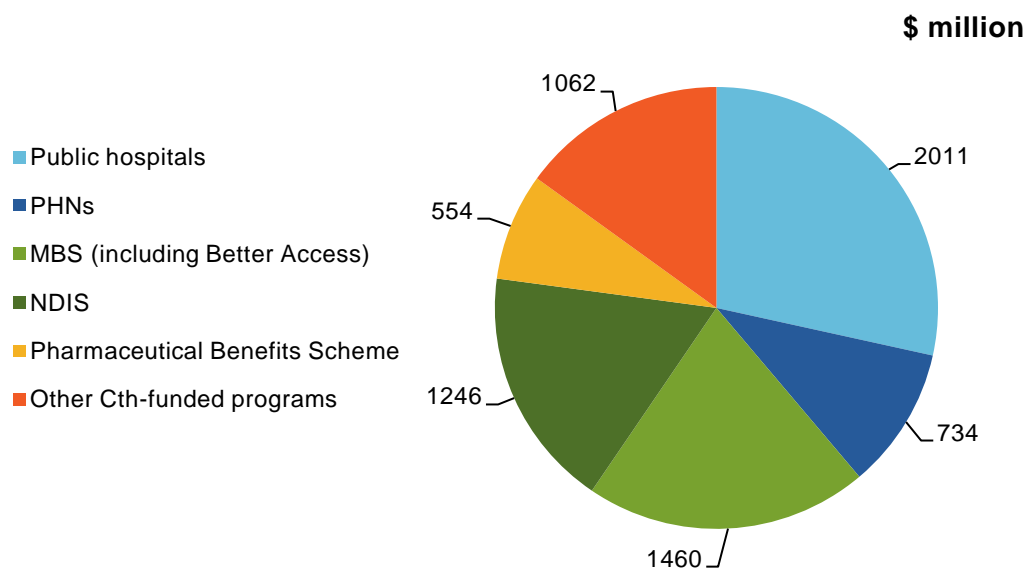
¹⁰ The Australian Government is responsible for Medicare-subsidised mental health services, subsidised mental health prescription medications, veteran’s mental health services, mental healthcare services delivered by general practitioners, primary care quality and access through PHNs and social security payments. State and Territory Governments are responsible for the management and administration of public hospitals, and funding and managing community-based mental health services (Cook 2019, p. 3).

¹¹ This captures mental health-related MBS items, including those provided by general practitioners, psychologists and psychiatrists.

Pharmaceutical Benefits Scheme — collectively totalling around \$2 billion in 2019-20 (figure 2.8). However, using MBS data to estimate expenditure on mental health services provided by general practitioners, who play a significant gatekeeper role in the mental health system, is likely to understate the extent of these services. For example, in 2015-16, the *Bettering the Evaluation and Care of Health* survey reported that there were almost 18 million mental health-related consultations with general practitioners, yet MBS data suggested only 3.2 million Medicare-subsidised mental health-specific services were delivered by general practitioners (AIHW 2021b).

Figure 2.8 Five programs make up the bulk of Australian Government spend^{a,b,c}

Australian Government spend on mental health and suicide prevention programs, 2019-20



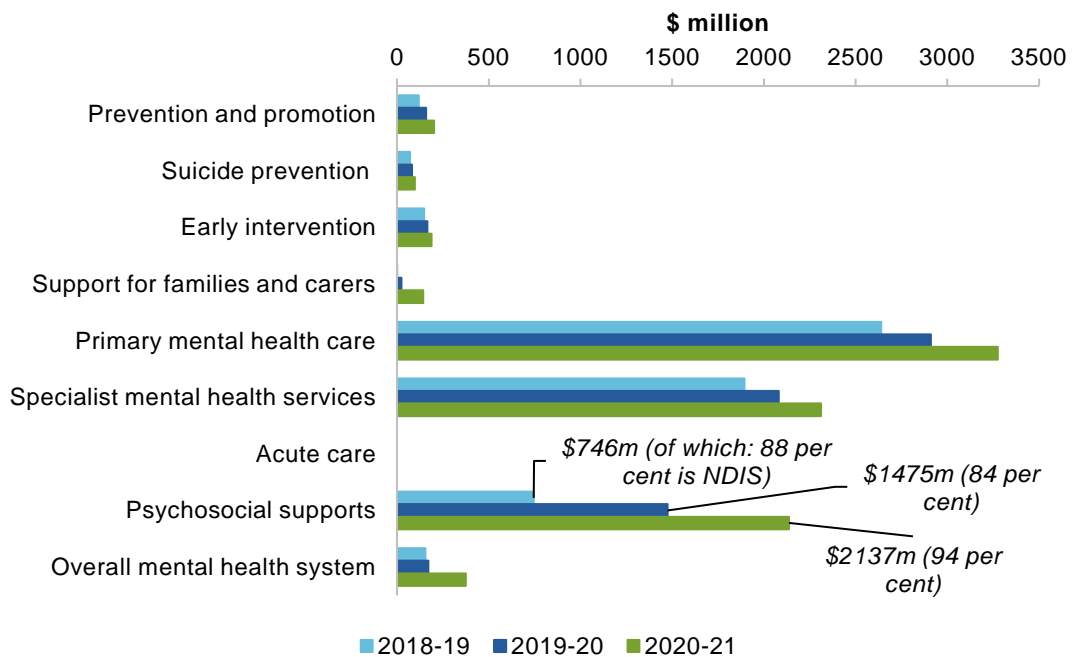
^a The Australian Government provides funding to State and Territory Governments for public hospitals under the National Health Reform Agreement. ^b Expenditure under the MBS includes Medicare rebates for mental health services provided by psychiatrists, psychologists and general practitioners as reported through relevant MBS items, and captures the Better Access program. ^c Expenditure under the Pharmaceutical Benefits Scheme is for mental health-related prescriptions only.

