Fourth National Mental Health Plan

An agenda for collaborative government action in mental health 2009-2014

Prepared by:
Fourth National Mental Health Plan Working Group

Draft 2 June 2009
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[To be completed by the Australian Health Ministers’ Conference once plan is endorsed]
Summary of priority areas, outcomes and actions

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<thead>
<tr>
<th>Priority area 1. Social inclusion and recovery</th>
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<tr>
<td><strong>Outcome</strong></td>
<td><strong>Actions</strong></td>
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<tr>
<td>The community has a better understanding of the importance and role of mental health and wellbeing, and recognises the impact of mental illness.</td>
<td>Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.</td>
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<tr>
<td>People with mental health problems and mental illness are valued and supported by their communities to realise their potential, and live full and productive lives.</td>
<td>Provide mental health education to front line workers in health, emergency, welfare and associated sectors.</td>
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<tr>
<td>Service delivery is organised to provide more coordinated care across health and social domains.</td>
<td>Coordinate effort between the health, education and employment sectors to provide supported education, employment and vocational programs which are linked to clinical and community living support mental health services.</td>
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<td>Improve coordination between primary care and specialist services in the community to develop recovery-oriented care, enhance consumer choice, and facilitate ‘wrap-around’ service provision.</td>
<td>Develop integrated programs between mental health services and housing agencies to provide tailored support to people with mental illness and mental health problems living in the community.</td>
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<th>Priority area 2. Prevention and early intervention</th>
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<tr>
<td><strong>Outcome</strong></td>
<td><strong>Actions</strong></td>
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<tr>
<td>People have a better understanding and recognition of mental health problems and mental illness. They are supported to develop resilience and coping skills.</td>
<td>Work with schools, workplaces and communities, including Indigenous and culturally and linguistically diverse communities, to deliver programs to improve mental health literacy and awareness and to support resilience and enhance coping strategies.</td>
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<tr>
<td>People are better prepared to seek help for themselves and to support others to prevent or intervene early in the onset or recurrence of mental illness.</td>
<td>Implement targeted prevention and early intervention programs for children and their families through partnerships with organisations such as maternal and child health services, schools and specialist mental health services.</td>
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<td>There is greater recognition and response to co-occurring alcohol and other drug problems and physical health issues. Generalist services have support and access to advice and specialist services when needed.</td>
<td>Further develop community-based youth mental health services which are accessible and which combine primary health care, alcohol and other drug services and mental health services.</td>
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<td></td>
<td>Align and coordinate new and existing State, Territory and Commonwealth suicide prevention strategies, plans and programs through a nationally agreed suicide prevention framework.</td>
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<td>Implement a renewed Aboriginal and Torres Strait Islander Social and Emotional Well Being Framework.</td>
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<td>Expand the level and range of support for families and carers of people with mental illness and mental health problems, including recognition of the risk experienced by children of a parent with a mental illness.</td>
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<td>Develop tailored mental health care responses for highly...</td>
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<td>Priority area 3. Service access, coordination and continuity of care</td>
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<td><strong>Outcome</strong></td>
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<tr>
<td>There is improved access to appropriate care, continuity of</td>
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<td>care and reduced rates of relapse and re-presentation to</td>
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<td>mental health services.</td>
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<td>There is an adequate level and mix of services through</td>
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<td>population-based planning and service development across</td>
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<td>sectors.</td>
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<td>Governments and service providers work together to establish</td>
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<td>organisational arrangements that promote the most effective</td>
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<td>and efficient use of services, minimise duplication and</td>
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<td>streamline access.</td>
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<td><strong>Actions</strong></td>
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<tr>
<td>Develop a national service planning framework that</td>
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<td>establishes targets for the mix and level of the full range</td>
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<td>of mental health services, backed by innovative funding</td>
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<td>models.</td>
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<td>Establish regional partnerships of funders, service</td>
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<td>providers, consumers and carers and other relevant</td>
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<td>stakeholders to develop local solutions to better meet the</td>
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<td>mental health needs of communities.</td>
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<td>Improve communication across primary care and specialist</td>
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<td>services, and across clinical and community support</td>
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<td>services, through the development of new systems and</td>
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<td>processes in order to promote continuity of care and service</td>
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<td>integration.</td>
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<td>Work with emergency and community services to develop</td>
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<td>protocols to guide and support transitions between service</td>
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<td>sectors and between jurisdictions.</td>
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<td>Improve linkages and coordination between alcohol and other</td>
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<td>drug services, mental health services and primary care</td>
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<td>services, in order to facilitate better integration, earlier</td>
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<td>identification, referral and treatment for mental and</td>
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<td>physical health care.</td>
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<td>Develop and implement systems to ensure information about</td>
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<td>the pathways into and through care is highly visible,</td>
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<td>readily accessible and culturally relevant.</td>
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<td>Better target services and address service gaps through</td>
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<td>cooperative service models for the delivery of primary</td>
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<td>mental health care that incorporate government and non-</td>
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<td>government activity.</td>
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<th>Priority area 4. Quality improvement and innovation</th>
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<tr>
<td><strong>Outcome</strong></td>
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<tr>
<td>The community has access to information on service delivery</td>
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<td>and outcomes on a regional basis. This includes reporting</td>
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<td>against agreed standards of care including consumers’ and</td>
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<td>carers’ experiences and perceptions.</td>
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<td>Mental health legislation meets agreed principles and is</td>
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<td>able to support appropriate transfer of civil and forensic</td>
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<td>patients between jurisdictions.</td>
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<td>There are explicit avenues of support for emerging and</td>
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<td>current leaders to implement evidence based and innovative</td>
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<td>models of care, to foster research and dissemination of</td>
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<td>findings.</td>
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<td><strong>Actions</strong></td>
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<tr>
<td>Review the Mental Health Statement of Rights and</td>
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<td>Responsibilities.</td>
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<td>Review and where necessary amend mental health legislation</td>
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<td>to support cross-border agreements and transfers of people</td>
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<td>under civil and forensic orders, and scope requirements for</td>
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<td>the development of nationally consistent mental health</td>
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<td>legislation.</td>
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<td>Develop and commence implementation of a National Mental</td>
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<td>Health Workforce Strategy that provides standardised</td>
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<td>workforce competencies or roles in clinical, non-government</td>
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<td>community support and peer support.</td>
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<tr>
<td>Increase consumer and carer employment in clinical and</td>
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and to further workforce development and reform.

non-government community settings.

Ensure accreditation and reporting systems in health and community sectors incorporate the National Standards for Mental Health Services.

Further develop and progress implementation of the National Mental Health Performance and Benchmarking Framework

Develop a national mental health research strategy to drive collaboration and inform the research agenda.

Better utilise innovative telephone and web-based services to address the needs of people in remote areas or who prefer anonymity.

**Priority area 5. Accountability – measuring and reporting progress**

<table>
<thead>
<tr>
<th>Outcome</th>
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<tr>
<td>The public is able to make informed judgements about the extent of mental health reform in Australia, including the progress of this Plan, and has confidence in the information available to make these judgements. Consumers and carers have access to information about the performance of services responsible for their care across the range of health quality domains and are able to compare these to national benchmarks.</td>
<td>Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs. Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders. Further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting. Conduct a rigorous evaluation of the Fourth National Mental Health Plan.</td>
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</table>
The Fourth National Mental Health Plan

Good mental health is a crucial aspect of good general health, and underpins a productive and inclusive society. For this reason, it is a priority area for all levels of government. This Fourth National Mental Health Plan sets an agenda for collaborative government action in mental health for the next five years. It provides guidance to improve community understanding of mental illness and mental health problems and the risk factors associated with them. It offers a framework within which to support a system of care that is able to intervene early and provide holistic integrated services across health and social domains. It provides direction to governments regarding future funding priorities. In this way, it promotes good mental health for all Australians.

Development

Development of the Fourth Plan began with a comprehensive analysis of recommendations of key national reports over the last five years, including the final reports of the Senate Community Affairs Committee and Senate Select Committee Inquiries into mental health services in Australia and the work of the National Health and Hospitals Reform Commission. This was followed by an extensive consultation process with consumers, their carers and families, service providers and policy-makers and planners from a range of government portfolios. The consultations included two national forums, a series of national and state/territory-based sessions, and formal discussions with a number of Ministerial Advisory Councils (see Appendix 1 for further detail).

A population health framework

The Fourth Plan adopts a population health framework. This framework recognises that mental health and illness result from the complex interplay of biological, social, psychological, environmental and economic factors at all levels. The determinants of mental health status include factors such as income, education, employment and access to community resources. The population health framework acknowledges the importance of mental health issues across the lifespan from infancy to old age, and recognises that some people may be particularly vulnerable because of their demographic characteristics (e.g. age, cultural background) or their experiences (e.g. exposure to trauma or abuse). Services must be flexible to meet the specific needs of different groups with different needs. This means that a holistic response to mental health problems and mental illness is required – one that recognises the importance of community support services and accommodation, as well as expert and appropriate clinical services. Interventions must be evidence-based, comprehensive and complementary, and cover the spectrum from prevention to relapse prevention and recovery. They must also recognise the importance of self-determination, self-care and self-help. Service development should strive to ensure equitable access and to achieve the best possible outcome. The Plan recognises effective linkages must be formed between different sectors for this holistic response to work.

A whole-of-government approach

The Fourth Plan operationalises the population health framework through a whole-of-government approach to achieving change. The whole-of-government approach involves a national effort which operates across Commonwealth and state/territory levels of responsibility, and extends beyond the mental health sector, in recognition of the fact that the determinants of good mental health, and of mental illness, are influenced by factors outside the health system. The Plan emphasises the way in which reforms in the mental health sector can inter-relate with policy directions of other government portfolios, with a view to ensuring that people with mental health problems and mental illness can benefit from them in the greatest way possible. As noted above, Ministerial Advisory Councils from beyond the health sector were involved in the development of the Plan. This enabled articulation of the current roles and responsibilities of other portfolios as they relate to improving mental health outcomes (see Appendix 2), and constitutes recognition of the responsibility that the health sector has in engaging with other sectors to achieve demonstrable gains in the mental health and wellbeing.
of the community. The Plan recognises that a number of other sectors have begun to make headway in this regard, and builds on current developments.