Data source: Data provided by the Australian Government.

There have been sizeable increases in the Australian Government’s funding for psychosocial supports over recent years (figure 2.9), driven by growth in mental-health related funding for the NDIS. While this is a substantial amount of government expenditure on supports for many people with psychiatric disability, it by no means covers the full extent of people with serious psychiatric illnesses who may be in need of broader support services. Outside of the NDIS, the Australian Government reported spending \$229 million on psychosocial support programs in 2019-20. Similar to State and Territory Government expenditures on psychosocial supports, this may well understate actual spend — the Productivity

Commission’s 2020 Mental Health inquiry estimated that the Australian Government spent around \$403 million on non-NDIS psychosocial supports in 2018-19 (box 1.2).

Figure 2.9 Australian Government spend on psychosocial support programs has increased significantly
 Australian Government program expenditure by service category, 2018-19 to 2020-21^a



^a Data reported for 2018-19 and 2019-20 are actual expenditure; data for 2020-21 are budgeted funding.
 Data source: Data provided by the Australian Government.

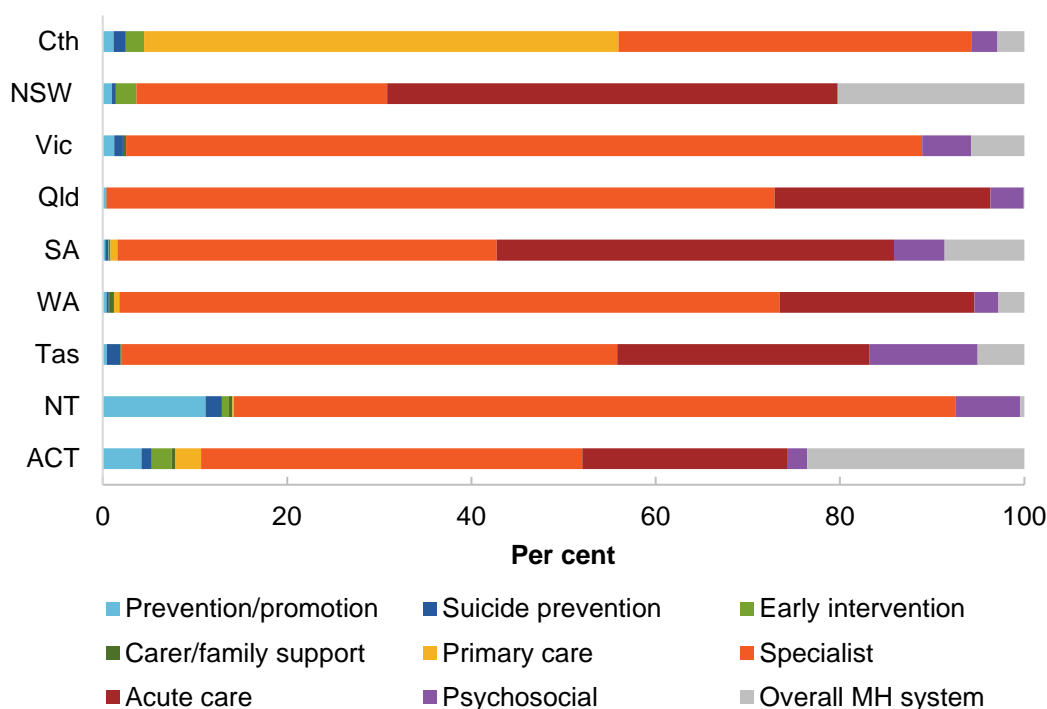
Notwithstanding the different funding responsibilities of the Australian and State and Territory Governments, reported program data suggest there are several areas where both levels of government fund similar services. These include student emotional wellbeing services, Aboriginal and Torres Strait Islander wellbeing and empowerment programs, psychosocial supports in the community (such as rehabilitation services and transition supports for recovery), and multiple programs designed to respond to specific disasters (such as bushfires, drought and COVID-19). While this is not necessarily evidence of any duplication or overlap in service delivery, it does underscore the importance of coordination between different levels of government, which is of particular relevance to the development of the new National Mental Health and Suicide Prevention Agreement.

Education portfolios generally focus on prevention and primary care

Unsurprisingly, agencies in the health portfolio predominantly funded programs in the specialist and acute care service categories, with primary care featuring prominently in reported health expenditure at the Commonwealth level (as discussed above) (figure 2.10).

Figure 2.10 Health portfolio programs are primarily in specialist mental health services and acute care

Distribution of each jurisdiction's health portfolio spend by service categories, 2019-20