The relationships between relevant portfolio areas must continue to be developed. This Plan provides a basis for governments to emphasise mental health in a more integrated way, as represented in Figure 1. Figure 1 does not seek to provide a comprehensive representation of all facets of a whole-of-government approach, but it does reflect that mental health is a shared responsibility across sectors, and that each sector should seek to better integrate mental health into its core business.

The whole-of-government approach will require different models of governance to be developed. Greater responsibility for service delivery will need to occur at a regional level, in order to cross sectoral boundaries and boundaries related to funding sources. Innovative models of employment may need to be considered in order to expand individuals’ roles and responsibilities.

Figure 1: A whole-of-government approach to mental health
Scope and directions

The Plan targets the full spectrum of people who experience mental health problems and mental illness, as well as their carers and families. It is not linked to diagnosis, level of disability or age.

The Plan is underpinned by eight key principles (see Box 1) and focuses on five priority areas for national action. These priority areas emerged from the above consultations, and are as follows:

- Social inclusion and recovery;
- Prevention and early intervention;
- Service access, coordination and continuity of care;
- Quality improvement and innovation; and
- Accountability – measuring and reporting progress.

For each priority area, key outcomes have been identified, along with actions to achieve these outcomes. The actions have been agreed to by all governments and encompass Commonwealth and state/territory areas of responsibility. The actions require collaborative national effort across different levels of government. They build on national reforms which are already in place, and complement activities being undertaken or planned in different jurisdictions under existing state and territory mental health plans. The actions primarily relate to service planning and delivery in the health arena, but they also rely on investment by other areas of government and community.

The actions will be progressed by governments independently and through the Australian Health Ministers’ Advisory Council. Some of the actions will require commitments of time and effort rather than financial investment to navigate the shared issues within and across sectors; others will require new or re-focussed funding. Not all actions will be able to be fully implemented within a five year framework, but many will, particularly with the commitment of government and community.

Advancing many of the actions related to service reform will require consideration of funding and governance arrangements, operational issues, and cross-portfolio and cross-government structures.

Improving accountability for both mental health reform and service delivery are central to the Fourth Plan. The Plan explicitly outlines indicators against which to measure progress. For some of these indicators, data is already available; for others, further development work is required and will occur during the first 12 months of the Plan. Specific targets have not yet been set for any indicators, but this will be also be given priority during the first year of the Plan. Collaboration between governments will be needed to fill data gaps and develop appropriate targets.
Box 1: Principles underlying the Fourth National Mental Health Plan

Respect for the rights and needs of consumers, carers and families

Consumers, their carers and families should be actively engaged at all levels of policy and service development. They should be fully informed of service options, anticipated risks and benefits. Consumers and carers should be able to access information in a language they understand or have access to interpreters. Mental Health legislation should be regularly reviewed to ensure compliance with relevant national and international obligations and charters.

Families and carers should be informed to the greatest extent consistent with the requirements of privacy and confidentiality about the treatment and care provided to the consumer, the services available and how to access those services. They need to know how to get relevant information and necessary support. The different impacts and burdens on paid and unpaid carers need to be acknowledged.

Services delivered with a commitment to a recovery approach

Mental health service providers should work within a framework that supports recovery – both as a process and as an outcome to promote hope, wellbeing and autonomy. They should recognise a person’s strengths including coping skills and resilience, and capacity for self-determination. This may require a significant cultural and philosophical shift in mental health service delivery.

Social inclusion

Recognition of the importance of social, cultural and economic factors to mental health and wellbeing means that both health and social issues should be included in the development of mental health policy and service development. The principle includes support to live and participate in the community, and effort to remove barriers which lead to social exclusion such as stigma, negative public attitudes and discrimination in health and community settings. The National Social Inclusion Principles (see Appendix 3) should underpin reform in mental health.

Recognition of social, cultural and geographic diversity and experience

Our community is rich in diversity. It embraces cultural and religious differences. This brings many strengths and opportunities, but we also need to recognise the challenges faced at times by some within our community. There should be demonstrated cultural competency in the planning and delivery of responsive mental health services.

There are particular issues faced by women in mental health services who may have previously experienced sexual abuse or other trauma as a child or adult. The mental health workforce needs to be aware of such issues and services provided to ensure a safe and respectful environment.

Indigenous communities and individuals require all providers to demonstrate cultural competency in the planning and delivery of culturally safe, responsive and respectful mental health services. It should be recognised that remote Indigenous communities face very different challenges from those in urban communities and that both face challenges that differ to other community groups.

Rural and remote communities face particular challenges. Workforce development and support, and equitable access to services are difficult to achieve in some parts of Australia and require recognition that communities may have different priorities that rely on local knowledge and need a whole of community response. They need innovative service development that enables use of new technology and flexible models to support the provision of access to specialist assessment and advice.

Recognition that the focus of care may be different across the life span

Mental health services, whether in the primary care or specialist sector, cannot be provided as a one size fits all across the age range. The family will play a different role where an infant or child is the
focus of care. Aged persons mental health care may involve greater support to their family or to staff of residential facilities.

**Services delivered to support continuity and coordination of care**

While recognising that different service types and locations are important, services across the spectrum of age and need should be developed and delivered in a way that reduces the risk of people falling through gaps, reduces unnecessary duplication and complexity and promotes information sharing. This depends on both collaboration between services at all levels, and integrated models of service delivery.

**Service equity across areas, communities and age groups**

Mental health should be provided at a standard at least equal to that provided in other areas of health. Services should be informed by the available evidence and look to innovative models as examples of service improvement.

While it is not appropriate or possible that uniform service provision exists in every area or across all age groups, we should strive for equity of access and equity of quality. Services should strive to be accessible and responsive. The level of service provision and the outcomes of care should be transparent to consumers and carers.

**Consideration of the spectrum of mental health, mental illness and mental disorder**

Mental health promotion, prevention and interventions need to include consideration of the spectrum from wellbeing to mental health problems to mental illness. The range of service options needs to include those illnesses that are most often managed within the primary care sector, as well as those that may require greater specialist involvement. Services should be provided on the basis of need, not diagnosis or whether an illness or disorder is common or uncommon. Service options need to be responsive to the needs of different age groups including young children and the aged, and to the differing needs of those who suffer particular illnesses such as perinatal mental health problems and eating disorders.
Setting the context

The magnitude of the problem

Mental illness and mental health problems affect many Australians (see Figure 2). The 2007 National Survey of Mental Health and Wellbeing showed that one in five Australians had experienced a common mental disorder in the year prior to the survey,\(^1\) results similar to those of an equivalent survey conducted in 1997. Rates varied across the lifespan, being higher during the early adult years. The survey also showed that people experiencing one mental disorder often experience another, or even two more.

Figure 2: Prevalence of common mental disorders among Australian adults, 2007

Not only is mental illness common, but it is also associated with high levels of disability. In fact, mental disorders are the largest single cause of disability in Australia, accounting for nearly 30% of the burden of non-fatal disease (see Figure 3).

Figure 3: Burden of mental disorders relative to other disorders, in terms of years lost as a result of disability

\(^1\) This picture underestimates the full magnitude of the problem because the 2007 National Survey of Mental Health and Wellbeing did not capture low prevalence disorders known to be associated with high service provision costs, and did not profile the epidemiology of mental disorders among children and adolescents or older people.
The National Mental Health Strategy

In response to the significance of mental illness and mental health problems, the National Mental Health Strategy has guided mental health reform in Australia since 1992. The National Mental Health Strategy has been articulated through a series of documents including the National Mental Health Policy (see below), three previous five-year National Mental Health Plans, the Council of Australian Governments (COAG) National Action Plan for Mental Health 2006-2011, and the Mental Health Statement of Rights and Responsibilities.

Internationally, Australia has been at the forefront of many areas of reform in mental health service delivery. Under the National Mental Health Strategy, there have been major changes in the delivery of state/territory-funded mental health services. For example, there has been an increase in the emphasis on community-based care and a decreased reliance on inpatient services (see Figure 4) and there has been a significant increase in the size of the mental health workforce (see Figure 5). There has also been an increased emphasis on the safety, quality and outcomes of care (e.g., through the development of protocols in relation to transport of people with mental illness, a reduction in the use of seclusion resulting from the National Seclusion Project, and the routine measurement of clinician-rated and consumer-rated outcomes).

**Figure 4: Community-based services as percentage of total State and Territory spending on mental health services**

![Figure 4: Community-based services as percentage of total State and Territory spending on mental health services]

The efforts of the National Mental Health Strategy have extended beyond state/territory-funded mental health services, and have focused on Commonwealth-funded services. For example, the addition of mental health items numbers on the Medicare Benefits Schedule has increased access to psychologists and other selected allied health professionals, and has encouraged collaboration between these providers and GPs.

The National Mental Health Strategy has also encouraged the development of recovery-oriented community support services through increased investment in living support services in the non-government sector.

At the commencement of the Strategy, 29% of State and Territory mental health spending was dedicated to caring for people in the community. By 2007, the community share of total mental health expenditure had increased to 53%.

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This Fourth National Mental Health Plan builds on the achievements of the three previous Plans. The first National Mental Health Plan provided clear goals related to structural changes in where and how mental health services were to be delivered. The Second National Mental Health Plan sought to broaden this and to engage service partners, consumers and carers more effectively in service delivery. The National Mental Health Plan 2003-2008 continued and expanded this approach. While the directions of each Plan were generally agreed, the pace of reform, and thus achievements under the Plans varied, often considerably, between jurisdictions.

There is a need for the Fourth National Mental Health Plan to continue the reform effort because although much headway has been made, there is still work to be done. The prevalence and impact of mental health problems remain significant issues, and, according to the 2007 National Survey of Mental Health and Wellbeing, only one third of those with a mental disorder receive mental health services each year. System challenges also continue to be problematic. For example, there are challenges in recruiting, retaining and supporting a workforce with appropriate competencies. The current Plan continues the reform efforts of the National Mental Health Strategy to improve the mental health of all Australians. Its whole-of-government emphasis distinguishes it from its predecessors.

National Mental Health Policy

The original National Mental Health Policy was released at the inception of the National Mental Health Strategy in 1992. The National Mental Health Policy 2008 was endorsed by the Australian Health Ministers’ Conference (AHMC) in December 2008 and released in March 2009. The Policy was updated to align with the whole-of-government approach articulated within the COAG National Action Plan on Mental Health and with developing policy and practice in other areas. The Policy provides an overarching vision for a mental health system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community. This vision should be seen in the context of the Social Inclusion Agenda which focuses on engagement of the whole community, especially in areas social and economic disadvantage. The Policy does not set out to provide explicit guidance for service delivery, nor does it set funding expectations, targets or deliverables.
The aims of the National Mental Health Policy are to:

- Promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness;
- Reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community;
- Promote recovery from mental health problems and mental illness; and
- Assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

This Fourth National Mental Health Plan furthers the aims of the Policy through actions which will:

- Maintain and build on existing effort;
- Integrate recovery approaches within the mental health sector;
- Address service system weaknesses and gaps identified through consultation processes; and
- Better measure how we do this and the outcomes achieved.

Consistent with the National Mental Health Policy, this Plan reaffirms our acknowledgement of Australia’s Indigenous heritage and the unique contribution of Indigenous people’s culture to our society. It recognises Indigenous people’s distinctive rights to status and culture, self-determination and connection to the land. It recognises that mutual resolve, respect and responsibility are required to close the gap on Indigenous disadvantage and to improve mental health and wellbeing.

The Social and Emotional Wellbeing Framework 2004-2009 (SEWBF) needs to be reviewed. The SEWBF 2004-2009 was developed to respond to the high incidence of social and emotional wellbeing problems and mental illness experienced by Aboriginal and Torres Straits Islander (ATSI) people and communities. This Plan recognises the importance of continuing a specific framework for ATSI people and communities and supports a review in the context of recent developments across a number of areas of government.

Most importantly, Australia is undertaking a comprehensive approach to “Closing the Gap” of Indigenous disadvantage in health. It is imperative that these efforts prioritise mental health, social and emotional wellbeing as this is critical to all efforts that aim to give Indigenous Australians the same health status as other Australians.

**Whole-of-government partnerships**

A number of recent significant initiatives have emphasised the importance of cross-sectoral partnerships in supporting mental health and wellbeing, and in responding to mental illness through an integrated and inclusive service system. Underpinning this thinking is the notion that circumstances in which individuals with mental health problems and mental illness come into contact with non-health sectors provide valuable starting points for further collaboration. These initiatives have helped to set the context for the Fourth National Mental Health Plan.

At a national level, the most salient example is the COAG National Action Plan on Mental Health 2006-2011. COAG considered mental health in 2006, in response to growing concern regarding the prevalence and impact of mental illness and mental health problems, and stakeholder dissatisfaction with how these issues were being addressed at a state/territory and Commonwealth level. The resultant National Action Plan emphasised the importance of governments working together better, and the need for more integrated and coordinated care. The National Action Plan led to a significant injection of funds into mental health by state, territory and Commonwealth governments. In particular, it led to the previously mentioned changes to the Medicare Benefits Schedule which improved access to psychological care delivered by psychologists and other allied health professionals, general practitioners (GPs) and psychiatrists. It also led to increased investment in community based mental health services, enabling them to better respond to consumers with severe and persistent mental health problems, and their carers and families. The National Action Plan also increased investment in areas outside health which frequently deal with people with mental health
problems and mental illness, including employment, education and community services. The aims of the National Action Plan have not yet been fully realised, particularly in the area of governments working together.

States and Territories have also developed their own specific mental health plans or strategies which help set the context for the Fourth National Mental Health Plan. Consistent with the COAG National Action Plan on Mental Health 2006-2011, these State and Territory plans and strategies have also reflected the shift towards a whole-of-government, cross-sectoral approach to mental health. At a state/territory level, stronger partnerships have been forged between mental health and other areas within health such as emergency departments, and with areas outside health such as community services and correctional services. Models of accommodation and support have been developed in each jurisdiction, as have specific mental health social and emotional wellbeing frameworks to work with people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander Communities.

The above initiatives are beginning to have their desired impact. For instance, work in the housing sector has led to consideration of the needs of those with mental health problems and mental illness when planning social housing initiatives, and developments in the justice sector have seen diversionary programs provided for people with mental illness or substance dependency.

There are still many areas where further consideration of how services could or should respond is warranted. In some of these areas, State and Territory COAG Mental Health Groups are beginning to take forward whole-of-government initiatives and foster stronger partnerships. Interdepartmental committees also exist in a number of jurisdictions. Under the Fourth National Mental Health Plan, consideration will be given to the membership and terms of reference of these cross-government committees at a state/territory and national level. A collaborative approach will foster complementary programs that deliver responsive services.
Priority area 1: Social inclusion and recovery

Outcome

The community has a better understanding of the importance and role of mental health and wellbeing, and recognises the impact of mental illness. People with mental health problems and mental illness are valued and supported by their communities to realise their potential, and live full and productive lives. Service delivery is organised to deliver more coordinated care across health and social domains.

Summary of actions

- Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.
- Provide mental health education to front line workers in health, emergency, welfare and associated sectors.
- Coordinate effort between the health, education and employment sectors to provide supported education, employment and vocational programs which are linked to clinical and community living support mental health services.
- Improve coordination between primary care and specialist services in the community to develop recovery-oriented care, enhance consumer choice, and facilitate ‘wrap-around’ service provision.
- Develop integrated programs between mental health services and housing agencies to provide tailored support to people with mental illness and mental health problems living in the community.

Cross-portfolio implications

To support a collaborative whole of government approach, these actions will require work across areas outside health such as employment, education, justice (including police courts and correctional services), Indigenous, aged services, community services and housing.

Indicators for which data are currently available

- Participation rates by people with mental illness of working age in employment.
- Participation rates by young people aged 16-30 with mental illness in education and employment.

Indicators requiring further development

- Rates of stigmatising attitudes within the community.
- Proportion of front-line workers within given sectors who have been exposed to relevant education and training.
- Percentage of mental health consumers living in stable housing.
- Rates of community participation by people with mental illness.

Mental health and wellbeing are important for the whole community, including the broad spectrum of people who experience mental illness. Consumers and their families have highlighted that stigma and discriminatory attitudes to mental illness are still prevalent. They have told us that stable housing and meaningful occupation are important aspects of their recovery and self determination. People should feel a valued part of their community, and be able to exert choice in where and how they live. Some groups are at risk of entrenched social exclusion, including those with chronic and persistent mental illness and mental disorders. Developing pathways that support community
participation and that allow movement towards greater independence minimises the risk of social exclusion.

Policy and service development needs to recognise the importance of a holistic and socially inclusive approach to health in promoting mental health and wellbeing, that includes social as well as health domains and supports people to establish community engagement and connectivity. This applies to all members of the community including those from culturally and linguistically diverse backgrounds and new arrivals. A socially inclusive approach is especially important during times of economic downturn. The role of the family in promoting wellbeing and recovery needs to be recognised, as does the importance of community acceptance. There have been very significant developments in these areas such as the development of the Homelessness White Paper, and the COAG National Partnership Agreement on Homelessness. Maintaining connections and support can be especially crucial during adverse events or periods of transition such as loss of employment, exposure to domestic violence, exiting from prison, family breakdown and disruption. Management of mental illness also needs to be linked to good physical health, with engagement between primary and specialised treatment and care. Likewise physical illness is often associated with mental distress and illness.

There are many good examples where mental health promotion has supported greater social inclusion. The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders developed in 2008 brings together a number of key findings in the area of promotion and prevention. Elements of this include the importance of population-based approaches to redress inequities and discriminatory practices, and joining up policies and practices across sectors. Information regarding mental health, mental health promotion and mental health interventions should be widely available, culturally appropriate and accessible, including to young people.

Despite very effective initiatives directed to promoting mental health and wellbeing (e.g., VicHealth), and improving awareness and understanding of mental illness (e.g., beyondblue), those with mental illness are still at risk of being discriminated against in areas such as employment and housing, and there are still stigmatising attitudes evident in the media and community. Discriminatory behaviour and stigmatising attitudes also occur within the health sector. The mental health workforce in clinical and community living support services needs to respect and adopt a recovery philosophy in how they provide services. The role of step up and step down services and community support is particularly important in preventing relapse and supporting community based recovery.

Recovery in the context of mental illness is often dependent on good clinical care, but means much more than a lessening or absence of symptoms of illness. Recovery is not synonymous with cure. For many people who experience mental illness, the problems will recur, or will be persistent. Adopting a recovery approach is relevant across diagnoses and levels of severity. It represents a personal journey toward a new and valued sense of identity, role and purpose together with an understanding and accepting of mental illness with its attendant risks. A recovery philosophy emphasises the importance of hope, empowerment, choice, responsibility and citizenship. It includes working to minimise any residual difficulty while maximising individual potential. This is relevant to all ages, including the elderly, and to all those involved – the individual consumer, their family and carers, and service providers.

Recovery may be defined as:

A personal process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources. (National Mental Health Policy, 2008)
Alternative definitions of recovery

The definition developed by Patricia Deegan, a consumer who contributed greatly in this area is:

“Recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again…. The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution.”

The definition provided by the NZ Mental Health Advocacy Coalition in ‘Destination Recovery’ is:

“a philosophy and approach to services focussing on hope, self-determination, active citizenship and a holistic range of services.”

Within current service delivery, a recovery focus has mainly been championed by the non-government community support sector and consumer advocacy bodies. This Plan intends that the attitudes and expectations that underpin a recovery focus are also taken up by clinical staff within the public and private sectors – both bed based and community based. This will strengthen the partnership and sharing of responsibility between the consumer, their families and carers, and service providers.