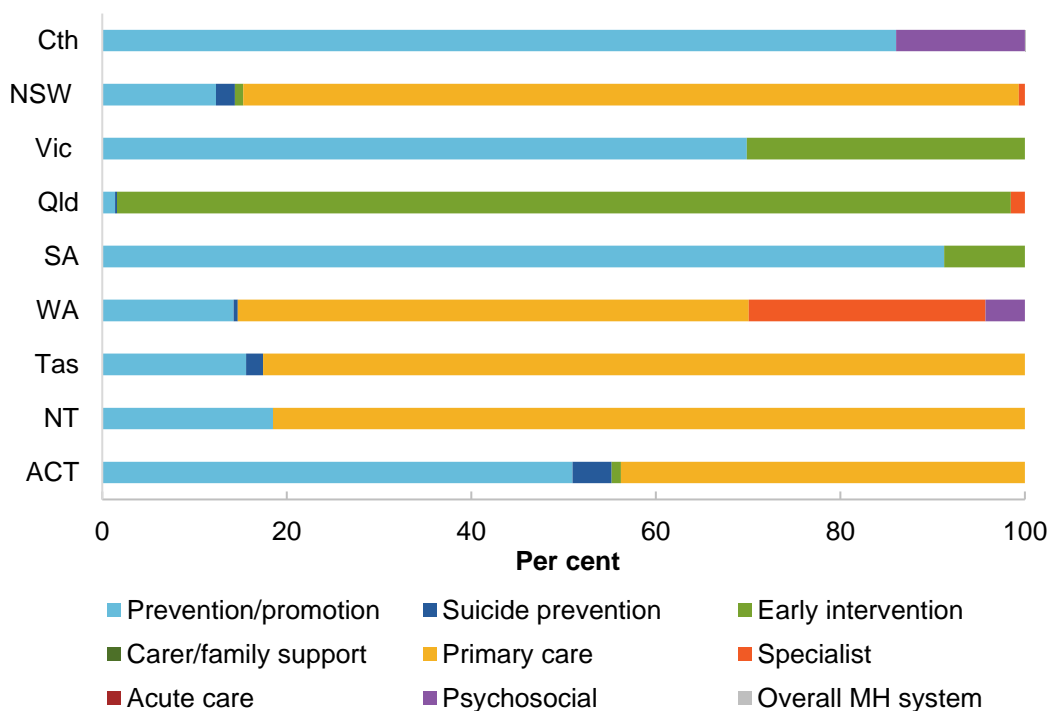
Data source: Data provided by Australian, State and Territory Governments

In contrast, reported programs from the education portfolio were primarily concentrated in prevention and promotion activities (such as teacher training to support student wellbeing), early intervention (such as guidance officers to assist students with complex mental health needs) and primary care (such as school counselling services and psychologists) (figure 2.11). Moreover, while the distribution of health expenditure by service category was reasonably consistent across jurisdictions, there was considerably more variation in how spending was allocated in the education portfolio.¹²

¹² The reasonably consistent distribution of health expenditure is notwithstanding some differences in the split between specialist services and acute care, as discussed above. Some of the variation in the allocation of education spend likely reflects differences in how jurisdictions interpreted the stocktake's services taxonomy.

Figure 2.11 Education portfolio programs are primarily in prevention and promotion, early intervention and primary care

Distribution of each jurisdiction's education portfolio spend by service categories, 2019-20



Data source: Data provided by Australian, State and Territory Governments

Evidence of targeted funding to vulnerable groups was limited

Individuals' mental health care needs can vary significantly depending on their age, background and other personal circumstances, and many jurisdictions fund programs and services that are targeted to supporting particular cohorts. While there is no single 'optimal' level of targeting for mental health and suicide prevention programs,¹³ shedding more light on the extent to which programs are currently targeted can provide a better understanding of the existing landscape of government funding.

For this stocktake, jurisdictions generally had difficulties reporting if and how their mental health and suicide prevention programs were targeted towards the severity of specific needs

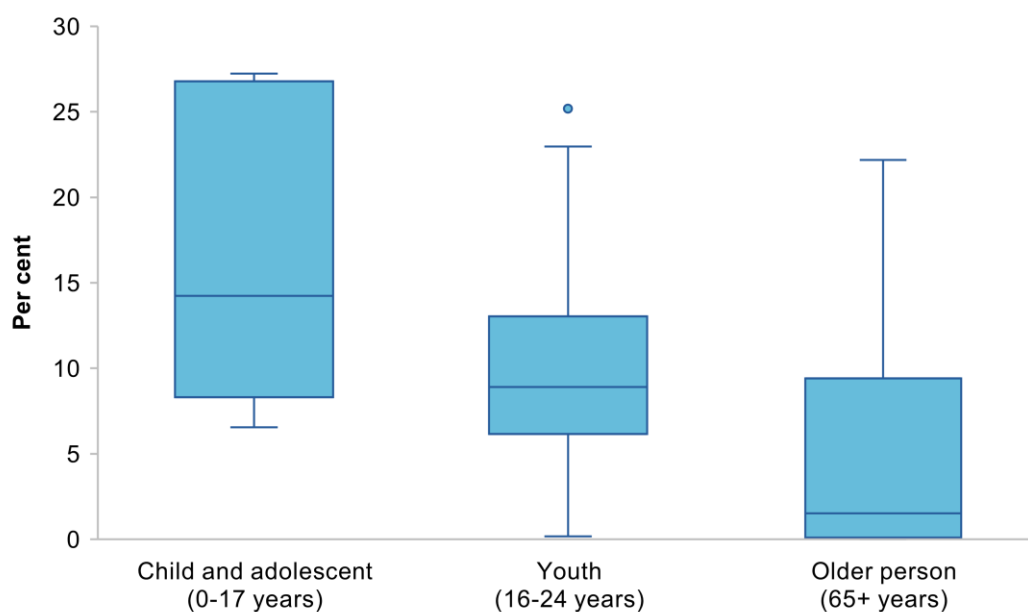
¹³ The appropriate amount of funding for different cohorts would vary across jurisdictions based on differences in population characteristics and the associated services demanded, and such a demand assessment has not been undertaken in this stocktake (chapter 4). In addition, it is not necessarily the case that higher rates of targeted funding are better — general programs that are not directed towards particular cohorts may, of course, still be consumed by these people.

(such as the at-risk population versus people with severe illness).¹⁴ While this suggests the data should be interpreted with caution, all jurisdictions reported that around 5–20 per cent of program expenditures were targeted towards the well population, and around 75–99 per cent were targeted to people with severe illnesses.