National actions under this area include:

Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.

Addressing community attitudes and behaviours requires sustained and multi-pronged activity. There are examples nationally and internationally of effective education and awareness campaigns – for example the “Like Minds, Like Mine’ campaign in New Zealand and the “See Me” campaign in Scotland, as well as Stigmawatch and beyondblue in Australia. Such campaigns directed at the whole community need to be supported by more local activity, including in the workplace, and need to work in partnership with the media. They need to include those illnesses that are more complex and difficult to understand such as psychosis. They should also work in conjunction with actions addressed to particular groups such as those from culturally and linguistically diverse backgrounds, rural and remote communities and particular age groups.

Legislation and the introduction of Rights-based charters are also ways to support de-stigmatisation. Feedback from consumers, families and carers has highlighted that stigmatising behaviour and attitudes are sometimes encountered in mental health services, and that consumers themselves may have stigmatising attitudes. These need to be the focus of targeted programs to address this, including the incorporation of a recovery approach in staff training and development. People affected by mental illness should be supported to take action on discrimination encountered in health, education, employment and community services.

Provide mental health education to front line workers in health, emergency, welfare and associated sectors.

Many groups who work in the community will come into contact with people at all stages of mental illness and recovery. Supporting them to better understand and recognise mental illness will improve earlier intervention and bring better outcomes for individuals and their families. Workers that are particularly important in this regard include police, ambulance, child protection workers, correctional services staff, employment support officers, pharmacists, residential aged care workers and teachers.
Mental Health First Aid is an example of a program that provides greater awareness and understanding of mental health issues. Again, while education regarding mental health problems should incorporate those issues and problems which are common, these workers also need to be able to recognise and respond appropriately to those who present with more complex problems, including personality disorders and psychoses, as well as having an appreciation of issues facing particular groups such as refugees. Education and training should be provided for people training for front-line worker professions. Education and training should also include consideration of the impact of substances such as alcohol, prescribed medication and illicit substances.

*Coordinate effort between the health, education and employment sectors to provide supported education, employment and vocational programs which are linked to clinical and community living support mental health services.*

Education and employment success has a significant impact on a person’s self confidence and wellbeing. It promotes development of friendship, community engagement and improved quality of life. Unfortunately mental illness and mental health problems are associated with increased risk of unemployment, and associated negative consequences.

There is now a good research base (for example, the work of the Centre for Mental Health Research in Queensland) that for those who experience mental illness, remaining or returning to employment can be improved through the introduction of vocational support closely linked to treatment service delivery and support in other areas of life. Some models involve clinical services; others have greater emphasis on non-government support agencies. Some involve post placement support as well as employment readiness support.

Mental health services can provide advocacy and take a leadership role in supporting closer engagement with employment and education sectors. For example, they can promote and facilitate the placement of vocational support officers within clinical and community support services. They can also assist a person to maximise their capacity to engage with the community through fully utilising the skills of a multidisciplinary team including teaching psychological techniques, and enhancing social skills training.

A Mental Health and Disability Employment Strategy is currently being developed through the Australian Government’s Department of Education, Employment and Workplace Relations (DEEWR) and Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).

*Improve coordination between primary care and specialist services in the community, to develop recovery-oriented care, enhance consumer choice, and facilitate ‘wrap-around’ service provision.*

Over the past few years, the range and focus of community-based services has increased. Community mental health services now include a range of clinical services provided through primary care and specialist mental health services, such as acute assessment, continuing care, and intensive outreach; and living support services, such as accommodation and support, home-based outreach, day program, carer respite and vocational support services delivered through non-government organisations. Some of these are targeted towards aged people in the community, others to adults or families. The importance of good physical health care has also been recognised as has the role of the GP. The private sector also needs to be recognised in the development of greater coordination.

However, community mental health services in a given area are often provided through different locations and different organisations with limited integration between service elements. Development of partnerships and linkages between service types – both through co-location and service agreements can promote coordination and continuity of care, and enhance consumer choice, as well as ensuring that physical and mental health care are considered jointly rather than separately.
Integrated Care Centres or greater utilisation of Community Health Centres may be options for the development of services to deliver coordinated care and improve access. The development of partnerships or ‘platforms’ which deliver a more holistic service response may require new governance models to oversee and drive change in service delivery. There will also need to be consideration of funding models and how these can be adapted to promote more flexible and person-centred responses. Determination of effectiveness could be supported by the adoption of a national tool to measure performance against recovery-based competencies.

_Develop integrated programs between mental health services and housing agencies to provide tailored support to people with mental illness and mental health problems living in the community._

Provision of a sufficient number and range of accommodation options with varying levels of support was an important recommendation from recent inquiries. Options may range from single person independent housing through to shared and intensively supported accommodation. Support may include clinical assessment and treatment, or living skills and vocational support. This depends on collaboration between agencies and engagement of local communities. In particular it requires close co-operation between the providers of public housing and tenancy management, and mental health support services to tailor support to that required by the consumer.

People need different types of support and assistance at different stages of illness and recovery, and at different ages. Elderly people with mental illness living in their own homes will require a different range of supports to a younger person seeking education or employment opportunities. There is good evidence that when clinical treatment and community support co-exist and complement each other it helps promote better outcomes for consumers, their families and carers, including tenancy stability and greater capacity to seek employment and other community activity. While there has been considerable attention to this area at a National level (white paper on Homelessness) and through State/Territory and Commonwealth partnerships, nationally consistent models to match support to a person’s needs require further development.
Priority area 2: Prevention and early intervention

Outcome

People have a better understanding and recognition of mental health problems and mental illness. They are supported to develop resilience and coping skills. People are better prepared to seek help for themselves, and to support others to prevent or intervene early in the onset or recurrence of mental illness. There is greater recognition and response to co-occurring alcohol and other drug problems and physical health issues. Generalist services have support and access to advice and specialist services when needed.

Summary of actions

- Work with schools, workplaces and communities, including Indigenous and culturally and linguistically diverse communities, to deliver programs to improve mental health literacy and awareness and to support resilience and enhance coping strategies.
- Implement targeted prevention and early intervention programs for children and their families through partnerships with generalist services such as maternal and child health services, schools, and mental health specialist services.
- Further develop community-based youth mental health services which are accessible and which combine primary health care, alcohol and other drug services and mental health services.
- Align and coordinate new and existing State, Territory and Commonwealth suicide prevention strategies, plans and programs through a nationally agreed suicide prevention framework.
- Implement a renewed Aboriginal and Torres Straits Islander Social and Emotional Well Being Framework.
- Expand the level and range of support for families and carers of people with mental illness and mental health problems, including recognition of the risk experienced by children of a parent with a mental illness.
- Develop tailored mental health care responses for highly vulnerable children, young people and their families.
- Work with housing, justice, community and aged care services to develop facilitated access to mental health assessment and treatment programs for adults at risk of homelessness and other forms of disadvantage.

Cross-portfolio implications

To support a collaborative whole of government approach, these actions will require the health sector to work collaboratively with departments and agencies representing areas such as community services, child and family services, aged care, alcohol and other drugs, housing, justice and Aboriginal and Torres Strait Islander partnerships.

Indicators for which data are currently available

- Proportion of primary and secondary schools with mental health literacy component included in curriculum.
- Rates of contact with primary mental health care by children and young people.
- Rates of use of licit and illicit drugs that contribute to mental illness in young people.
- Rates of suicide in the community.

Indicators requiring further development

- Rates of understanding of mental health problems and mental illness in the community.
- Prevalence of mental illness.
The importance of promotion, prevention and early intervention (PPEI) in mental health has been recognised in previous plans. The PPEI monograph and subsequent National Action Plan on Promotion, Prevention and Early Intervention in Mental Health remain key documents informing action in this area. In recent years there has been development of a stronger evidence base to support models of intervention in children and young people – especially in areas such as early intervention in psychosis, and school and family based interventions for challenging behaviours. But we also need to recognise the importance of relapse prevention and early intervention for people who experience recurrent episodes of illness, to minimise the distress and disruption experienced by the consumer and their families and carers. Prevention and early intervention activities are therefore best considered from three perspectives - early in life, early in illness and early in episode. The primary care sector has a particularly important role to play in prevention, both in promoting behaviours that support good mental health, and in the management of chronic or recurring illness to lessen the negative impact of illness.

Primary prevention endeavours to avoid the development of an illness, generally through population-based health activities, mental health promotion and reduction of known risk factors such as exposure to child abuse, sexual assault and domestic violence. Secondary prevention aims to prevent progression through recognition of emerging symptoms and early intervention. Tertiary prevention targets the negative impact of an illness through continuing treatment and rehabilitation. Prevention activities can also be considered across universal, selected and targeted areas. Responsibility for prevention is shared by individuals, families and the community.

Mental health needs to be seen as important for the whole population, with better awareness of factors that support resilience and coping strategies including self care, community connectedness and engagement. Not all mental illnesses can be prevented. However the impact and subsequent disability can be lessened by early and effective intervention. While prevention and early intervention are relevant at all ages, it is recognised that there is increased risk of mental illness at some life stages, in certain groups within the Australian community, and in association with critical life events. For example, intervention directed to parents and infants in the perinatal period to encourage positive attachment, and in early childhood to support appropriate social interaction and engagement, has been shown to enhance resilience.

Recognising children who are showing disturbed behaviour and intervening in school and family environments can lessen the risk of subsequent conduct disorder and propensity to substance dependence. Some groups experience multiple areas of disadvantage and vulnerability. For example, children in care may have experienced parental rejection, inconsistent care or domestic violence. Young people in youth justice are often disengaged from their families or other social supports, and have engaged in risk taking behaviour including substance use. There should be a particular priority given to addressing the multiple needs of such groups, including their mental health needs.

Mental health problems are also more likely to occur in association with disability, including intellectual disability, and with physical ill health. Serious mental illnesses such as schizophrenia and anorexia nervosa may first become apparent during adolescence and early adulthood – a time critical for the establishment of relationships, family and vocation. Intervening early in the onset of a dementing illness, or depression with onset in old age will assist in sustaining independent living or maintenance in familiar surroundings.