Jurisdictions reported some targeting of their mental health and suicide prevention programs based on demographic characteristics. For example, children and adolescents currently receive some targeted funding, though to varying extents across the jurisdictions (figure 2.12).

Figure 2.12 Children and adolescents receive relatively more targeted funding, with considerable variation between jurisdictions

Distribution of all jurisdictions' proportion of program expenditure targeted to particular age groups, 2019-20^a



^a This 'box and whisker' plot illustrates the spread of the proportion of jurisdictions' expenditure targeted to each age group. The middle horizontal line represents the median proportion across all jurisdictions. The bottom and top of the 'box' respectively illustrate the first and third quartiles (which have been calculated inclusive of the median). The bottom and top of the 'whiskers' respectively illustrate the minimum and maximum proportions across all jurisdictions, with dots indicating outliers that are more than 1.5 times the interquartile range above the third quartile.

Data source: Data provided by Australian, State and Territory Governments.

¹⁴ Target groups by severity of care needs were not required to be mutually exclusive, recognising that some programs may be targeted to more than one cohort. However, most jurisdictions had challenges in separately identifying targeted spend towards the at-risk population, people with mild conditions and/or people with moderate conditions — for much of the reported expenditure, multiple target groups were selected (or not selected) in an identical manner across many of a jurisdiction's programs. Moreover, in some cases, the highly aggregated nature of reported programs contributed to an inability to identify specific target groups (chapter 4).

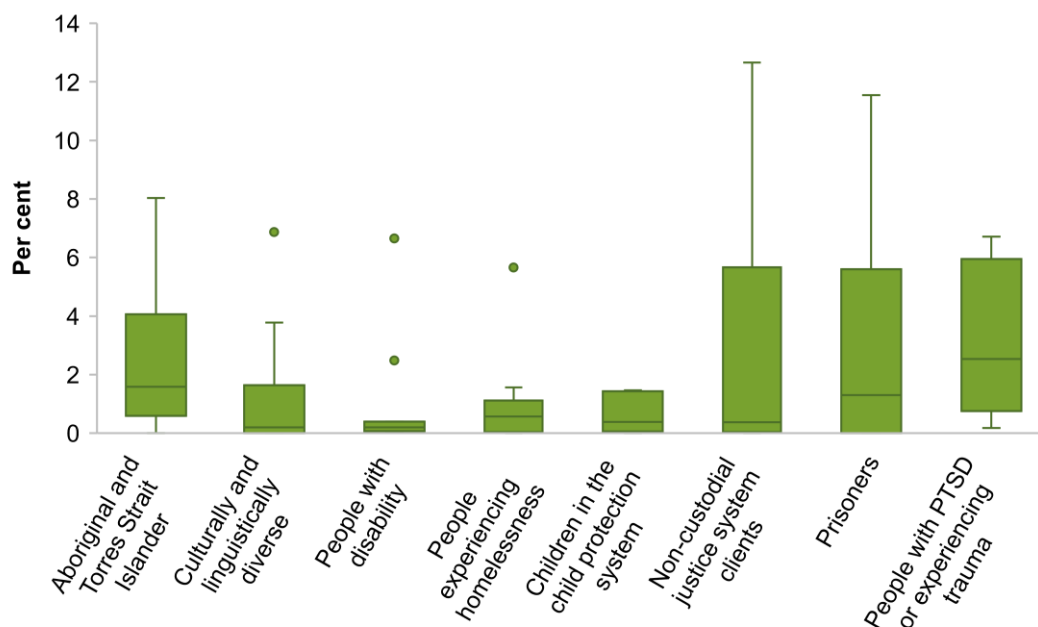
The stocktake revealed little evidence of targeted mental health and suicide prevention programs for other vulnerable subgroups, such as people experiencing homelessness and children in the child protection system (figure 2.13). That said, the reported data do highlight useful examples of the types of programs that some governments currently fund to benefit particular subgroups. For instance, across all jurisdictions in 2019-20:

- a median of 14.2 per cent of program expenditure was reported to be targeted towards children and adolescents, but this ranged from 6.6 to 27.2 per cent
 - examples of programs funded by State and Territory Governments included the provision of student wellbeing leaders, school psychologists and guidance officers
 - the Australian Government also had large expenditures targeted towards children and adolescents, including youth mental health services (such as those commissioned by PHNs, box 2.1) and the National School Chaplaincy Program to support students' emotional wellbeing
- a median of 1.6 per cent of program expenditure was reported to be targeted towards Aboriginal and Torres Strait Islander people, and this ranged from 0 to 8.0 per cent
 - examples of these programs included youth networks for prevention and promotion purposes, social and emotional wellbeing support for local communities, and mental health-related components of Aboriginal Medical Services
 - the extent to which this expenditure is used to deliver culturally competent care was unclear in the data received for the stocktake. However, only a very small number of programs were reported to provide funding to Aboriginal Community Controlled Organisations and other Aboriginal or Torres Strait Islander-owned or controlled service providers¹⁵
- a median of 0.6 per cent of program expenditure was reported to be targeted towards people experiencing homelessness or in unstable housing, and this ranged from 0 to 5.7 per cent
 - the limited reported programs were predominantly comprised of psychosocial supports, such as personalised housing support services delivered in the community, with a small amount of specialist services (for example, residential programs that assist with recovery following an acute episode of mental illness)
- a median of 2.5 per cent of program expenditure was reported to be targeted toward people with post-traumatic stress disorder or experiencing trauma, and this ranged from 0.2 to 6.7 per cent
 - examples of these programs included training to support first responders; counselling for survivors of torture, family and domestic violence; integrated specialist services for adult survivors of child sex abuse; mental health-related assistance for asylum seekers and refugees; and supports for people affected by road trauma.