If a person has experienced a mental illness, better knowledge about the illness will assist them and their family and carers to be aware of warning signs of relapse and the steps to take to intervene early. This can circumvent the development of an episode of illness and the associated personal and social disturbance. Additional effort through re-orienting the service system can bring substantial improvement to individual and community outcome.
National action under this area includes:

*Work with schools, workplaces and communities, including Indigenous and culturally and linguistically diverse communities, to deliver programs to improve mental health literacy and awareness and to support resilience and enhance coping strategies.*

Mental health promotion includes a range of strategies and activities which aim to have a positive impact on mental health through improved living conditions, supportive, inclusive communities and healthy environments. It may be targeted to addressing negative behaviours such as bullying, or to supporting and respecting the rights of others. Promotion activities can be run at a local level, in particular services such as child care centres or schools, or delivered through mass media campaigns (e.g., VicHealth). The media are also important partners in delivering information to improve the mental health literacy of the general community.

Better understanding and recognition of mental health problems and illness will help to lessen discrimination and stigmatisation, increase help seeking and promote supportive and inclusive communities. This needs to include the spectrum of mental health problems and mental illnesses, including those that are less common such as schizophrenia and other psychoses, and the more common anxiety and mood disorders. The *National Survey of Mental Health and Wellbeing 2007* found that amongst those people who met the criteria for a mental illness who may have benefited from accessing services the most frequent reason they did not do so was that they did not believe they had a need for this help.

Schools are important not only for improving mental health literacy but also for supporting resilience and developing coping skills. Examples of programs that address such issues in schools are *KidsMatter* and *MindMatters*. School-based programs should be consistent in their approach. National initiatives such as *beyondblue* have had a significant impact in improving the understanding and awareness of depression and related disorders, and how to access treatment and care. Workplaces are also important settings for building resilience and fostering coping strategies.

*Implement targeted prevention and early intervention programs for children and their families through partnerships with organisations such as maternal and child health services, schools and mental health specialist services.*

It is recognised that different developmental stages will need different service responses. For example, the early years of life are crucial in establishing attachment and resilience to later life stressors. Supporting parents who have a mental illness and their children will lessen the risk of later development of mental health problems. The *National Perinatal Depression Initiative* recognises that depression is common in the perinatal period and that maternal wellbeing is critical for early attachment. Good parenting, support to children in schools and families in contact with child protection services through better linkages and engagement across community and specialist mental health services will lessen the risk of future mental health problems. There need to be formal links between generalist and specialist services to provide support and advice, and to facilitate referral for treatment and care when needed.

*Further develop community-based youth mental health services which are accessible and which combine primary health care, alcohol and other drug services and mental health services.*

It is known that adolescence and early adulthood are times of transition and challenge. They are also the time when there is the greatest risk of emergence of mental health problems and mental illness, and yet young people are often reluctant to seek assistance. How and where we provide services to young people needs to be reconsidered. This may involve greater use of web-based technology, and joining up of mental health, primary care and alcohol and other drug services.

There should be the development of nationally consistent principles to guide the establishment of youth focussed services that are relevant and accessible and support better
engagement. There should be close links between youth focussed components of care delivery, and capacity to assist those presenting with a range of problems. Where services to respond to the early onset of psychotic illness have already been established, these need to be linked in with other youth mental health supports.

**Align and coordinate new and existing State, Territory and Commonwealth suicide prevention strategies, plans and programs through a nationally agreed suicide prevention framework.**

While there has been considerable attention to suicide prevention activities, there has not always been good coordination between actions at a jurisdictional level. Suicide prevention strategies need to consider what services are already in place and how best to complement rather than duplicate programs, and how to make sure that successful programs are generalised across the service system rather than delivered as a time limited project. Consistent and sustained education and support should be in place to ensure that relevant professionals are aware of the signs and periods of increased risk, and how to put in place strategies to reduce this risk. Where there are particular populations at risk, for example prisoners, there needs to be consistent terminology and clear communication across different areas of service provision and professions.

**Implement a renewed Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework.**

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples’ Mental Health and Social and Emotional Wellbeing 2004-2009 (the Social and Emotional Wellbeing Framework) was a joint initiative across Health and Aboriginal and Torres Strait Islander areas. It emphasised a number of important areas for shared action and initiatives. These remain relevant but need to be re-visited and implemented in the new environment of joint government endeavour. This work needs to take into account other developments through COAG and other Departments relevant to a social and emotional wellbeing strategy.

**Expand the level and range of support for families and carers of people with mental illness and mental health problems, including recognition of the risk experienced by children of a parent with a mental illness.**

Some mental illnesses carry a high risk of relapse. Often families and carers are in the best position to recognise and support a person early in relapse to get back into treatment and back on the road to recovery. But this can place considerable burden on family members and sometimes the most effective way to support a person at risk of relapse will be to support the family system around them. Recognition of the needs of young carers, and of families with younger children is important when considering the types of respite and support required. Families and carers in rural, regional and remote areas may feel particularly isolated in such situations. Provision of respite and access to support should ensure equitable access by all communities.

Children of parents with a mental illness are at greater risk of themselves experiencing mental health problems. Early intervention can reduce this risk. The National Framework for Protecting Australia’s Children 2009-2020 recognises the need to address major parental risk factors that are associated with child abuse and neglect, including mental illness. Targeted programs have begun to address this issue. The next step is to embed capacity to identify and respond to these issues across the service system, including family welfare and child protection agencies, GPs and other health professionals working with families and young children, and specialist mental health services.

**Develop tailored mental health care responses for highly vulnerable children, young people and their families.**

Addressing mental health issues of highly vulnerable children and young people is a critical aspect of an integrated response to improve their life chances. Children and young people who have experienced family violence, sexual abuse and other trauma are more likely to
develop mental health problems than those who have not. Highly vulnerable children and young people can be identified in a range of settings, including homeless services, drug and alcohol services, child protection, out-of-home-care and youth justice. Children and young people are often reluctant to engage in treatment and mental health services have not always provided an adequate response.

The National Framework for Protecting Australia’s Children 2009-2020 emphasises the importance of enhancing access to appropriate support services for recovery, where abuse and neglect has occurred, and improves support for young people leaving care. A new level of collaborative service provision is now required. Tailored service models for these groups could include flexible, community outreach teams linked to clear referral pathways; dedicated positions in specialist mental health services linked to statutory services; inclusion of family therapy in treatment plans; intensive therapeutic services for children and young people in care; and models for greater involvement from GPs and other health professionals working with families with young children.

Work with housing, justice, community and aged care services to develop facilitated access to mental health assessment and treatment programs for adults at risk of homelessness and other forms of disadvantage.

In addition to young people, some adults most at risk of developing a mental illness, for a range of reasons, cannot access services in clinics or other community settings. Ways need to be found to facilitate their access and engagement. Intervening to address mental illness may need assertive and flexible models of care – able to engage the person at a time and location that best meets their needs, and in a way that supports continuity through key transition periods. The development of service models embedded in relevant services or locations – e.g. Homelessness services and social housing initiatives, correctional facilities, residential child welfare services and workplaces, or which respond to particular events such as in the aftermath of natural disasters – will support better recognition, engagement and effective interventions. Where mental health services are provided in particular service settings, such as a correctional services facility or residential setting, it is important that there is close liaison between the mental health service providers and other workers to ensure clear communication and common understanding – for example in relation to prisoners at risk of self harm, and the management of those with severe personality disorders.
Priority area 3: Service access, coordination and continuity of care

Outcome
There is improved access to appropriate care, continuity of care and reduced rates of relapse and re-presentation to mental health services. There is an adequate level and mix of services through population-based planning and service development across sectors. Governments and service providers work together to establish organisational arrangements that promote the most effective and efficient use of services, minimise duplication and streamline access.

Summary of actions
- Develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.
- Establish regional partnerships which include funders, service providers, consumers and carers, in order to develop local solutions to better meet the mental health needs of communities.
- Improve communication across primary care and specialist services, and across clinical and community support services, through the development of new systems and processes in order to promote continuity of care and service integration.
- Work with emergency and community services to develop protocols to guide and support transitions between service sectors and between jurisdictions.
- Improve linkages and coordination between alcohol and other drug services, mental health services and primary care services, in order to facilitate earlier identification, referral and treatment for mental and physical health care.
- Develop and implement systems to ensure information about the pathways into and through care is highly visible and readily accessible and culturally relevant.
- Better target services and address service gaps through cooperative service models for the delivery of primary mental health care that incorporate government and non-government activity.

Cross-portfolio implications
To support a collaborative whole of government approach, these actions will require work across State, Territory and Commonwealth governments, including work with acute health, community mental health, community support, income support, housing, Indigenous, primary care, alcohol and other drug services and justice programs.

Indicators for which data are currently available
- Percentage of population receiving mental health care.
- Readmission to hospital within 28-days of discharge.
- Rates of pre-admission community care.
- Rates of post-discharge community care.

Indicators requiring further development
- Proportion of specialist mental health sector consumers with nominated GP.
- Average waiting times for consumers with mental health problems presenting to emergency departments.
- Prevalence of mental illness among homeless populations.
- Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities.
The past few years have seen major changes in how mental health services are provided in primary care, especially through the development of initiatives such as the Better Outcomes in Mental Health Care program and the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule (Better Access) initiative. These initiatives recognised that people commonly present to their GP with mental health problems, and provided increased access to psychological treatments funded through the Medicare Benefits Schedule.

A number of state/territory-based initiatives also provide enhanced support to primary care. These developments recognised the high prevalence of mental health problems, and also the need to improve physical health care for those who experience mental illness. There has also been expansion of living support services provided by non-government organisations in the community which complement the treatment and care provided by clinical mental health services.

These initiatives have greatly increased the range of services provided, including models that cross sectors such as step-up/step-down facilities located within community settings but with strong input by clinical staff. There have been improvements in design and amenity – for example through the development of dedicated areas within emergency departments, or consideration of gender specific issues in bed based hospital and community units. The need for services which respond to particular groups or issues such as mother baby units, secure forensic units or services for people with personality disorders also need consideration.