¹⁵ These data were likely to be incomplete as several larger jurisdictions reported few or no such programs.

Figure 2.13 Vulnerable cohorts generally do not receive much targeted funding

Distribution of all jurisdictions' proportion of program expenditure targeted to particular vulnerable cohorts, 2019-20^a



^a This 'box and whisker' plot illustrates the spread of the proportion of jurisdictions' expenditure targeted to each vulnerable cohort. The middle horizontal line represents the median proportion across all jurisdictions. The bottom and top of the 'box' respectively illustrate the first and third quartiles (which have been calculated inclusive of the median). The bottom and top of the 'whiskers' respectively illustrate the minimum and maximum proportions across all jurisdictions, with dots indicating outliers that are more than 1.5 times the interquartile range above the third quartile.

Data source: Data provided by Australian, State and Territory Governments.

Moreover, people in rural, regional and remote communities are a specific subgroup of the population that can face barriers in accessing mental health and suicide prevention services. While limited in its granularity, the information reported to this stocktake included a handful of programs specifically targeted at these localities, such as:

- emergency mental health telehealth services provided in regional and remote areas
- counselling support programs in regional and remote hospitals
- initiatives to improve the emotional wellbeing of support workers in remote areas.

In addition, even if they are not targeted towards people living in rural, regional and remote areas, mental health services that are delivered over the phone or online — box 2.3 — can also assist in supporting these communities.

Box 2.3 How were programs delivered over the phone or online reported in the stocktake?

Online and telehealth services play an important role in providing access to mental health and suicide prevention services, given resource constraints and prevailing service gaps (particularly for low-intensity services). They also improve consumer choice and provide a convenient and low-cost way for consumers to manage their mental ill-health, by enabling people to undertake treatment at a place and time that is suitable for them. They can have particular benefits in meeting the needs of rural, regional and remote communities where access to quality care may otherwise be limited (for example, due to a local shortage of mental health professionals).

A range of mental health and suicide prevention programs reported to this stocktake were delivered online or over the telephone. Many of these were provided by general practitioners or other private mental health professionals, so were largely funded by the Australian Government. These programs included the Digital Mental Health Services Program; elements of the COVID-19 Emergency Response; Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule; and Better Access Telehealth Services. There has been increased funding and focus on online and telehealth services during and following the COVID-19 pandemic, given the reduced access to face-to-face services over this period.

State and Territory Governments' expenditure on programs delivered online or over the telephone appears to be relatively smaller — examples reported in the stocktake included funding for mental health services helplines and digital programs to support employee mental health (such as an online hub for mentally healthy workplaces and a wellbeing app). However, State and Territory Governments may fund other services delivered online or by telephone that were not able to be captured by the stocktake, due to the limited information provided regarding individual programs. Notwithstanding this limitation, there is likely to be room for increased online delivery of mental health and suicide prevention programs.

Sources: Data provided by Australian, State and Territory Governments.

Overall, the difficulties that jurisdictions experienced in reporting data on how mental health and suicide prevention programs are targeted to particular groups suggest that it is a challenge for governments to identify the different types of consumers that their services are aimed at. Governments generally demonstrated a good awareness of the types of programs that are being funded in this stocktake. However, the limited understanding of target groups (such as by severity of care needs or geography) appears to be a barrier to implementing consumer-focused strategies that reach segments of the population in the most suitable ways.

3 Implications for developing the National Agreement

The Productivity Commission’s 2020 Mental Health inquiry recommended a National Mental Health and Suicide Prevention Agreement should be developed to ‘clarify the roles and responsibilities of the Australian Government and State and Territory Governments and establish funding commitments by both levels of government’ (PC 2020, p. 57). Governments have committed to finalising an agreement by November 2021.

Despite the challenges inherent in undertaking this stocktake, it has provided insights on Australia’s mental health and suicide prevention system that will be useful for informing the National Agreement. It has demonstrated that both the Australian and State and Territory Governments play significant roles in mental health and suicide prevention funding, and while the two levels of government generally fund different types of programs, the need for coordination remains strong given the importance of integration across the system.

A significant portion of expenditure on mental health and suicide prevention programs is allocated to activity-based or demand-driven health services. Based on stocktake data, the Productivity Commission estimates that in 2019-20, \$7.9 billion was spent on hospital beds, emergency and first response services, MBS items for primary mental health care (including the Better Access program), and subsidised mental health-related prescriptions.¹⁶ This expenditure is effectively incurred (and recurs) automatically as mentally unwell people access care and treatment, almost entirely in the health system — funding for mental health and suicide prevention programs outside of health portfolios is largely not activity based.

However, the large amount of funding for activity-based programs does not necessarily mean that people with mental ill-health are receiving the services they need. Many individual aspects of these programs are driven by decentralised decisions — for example, practitioners decide to admit a patient into hospital, items on the MBS and Pharmaceutical Benefits Scheme are individually assessed before they are listed, and general practitioners refer patients to psychologist or psychiatrist services to receive MBS funding. These ‘bottom-up’ decisions are important elements of a consumer-focused approach to mental health care.

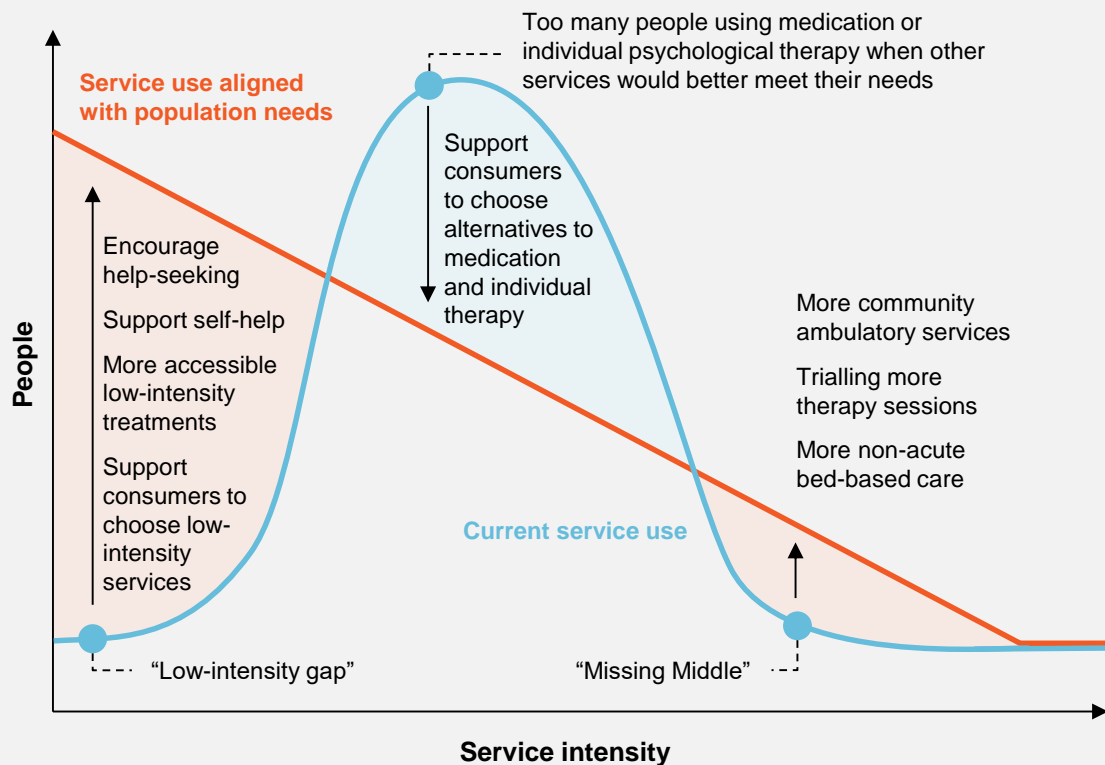
But decision making can be distorted if there are gaps in the services provided across the mental health and suicide prevention system. For example, the Productivity Commission’s 2020 inquiry highlighted a lack of mental health services with regards to both the ‘low

¹⁶ This estimate includes all expenditure reported by State and Territory Governments as acute care, and half of their reported expenditure on specialist mental health services (using the rough assumption that State and Territory Governments’ expenditures on specialist mental health services are about evenly split between hospital- and community-based services).

intensity gap’ and the ‘missing middle’ (box 3.1). Where these gaps exist, activity-based funding mechanisms that effectively allocate funding in line with apparent demand will not result in the best consumer outcomes or value for money. They can lead to imbalances in the services that are funded across the system, and as such, what the system delivers may not necessarily be the optimal mix of services that people need. Overall, the significant share of governments’ mental health and suicide prevention funding allocated to activity-based services suggests that such imbalances are worth further examination, to better understand whether the expenditure is producing the right mix of services to meet consumers’ needs.

Box 3.1 Low intensity services and the missing middle are key gaps in the mental health system

The Productivity Commission specifically identified two key gaps in clinical mental health services in its 2020 Mental Health inquiry — the low intensity gap and the missing middle (figure below).



The low intensity gap is a shortfall in the utilisation of low cost, low risk and easy to access mental health services. This gap affects two groups: people who are not accessing any mental health services but could benefit from services matched to their needs (as they may have a mental illness, or be at risk of developing one); and people who are taking mental health medication, or accessing individual psychological therapy, but would be better served by low-intensity options.

The missing middle captures Australians whose illnesses are too complex, too severe or too enduring to be treated by primary care services alone, but who are deemed ‘not sick enough’ to access specialist mental health services, or who access some care but not enough. It largely reflects a lack of community mental health services to meet these individuals’ care needs.

Source: PC (2020).

In this context, a National Mental Health and Suicide Prevention Agreement provides an opportunity to be more purposeful and strategic in how government funding is allocated across the system. This stocktake has revealed that jurisdictions are not starting from zero when it comes to funding proactive and deliberately directed programs. While expenditures on areas such as prevention and promotion, early intervention and suicide prevention are low as a proportion of total spend, the types of programs currently being funded by education portfolios — and by justice and police portfolios in some states and territories — are a solid basis on which future expenditure can build.