However, despite increased funding to primary and specialist services, treatment rates for people with mental illness remain low compared with the prevalence of illness. For access to the right service to be improved, there needs to be an agreed range of service options, across both health and community support sectors. This should be informed by population-based planning frameworks that specify the required mix and level of services required, along with resourcing targets to guide future planning and service development that are based on best practice evidence.

A nationally agreed planning framework would also include delineation of roles and responsibilities across the community, primary and specialist sectors, including the private sector, and consideration of the workforce requirements to deliver the range of services. Some service planning work along these lines has been commenced at a state/territory level – in New South Wales and Queensland in particular – and provides a foundation for building a comprehensive nationally service planning framework for mental health services.

In order to use the service system most effectively and appropriately, there is a critical need for links across and between sectors. Considerable work has already been undertaken or is underway that has relevance to this aspect of mental health service delivery. These include the evaluation of the Better Access initiative, the Primary Care Strategic review, and the work of the Health and Hospital Reform Commission. There has also been service mapping and modelling work at a state/territory level – for example in New South Wales and Queensland.

For outcomes to improve, access pathways should be clear, and consumers, their families and carers engaged so that they can make an informed choice regarding the most appropriate service. This may be particularly important in those illnesses where recurrence or relapse is likely so that consumers and their carers can access care as early as possible. Service providers need to inform consumers about how to re-access their service when doing discharge planning. There needs to be coordination between the elements of care of the kind portrayed in Figure 6 to promote continuity and lessen the risk of dropping out of services at periods of transition. These include both across the life span, and also in particular groups such as those in the justice system, children in protective services, and those with chronic physical illness or disability.
This connectivity and collaboration needs to be embedded across sectors including the public and private, primary and specialist, clinical and community living support sectors, and coordinated at a local or regional level, recognising that the service mix will vary, given the diversity of Australian communities across metropolitan, rural and remote areas.

Services will work in more collaborative ways if there is greater understanding and respect across and within sectors, and if funding supports flexible and responsive models rather than discrete and often rigid silos. There are particular areas of tension in this area, such as transport of people experiencing acute mental illness, access to inpatient units when demand is great, and management of people who may be acutely ill or intoxicated or both in an emergency department setting. How such tensions are resolved will depend on the development of local solutions backed by good collaboration between sectors and recognition of roles, responsibilities and limitations. Consumers and carers should routinely be involved in such deliberations.

National action under this area includes:

*Develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.*

A national service planning framework should include acute, long-stay, step-up/step-down and supported accommodation services across the clinical and non-government sectors, and primary care and private mental health service providers. It should include services required for children and young people, adults and aged people. Planning targets must be based on clear role definitions and delineations to determine the appropriate mix of services, and address scarcity or mal-distribution in some geographical locations. These need to be supported by innovative funding models that guide resource allocation towards targets specified by the planning framework.

Jurisdictions across Australia have moved from a bed-based to a largely community-based mental health system. While access to inpatient care is vital during the acute phase of some
illnesses, innovative models of support in the community have been developed and have demonstrated that they can reduce the need for inpatient beds. However, to improve access and promote equitable access and consumer choice, we need to have a better understanding of the necessary components and best mix of services, recognising that there will be variation between areas, and for different age groups.

For example, aged people may need the support of mental health services in their homes and in generic hostel and nursing home accommodation, as well as access to specialist services when they experience more severe problems. There needs to be clarity regarding responsibility for service provision between health, mental health and aged care. The relationship and governance arrangements between components should enable access on the basis of an individual’s need rather than the structure of the service. Service planning should include those involved in the planning and delivery of supported accommodation and community health. Service frameworks should include consideration of socio-demographic factors such as culturally and linguistically diverse groups in a given community.

*Establish regional partnerships which include funders, service providers, consumers and carers, in order to develop local solutions to better meet the mental health needs of communities.*

Most people access services in their local community. The service systems should be able to respond to the needs of people of all ages in their community. Services should operate through a local or regional organisation or partnership arrangement to lessen duplication and promote shared information and continuity. Regional partnerships should recognise the importance of the interface between primary and specialist services.

Further development of locally responsive area-based services and specialist services with regional responsibility will increase access to care, including that to areas traditionally under serviced such as rural and remote communities. Where population size or geographical location means that a specialist service cannot viably be provided locally, alternatives through the development of improved technology, and support of generic services should be systematically put in place to reduce risk of ‘falling though the gaps’.

Supporting local solutions for local communities will enable ‘wrap around’ services to better respond flexibly to individuals with complex needs, while understanding the constraints imposed by geographical location, and workforce availability. The service mix should include community supports such as drop in centres and peer support, consumers and carers should be actively involved to better contribute to service development.

*Improve communication across primary care and specialist services, and across clinical and community support services, through the development of new systems and processes in order to promote continuity of care and service integration.*

A key impediment to seamless joined up services and co-operation between service providers are the different systems of communication and documentation that currently exist. The need for confidentiality and respect for privacy does not preclude sharing information across providers with the consent of the person, and will lessen duplication and fragmentation of services. In particular, systems should enable better communication between areas funded through different levels of government such as primary care and mental health services. They should support the integration between specialist mental health (private and state/territory-funded) and primary care. Technological advances should support the provision of safe and efficient treatment and support. There should be consistency and compatibility in the information technology used across jurisdictions wherever possible. Improvement in the interface and accessibility of private and public service is needed. Systems need to support better continuity of care for those presenting with mild through to severe mental health problems and illness.
Work with emergency and community services to develop protocols to guide and support transitions between service sectors and between jurisdictions.

People and families who experience mental illness may also have involvement with other services such as emergency services (ambulance, police and fire fighters), child protection services, and may move between jurisdictions. To further support coordination of care, there needs to be shared responsibility and clear understanding of roles and responsibilities across sectors to ensure good communication and responsivity.

This can be especially important in complex and busy environments such as hospital emergency departments, or where there are differences in legislative framework and core business such as between corrections and health sectors, or where resource limitations mean that, for example, police are used to transport those experiencing a mental health crisis. Transitions are often associated with increased risk of dropping out of care, or being lost to follow up. Agreements between service areas and improved means of communication provide some strategies to minimise this risk.

Improve linkages and coordination between alcohol and other drug services, mental health services and primary care services, in order to facilitate better integration, earlier identification, referral and treatment for mental and physical health care.

Most people who seek help for mental health problems or for problems associated with use of alcohol or other drugs will do so through their GP. Often these problems will occur together and may be complicated by poor physical health. The impact of misuse of prescribed drugs as well as use of illicit substances needs to be recognised. The impact of combined mental health problems and substance use may require referral from primary care to more specialist assessment, treatment or support. However, the provision of services varies and is often poorly coordinated across and within drug and alcohol services, mental health services, and primary care.

The different service sectors do not always work well together, nor have an understanding of roles, responsibilities or limitations. Developing better reciprocal understanding and awareness will support better joint service development and delivery that addresses the physical and mental health needs. This will also support a ‘no wrong door’ approach, and lessen the frustration experienced by consumers, their carers and families.

Develop and implement systems to ensure information about pathways into and through care is highly visible, accessible and culturally relevant.

For many people, knowing who to contact and how in the event of a mental health crisis or problem is confusing. The system can be complex to navigate and the response uncertain. Developing clearer pathways will support early intervention, and diversion to the most appropriate service. We need to incorporate new technological advances that will promote access and information about services. This may involve mapping available support services and considering a portal between nationally available services such as crisis telephone services, specialist helplines and online services, and those available in the person’s local area.

The mental health system is only one component of mental health care. In some places – particularly in rural and remote communities – primary care will play the central role in service coordination. For many people, mental health care will only involve the primary care sector, but for those with more complex needs, there should be an integrated response which is better able to address the needs of individuals and their carers or families. Transition between service areas or components should be experienced as responsive rather than rejecting by consumers, their families and carers. Discharge planning should involve transfer of sufficient information to the continuing care provider and appropriate engagement of family and carers.
Better target services and address service gaps through cooperative service models for the delivery of primary mental health care that incorporate government and non-government activity.

Many people, who for reasons of geographical location or other barriers such as service delivery options or workforce constraints, are not able to easily access private mental health care services, such as Medicare based mental health support. Commonwealth and state and territory government primary mental health care programs, which utilise the non-government sector, are well placed to utilise innovative service delivery models that assist to target service gaps, making primary mental health care more accessible. An example is the Commonwealth Government’s Access to Allied Psychological Services Program. Work has previously been undertaken to develop cooperative approaches to primary mental health care service delivery at the state/territory level, such as Partners in Mind, the Queensland Framework for Primary Mental Health Care.

Innovative models may offer more flexibility at the local level, enabling non-government primary mental health care service providers to manage local workforce recruitment and retention issues, and provide targeted services that address service gaps.
## Priority area 4: Quality improvement and innovation

### Outcome

The community has access to information on service delivery and outcomes on a regional basis. This will include reporting against agreed standards of care including consumers’ and carers’ experiences and perceptions. Mental health legislation meets agreed principles and is able to support appropriate transfer of civil and forensic patients between jurisdictions. There are explicit avenues of support for emerging and current leaders to implement evidence based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.

### Summary of actions

- Review the Mental Health Statement of Rights and Responsibilities.
- Review and where necessary amend mental health legislation to support cross-border agreements and transfers of people under civil and forensic orders, and scope requirements for the development of nationally consistent mental health legislation.
- Develop and commence implementation of a National Mental Health Workforce Strategy that provides standardised workforce competencies or roles in clinical, non-government community support and peer support.
- Increase consumer and carer employment in clinical and non-government community settings.
- Ensure accreditation and reporting systems in health and community sectors incorporate the National Standards for Mental Health Services.
- Further develop and progress implementation of the National Mental Health Performance and Benchmarking Framework.
- Develop a national mental health research strategy to drive collaboration and inform the research agenda.
- Better utilise innovative telephone and web based services to address the needs of people in remote areas or who prefer anonymity.