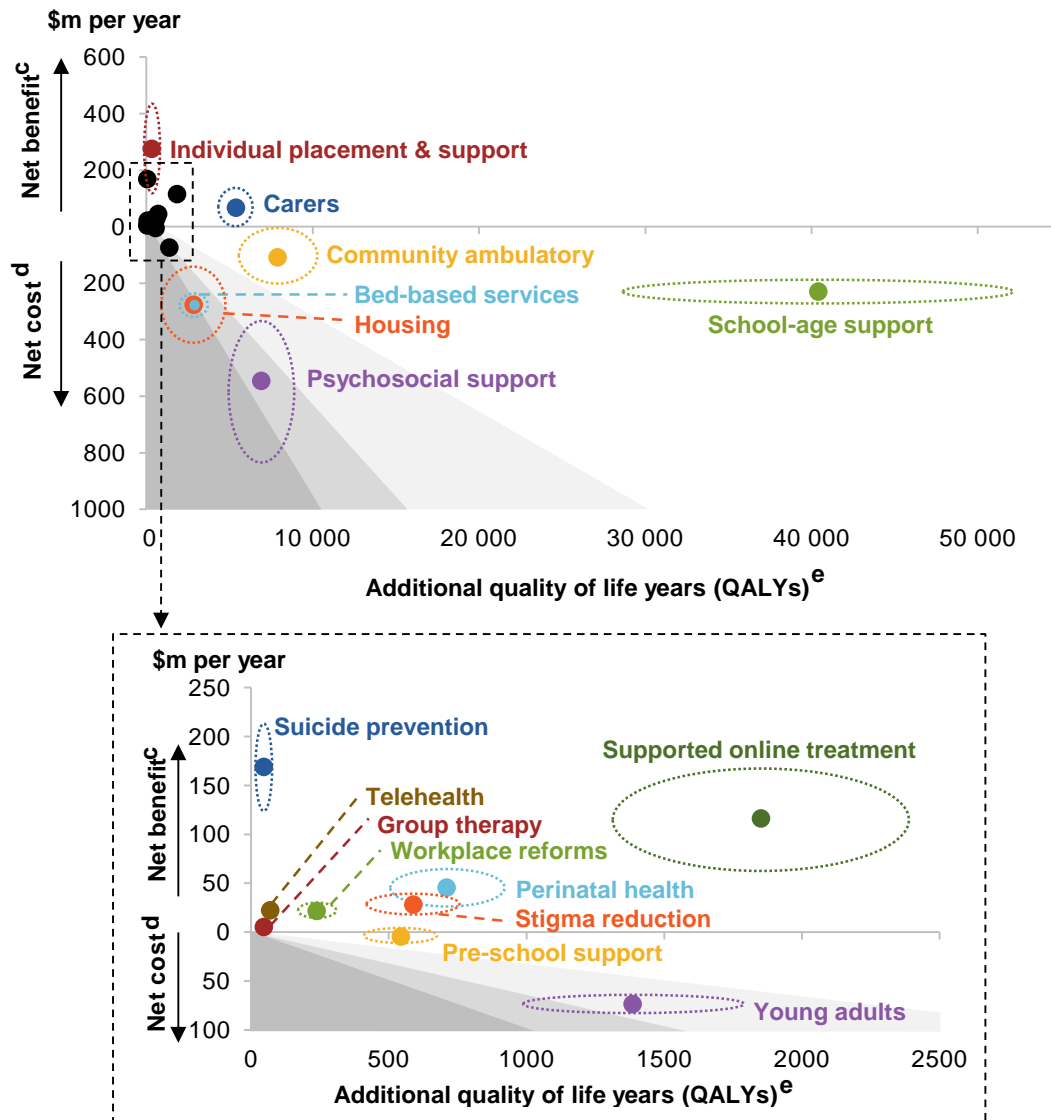
Current programs in the education sector are particularly important to build upon, as the Productivity Commission has previously identified that further investment in school-age mental health and wellbeing supports would lead to a significant increase in quality of life years, due to the resulting reduction in the duration and severity of mental illness (figure 3.1). The Commission's 2020 inquiry also highlighted the potential value in a range of other government-funded services that would assist in meeting consumers' needs in the 'low intensity gap' and the 'missing middle', but that would require more conscious investment decisions at a system level (as compared with the demand-driven services discussed above). These include suicide prevention initiatives, supported online treatments and community-based ambulatory services (figure 3.1).

The development of a National Agreement also provides an opportunity to clarify the roles and responsibilities of *all* areas of government — both health and non-health portfolios. This will be critical in enabling a holistic and integrated approach to managing mental ill-health, and improving mental health and suicide prevention outcomes. Indeed, this stocktake has revealed that many portfolios that should — and often do — have a role in supporting mental health do not always regard themselves as part of the system, and/or do not have a good understanding of their consumers' needs. This was indicated by a dearth of data on:

- mental-health related expenditure in areas such as housing, justice and community services (chapter 1) — despite estimates from the Productivity Commission's 2020 Mental Health inquiry suggesting that governments spend significant amounts in these areas (box 1.2)
- the targeted beneficiaries or consumers (in terms of severity of condition, location and so on) of programs that focus on mental health or suicide prevention (chapter 2).

In some ways, this stocktake — which finds that the large bulk of reported program expenditure stems from health portfolios — highlights the risk of an overly health-centric approach, which governments have traditionally taken to improving mental health and suicide prevention outcomes. System improvement will require broad commitment and reform across *all* areas of government, not just health.

Figure 3.1 **Investing in school-age supports can lead to large gains**
 Recommended reforms from the Productivity Commission's 2020 inquiry^{a,b}



a Chart shows only those reforms that were able to be quantified. Dotted orbits represent uncertainty in estimates for each reform, showing the range of simulated estimates between the 5th and 95th percentiles for changes in costs and quality-adjusted life years (QALYs). **b** Shaded areas show thresholds of cost effectiveness — darker shading indicates lower cost effectiveness (appendix I). Reforms that sit above zero are cost saving. Reforms that sit below zero and outside the shaded areas cost less than \$33 000 per QALY gained. Reforms that sit in the lightest shaded area cost \$33 000–\$64 000 per QALY gained. Reforms that sit in the medium shaded area cost \$64 000–\$96 000 per QALY gained and are considered marginally cost effective. Reforms that sit in the darkest shaded area cost more than \$96 000 per QALY gained and are considered not cost effective. **c** 'Net benefit' is the estimated cost savings and additional employment income generated by the reform that exceeds the estimated cost of implementing the reform (every dollar spent will generate a benefit of more than one dollar). **d** 'Net cost' means the estimated cost of implementing the reform is larger than the estimated cost savings and additional employment income generated by the reform (every dollar spent will generate a benefit of less than one dollar). **e** QALYs measure the improvement in health experienced by reductions in the duration and severity of illness.

Data source: PC (2020).

The National Agreement also represents a chance for governments to more actively and explicitly identify the mental health and suicide prevention outcomes being sought via their expenditures, and design programs with the characteristics and needs of consumers front of mind. This does not necessarily mean devising more programs explicitly badged as being ‘about mental health’, or re-branding existing programs with this focus. Rather, it is about harnessing all areas of government to work towards a shared aim of improving mental health and suicide prevention outcomes.

This stocktake has uncovered a range of programs and types of services funded by different jurisdictions, which highlights the importance of several other desirable features of a National Mental Health and Suicide Prevention Agreement, including that it:

- provides some impetus for jurisdictions to learn from each other on what (and how) programs could be funded in different areas
- embeds a greater commitment to program evaluation into the mental health and suicide prevention system (chapter 4)
- is sufficiently flexible to accommodate the diversity of needs across different jurisdictions, and allows for localised agreements and decision making within the national arrangements
- pursues further opportunities to refine data gathering efforts and share information (chapter 4).

4 Future opportunities

In undertaking this stocktake, the Productivity Commission encountered information gaps that limited its ability to compile a complete and consistent dataset (chapter 1). Furthermore, even if the stocktake data had been more comprehensive, there is a limit to the usefulness of expenditure information alone for targeting and implementing future reforms to Australia's mental health and suicide prevention system. This chapter outlines some opportunities for further data collection and research that have been illuminated by the stocktake. These future opportunities can be pursued as part of the National Mental Health and Suicide Prevention Agreement, and do not necessarily need to take place prior to its development.

Improving the quality of program data

Comprehensive data on governments' expenditures on mental health and suicide prevention programs — across *all* levels of government, portfolios and target groups — are required to inform and coordinate future reform efforts. For this stocktake, some jurisdictions experienced challenges in providing information on relevant expenditure, including:

- limited ability to identify and/or estimate funding for mental health and suicide prevention programs, particularly outside the health portfolio
 - for example, an inability to provide expenditure on mental health-related training for police or corrections services, or to estimate the portion of overall funding for some programs (such as school nurses or general supports) that was dedicated to mental health
- difficulty reporting details of identified expenditures, including limitations on the extent to which aggregated funding could be meaningfully split into separate programs
 - for example, reporting combined spend on hospital- and community-based specialist mental health services, or grants provided to organisations that deliver programs across multiple service categories.

More granular information is needed for a detailed understanding of where governments' current funding efforts are concentrated in the mental health and suicide prevention system, and to be able to deliberately target programs and services towards addressing individual and community needs. In addition, a holistic and integrated approach to improving mental health and suicide prevention outcomes requires visibility over these data across the system, including from portfolios that may not currently regard themselves as playing a role in supporting mental health (chapter 3).

The Productivity Commission notes that jurisdictions varied in their ability to identify and report relevant programs and services. For example, some jurisdictions were able to separately identify community-based specialist services (from hospital-based services), or to

apportion the mental health component of broader programs using other available data (such as the number of service users with mental illness). This suggests that jurisdictions could learn from each other regarding how to improve their monitoring and reporting of government expenditure on mental health and suicide prevention, in order to better understand the funding landscape across all sectors.

Assessing what works in improving mental health outcomes

Evaluations are an important part of the policymaking process. They help policymakers understand whether funding has improved outcomes and met community needs, as well as identify lessons about whether and why particular elements were successful. However, the stocktake revealed that only a small proportion of mental health and suicide prevention programs had been evaluated — less than 10 per cent of reported program expenditures in most jurisdictions. A key contributing factor was that many programs that had significant allocated funding had not been evaluated, both in and outside the health portfolio. Smaller programs were more likely to have undergone evaluation — however, evaluation completion rates for even these programs were patchy across jurisdictions and agencies.

Given the critical role evaluations play in improving the design and implementation of government-funded programs, mental health and suicide prevention programs should be evaluated more regularly. This is particularly the case for programs and services that represent a relatively large share of expenditure, as these have the potential to significantly impact outcomes (or to represent poor value for money if ineffective).

Bringing together a full picture of the system

There are various opportunities for jurisdictions to undertake further research that would complement the findings of this stocktake, by gathering and analysing data that were unable to be captured here given time and scope constraints. For instance:

- A range of other stakeholders outside of governments also fund mental health and suicide prevention programs. These include local governments, non-government organisations such as charities or community groups, and private sources of funding (including payments by individual consumers). Compiling expenditure data from these other sources would provide a more complete picture of the funding landscape.
- Examining what is commissioned and delivered ‘on the ground’ using government funding would enable a better understanding of whether community needs are being met. This could include, for example, investigating the services that are commissioned with the Australian Government funding provided to PHNs, and understanding who receives grants from State and Territory Governments and what services they deliver with this

funding. This would enable more detailed insights on what community-based mental health services are delivered with funding provided by governments, and where.

- Identifying gaps in the mental health and suicide prevention system requires measuring service demand at a local level. This is necessary to determine whether the services being funded and delivered align with the needs of particular communities and target groups. Estimating demand and service shortfalls was also recommended in the Productivity Commission’s 2020 inquiry, in areas such as community ambulatory services, bed-based mental health services and psychosocial supports (PC 2020, pp. 71–72, 76).

This stocktake of government-funded mental health and suicide prevention programs represents an important piece of a larger puzzle in developing a collective understanding of the system. A National Mental Health and Suicide Prevention Agreement could entrench further data collection and research that complements this stocktake and builds on its findings. This will assist in promoting continuous improvement in developing, targeting and implementing future reforms.

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