### Cross-portfolio implications

To support a collaborative whole of government approach, actions in this area will require the health sector to work collaboratively with justice, community services, workforce accreditation and registration agencies, and research funding bodies.

### Indicators for which data are currently available

- Proportion of total mental health workforce accounted for by consumer and carer workers.
- Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards.
- Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system.

### Indicators requiring further development

- Proportion of consumers and carers with positive experiences of service delivery.
Mental health service quality should be at least equal to that of other health services. In addition, because those who experience mental illness may be treated under the provisions of mental health legislation, services should meet all legal requirements and the expectations of Rights charters or agreements.

Service amenity and legislative provisions should ideally be consistent across the nation and accord with national standards and agreements. In practice, uniform legislation is difficult to achieve because of the many inter-related state/territory-based pieces of legislation. But we can work towards consistent legislative frameworks, and we can minimise the disruption to treatment and care caused by incompatibility between state/territory-based mental health legislative frameworks. The rights of consumers and the needs of carers must be recognised and monitored through efforts to improve the carer and consumer experience of engagement with mental health services, including those from culturally and linguistically diverse backgrounds. Service development should include mechanisms to support advocacy and enable self determination to the greatest extent possible.

The National Mental Health Performance Framework has proven useful for developing Key Performance Indicators (KPI) for each domain. The KPIs that have been endorsed for Australian Public Mental Health Services will be considered for further development and adaptation to other service settings.

Workforce development is a crucial aspect of quality and a critical enabler for mental health reform. Like many other areas, workforce development crosses areas of Commonwealth and state/territory responsibility through undergraduate and postgraduate training places, and continuing education and professional development. The mental health workforce includes those who work in primary care, the public and private sectors, and the non-government community support sector. It includes a broad range of professionals including counsellors, social workers, psychologists, occupational therapists, nurses and doctors. Workforce issues cross areas of direct service provision, teaching, research and administration. Understanding workforce issues also requires consideration of workplace culture and practices, which then influence recruitment and retention.

Although mental health was proactive in developing a multi-disciplinary workforce, like other areas of health, it still faces problems of limited supply, an insufficient and poorly distributed workforce, and, particularly in some professions and areas, an ageing workforce. Particular challenges face the workforce in rural and remote areas. We need to not only attract more staff, but also to consider how to use the skills and talents of the current workforce to best advantage. That may mean re-consideration of the role of psychiatrists in private practice, greater use of nurse practitioners or mental health nurses in primary care settings.

The use of innovative technology as a means of increasing access to treatment for people in remote areas can overcome some of the workforce challenges in these areas, along with enabling access for people who wish to remain anonymous. There has been insufficient development of the workforce in non-government organisations and a lack of clarity about roles, responsibilities, competencies and need for support across the different sectors. Staff in the mental health sector need to have a greater understanding of how to promote social and emotional well-being and bring a stronger recovery orientation to their work.

Supporting and developing leaders in mental health service delivery is crucial to the development of sustainable innovative services. Leaders and champions are important in all professions and all sectors, including government, to support the implementation of new and proven service models and practices. This needs to be underpinned by an active research agenda, including both quantitative and qualitative research led by or involving consumers.

Research and evaluation should cover relevant areas such as effectiveness of treatment, community support services, service coordination models, prognosis and course of illness; and should cover the life span and service system so that we can develop or expand services based on a solid body of information regarding their effectiveness. Clinician led research, and engagement of the academic sector with clinical service development has been shown to support the evaluation and acceptance of evidence-based methods into mainstream practice. Several models of better promulgating research
exist – including Cochrane collaborations and the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom.

National action under this area includes:

**Review the Mental Health Statement of Rights and Responsibilities.**

The Mental Health Statement of Rights and Responsibilities was developed in 1991 at the beginning of the National Mental Health strategy. Although it remains a valid document, in the context of expanded service provision in primary care and the whole-of-government responsibility for mental health, it is timely for the document to be reviewed.

**Review and where necessary amend mental health legislation to support cross-border agreements and transfers of people under civil and forensic orders, and scope requirements for the development of nationally consistent mental health legislation.**

Mental health legislation exists in each jurisdiction. There are some significant differences, especially in relation to model of external review, and interaction with related legislation. However, Australia is a signatory to national and international instruments regarding human rights, and some jurisdictions have developed their own Human Rights Charter. All mental health legislation should meet principles in accordance with these agreements. In addition, people who are receiving treatment under mental health legislation – both civil and forensic – should be able to be transferred between jurisdictions when it is in their best interests and accords with their wishes. Mental health legislation in all jurisdictions needs to be reviewed and where necessary amended to meet these expectations. This may require consideration of the interface between mental health legislation and related legislation such as guardianship and administration, and aged care, to identify barriers these create for the care of individuals that may be affected by more than one Act in order to scop opportunities to overcome such barriers.

**Develop and commence implementation of a National Mental Health Workforce Strategy that provides standardised workforce competencies or roles in clinical, non-government community support and peer support.**

Recruiting, retaining and ensuring future supply of a suitably qualified staff across the diverse range needed in mental health service delivery is a challenge for all governments. Mental health requirements should be considered when determining the number of undergraduate places in courses such as medicine, nursing, psychology and allied health. The mental health content of relevant undergraduate and post graduate courses should be of sufficient quantity and quality to enable competency at the level required.

Mental health should be developed as a workplace of choice, with an open and inclusive workplace culture. There needs to be consideration of supply, including how to market mental health as an exciting and rewarding area in which to work. There should be better integration of the workforce across public and private sectors, and between primary care and specialist services to make best use of skills and interests. Having clear guidelines to determine roles, competencies, skill mix and professions required for a capable workforce will improve consistency of care and increase the effective and efficient use of the available workforce. These developments should be consistent with the National Practice Standards.

There should be sufficient flexibility to take into account the very different pressures that may exist across rural and remote communities to enable local solutions to workforce constraints. This should include assisting people of Aboriginal and Torres Strait Islander background to become mental health workers. The mental health workforce should be inclusive of those in other sectors who also provide support and care to people with a mental illness. For example, the Industry Skills Council’s Mental Health Articulation Project is considering the competencies required by community support workers in the mental health area.
Increase consumer and carer employment in clinical and non-government community settings.

Although consumers and carers are employed in some service sectors, their expertise and utility is under-recognised. Utilising the skills and knowledge of those with ‘lived experience’ has been shown to improve engagement and outcomes for people with mental illness in a range of settings. Consumers and carers should also be utilised in staff training programs and in staff selection processes. There are a variety of models of employment of consumers and carers in community and bed-based settings, but this has not been systematically developed or implemented in Australia compared with other parts of the world. We do not have minimum standards to guide the number or available hours of consumer and carer support workers across the community and bed-based sectors. We need to develop models that provide sufficient support and determine the role and responsibilities of peer employees.

Suitable training, supervision and roles need further exploration. Development of a strategy needs to incorporate findings and proposals from other projects and National activity including developments related to accreditation and registration.

Ensure accreditation and reporting systems in health and community sectors incorporate the National Standards for Mental Health Services.

There have been considerable advances in the introduction of standards and monitoring through accreditation programs, especially in the clinical sector. These have not been implemented to the same extent in the community support sector. Different accountability regimes apply to some sectors such as general practice and hospital based services, and these need to be made consistent where possible. Accreditation provides an opportunity for influencing cultural change, supporting leadership, and improving the attractiveness of mental health as a career of choice. There should be consideration of rewards or incentives linked to practices which lead to improved outcome and are experienced as positive by consumers and carers. Consumer, carer and staff perceptions and experience should be sought and taken into consideration when considering the quality of service provision and how to improve this.

Further develop and progress implementation of the National Mental Health Performance and Benchmarking Framework.

Developing a clear performance and benchmarking framework across the service system enables comparison between services and within services over time, and are key tools for promoting quality improvement in health care. The performance framework and associated indicators developed over recent years cover public sector clinical services but we do not yet have agreed frameworks against which to report on performance and quality that includes all mental health sectors – private, public and non-government organisations. These will be developed under the Fourth National Mental Health Plan, along with increased effort to build a culture of continuous quality improvement in all sectors involved in mental health care.

Develop a national mental health research strategy to drive collaboration and inform the research agenda.

Research and evaluation are critical to maintain momentum of reform and to question models of treatment and service delivery and whether we could do better or invest more wisely. Research and teaching activity is also important in maintaining the interest and enthusiasm of our workforce through development of academic positions and promotion of mental health leaders.

Considerable mental health research activity is undertaken across Australia and internationally. But it is often poorly coordinated and there is limited translation of the resultant evidence base into practice. The research is not always directed to areas in a targeted or coordinated manner, so that some areas and some populations are relatively under-researched.
Compared to the clinical sector, research and evaluation in the community non-government sector has received less funding and is less developed. Strong leadership is needed to support better collaboration and to drive a better coordinated future research agenda. Better access to this information, such as through a clearing house mechanism similar to that developed through the National Drug and Alcohol Research Centre (NDARC) will improve the promotion of new and effective programs and models of service delivery. A requirement to demonstrate implementation of accepted treatment or support models will further support effective and efficient service models. Future investment should be prioritised to those areas where there is evidence of need, or a solid basis for the effectiveness of particular models or approaches.

**Better utilise innovative telephone and web-based services to address the needs of people in remote areas.**

Telephone and internet-based services and treatment programs provide a valuable opportunity to enhance mental health service delivery due to their inherent accessibility and capacity to address current service deficits, as either a supplement to or substitute for existing face to face services for mild to moderate mental disorders. There is strong domestic and international evidence to support the use of internet-based clinical treatments as a cost effective and beneficial alternative or adjunct to traditional treatment options.

The emerging field of e-mental health solutions has a potentially important role in extending mental health service delivery. E-mental health treatments extend access and aim to address the service deficit through the provision of innovative treatment and support options for people with mental disorders, their families and carers. These initiatives aim to capture populations currently not accessing traditional services, particularly rural and remote communities, those isolated due to other causes, and those for whom anonymity is a priority or who prefer a non-clinical setting.
Priority area 5: Accountability – Measuring and reporting progress

**Outcome**

The public is able to make informed judgements about the extent of mental health reform in Australia, including the progress of this Plan, and has confidence in the information available to make these judgements. Consumers and carers have access to information about the performance of services responsible for their care across the range of health quality domains and are able to compare these to national benchmarks.

**Summary of actions**

- Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs.
- Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers, carers and other stakeholders.
- Further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting.
- Conduct a rigorous evaluation of the Fourth National Mental Health Plan.

**Cross-portfolio implications**

Responsibility for establishing an accountable mental health service system lies primarily with the health sector. Health will need to collaborate with other sectors including community services, housing, and correctional services to assist them with developing indicators to monitor the extent to which they are having an impact on the community’s mental health. Health will also need to work with other sectors in the overarching evaluation of the Fourth National Mental Health Plan.

**Indicators for which data are currently available**

- N/A

**Indicators requiring further development**

- Proportion of mental health service organisations publicly reporting performance data.

Building a more accountable and transparent mental health system is an essential step to establishing public confidence. Confidence is needed at two levels. At the broad policy level, the public needs to have confidence in the mental health reforms agreed by governments, and that governments are doing as promised. At the service delivery level, consumers and others who depend on mental health services need to be confident that those services are providing quality care in a manner consistent with modern standards. Both of these aspects of accountability have been a source of community concern, and will be central to actions taken under the Fourth National Mental Health Plan.

Processes designed to improve accountability depend on the right information being available. In the mental health sector, there is a complex mix of stakeholders, each with different information needs, but who share a common interest in knowing how the mental health system is performing. Consumers are the central group. They need the health organisations responsible for their care to make information available that allows them to understand treatment options, make informed decisions and participate actively in their care. This should include information about how the organisation performs in comparison to its peers on a range of health quality indicators, presented in a way that is will assist the person to understand what they can expect as a consumer of the
organisation. While there are few examples of such practice being adopted in Australian mental health services, there are multiple innovations in this direction developing overseas and in areas outside mental health within Australia.

Beyond consumers, other stakeholders have legitimate needs for information about mental health system performance. Carers need information to be able to understand the treatment being offered to their relative or friend, and the outcomes that can be expected for the person while they are receive treatment provided by the organisation. Mental health service providers also need information about how the treatments they provide compare with similar organisations so that they can establish evidence-based care treatment systems. Service managers need information about the performance of services for which they are responsible (and other similar services), in order to make operational decisions that will affect the efficiency and effectiveness of the service. Mental health policy makers and planners need a wide range of information about how the mental health system is performing to enable them to determine priorities for resource allocation, plan and pay for services, and monitor the achievement of outcomes.

Australia’s mental health sector has been a world leader in reporting on indicators of mental health reform, and has a longer and stronger history of doing so than many other sectors. The process began with the original National Mental Health Plan in 1992, when Health Ministers imposed on themselves the discipline of public reporting on reform progress through the National Mental Health Report. Having no international counterpart, ten reports were released over the period 1994 to 2008, charting the progress of all governments in reforming their mental health service systems. Complementing this work, first and second editions of a national mental health information development plan were prepared to guide the developmental work needed to build an ‘informed mental health system’.

These plans drove a number of major achievements, including: the implementation of routine outcome measurement for all consumers receiving care through state and territory mental health services; the development of national performance indicators for public mental health services and the introduction of service-level benchmarking; the establishment of national minimum data sets to cover all aspects of public sector mental health service delivery; and the conduct of various population-based mental health surveys designed to monitor the prevalence of mental illness in the community.

Despite these achievements, a range of concerns have been raised about existing mechanisms for promoting accountability. The area of reporting on mental health reform has been particularly targeted, with calls for information to be more readily available, timelier and of greater relevance to the current national reform agenda. Additionally, significant gaps remain in the information collections that underpin national reporting, restricting what we are able to routinely monitor about mental health system performance. Foremost among these are nationally consistent measures of consumers’ experiences of services, recovery-based outcome measures and collections that cover the growing specialised mental health non government sector. At the service delivery level, very little information is readily available to consumers and other stakeholders on the performance of their local mental health services.

The Fourth Plan acknowledges these concerns and responds by committing governments to a series of actions designed to build an accountable and transparent mental health system. These actions will work across both the policy level and the service delivery level, recognising that each level of the mental health system has a unique contribution to make in establishing public confidence.

- At the policy level, accountability is about ensuring that governments are doing what they promised to do, and monitoring whether actions taken are effective. Accountability arrangements at this level primarily involve public reporting on performance.

- At the service delivery level, processes to strengthen accountability need to be progressed within a quality improvement framework. Services that actively pursue quality inherently seek to be transparent and accountable to those they serve. Steps to build stronger accountability at this level involve providing tools and incentives to support service managers and clinical leaders establish a culture of continuous quality improvement. Accountability arrangements at this level
include such efforts as benchmarking exercises and transparent reporting of a variety of indicators across the domains of health quality.

Figure 7 summarises the approach.

**Figure 7: Multi-level approach to building an accountable and transparent mental health system**

<table>
<thead>
<tr>
<th>POLICY LEVEL</th>
<th>What needs to be done at this level</th>
<th>Promoting accountability through...</th>
</tr>
</thead>
</table>
| Actions by governments and central administrations | • Appropriate resourcing of mental health services  
  • Appropriate legislative, governance and service delivery frameworks  
  • Follow-through of commitments to implementing the 4th National Mental Health Plan’s agreed actions | • Regular (annual) national reporting on the implementation of the 4th National Mental Health Plan and available data on outcome indicators, via a redesigned National Mental Health Report |
| SERVICE DELIVERY LEVEL | • Implementation of quality improvement systems, including systems for monitoring key aspects of service delivery performance against national benchmarks  
  • Establishment of transparent reporting to local constituencies through mechanisms such as web-based access to information about how services compare to similar services elsewhere | • Development of a range of supports and incentives to assist service organisations to introduce local transparent reporting on mental health service delivery |

National action under this area includes:

*Establish a comprehensive system of reporting on the progress of mental health reform which responds to the full range of stakeholder needs.*

The Fourth National Mental Health Plan provides an opportunity to develop a comprehensive, tailored system of reporting on performance, both within and beyond the health sector. There are currently several vehicles for regular reporting on mental health in Australia that provide a good foundation but these need to be overhauled to remove duplication and improve their timeliness and relevance (see Table 1). Amongst these, a restructured and modernised National Mental Health Report will be the primary vehicle for reporting on mental health reform, including the progress of the Fourth National Mental Health Plan. Health Ministers will jointly authorise this report, and commit their respective administrations to the collection and reporting of all required data in a timely way. The report will be developed in a way that builds the momentum for change through its role in encouraging peer pressure and enabling of public scrutiny.

The National Mental Health Report will draw on and interpret a range of data sources, including the Mental Health Services in Australia report, prepared annually by the Australian Institute of Health and Welfare. In addition to presenting analysis of reform trends, the
redesigned National Mental Health Report will include independent commentaries from invited national stakeholder and other bodies, to contribute to the ongoing analysis of mental health reform in Australia. As such, the report will not only present the ‘good news’, but also point to where further action is needed to achieve the vision of the National Mental Health Policy for services to people with mental disorder in Australia.

**Table 1: Regular national-level reports contributing to comprehensive information about mental health services in Australia**

<table>
<thead>
<tr>
<th>Title</th>
<th>Purpose</th>
<th>Prepared/Released by</th>
<th>How the report will be developed 2009-14</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Mental Health Report</td>
<td>Principal report for monitoring progress of mental health reform in Australia. Presents analysis of reform against specified indicators.</td>
<td>Australian Government, for AHMC</td>
<td>Focus to be on reporting progress and outcomes of Fourth National Mental Health Plan. Key contextual indicators used in previous National Mental Health Reports to be continued, to allow monitoring of long term trends in mental health resourcing and service mix. Special commentaries to be added to allow stakeholder opinion and analysis to inform national debate.</td>
<td>Annual</td>
</tr>
<tr>
<td>Mental Health Services in Australia</td>
<td>Presents the source descriptive data on the activity of mental health services, primarily based on annual National Minimum Data Sets. Also includes descriptive information on activities of services operating beyond the health sector which are of relevance to mental health.</td>
<td>Australian Institute of Health and Welfare, funded by Australian Government</td>
<td>Publication to be developed as the comprehensive report for all source data that describe mental health services in Australia. Increasing range of source data and customised analyses to be developed for on-line access</td>
<td>Annual</td>
</tr>
</tbody>
</table>

Indicators to be used to monitor the success of the current National Mental Health Plan are listed in Table 2. The National Mental Health Report will publish updates on these indicators as they become available, along with reporting on the progress of the actions committed by governments in each of the five Priority Action Areas. Complementing this information, future National Mental Health Reports will continue to analyse and report on other key measures currently used for national monitoring (for example, per capita expenditure, workforce levels, hospital-community mix). These are important measures to add to understanding of the long term trends in mental health reform in Australia as well as providing essential context for the new indicators to be reported.

The indicators summarised in Table 2 represent core measures for assessing the achievements of the Plan, and details on data sources for these indicators are provided in Appendix 4. For some of these indicators, relevant data are already available and are used for current monitoring of the performance of the mental health system. For other indicators, relevant data collections are not in place, or, where they are, further work is needed to enable them to be used to inform the indicator. Collaboration between governments will be needed to fill these data gaps.
Targets have not been set for the indicators outlined in Table 2 but will be developed during the first twelve months of the Plan. The setting of targets should not be done arbitrarily but needs to take into account objective evidence derived from local and international research, as well as best practice guidelines and opinions of both experts and stakeholders. As with the collaborative work needed to fill the data gaps, the contributions of all governments will be needed to develop performance targets for each of the indicators that are credible and expressed in a way that is meaningful to all parties.

Table 2: Indicators of outcomes of the Fourth National Mental Health Plan

<table>
<thead>
<tr>
<th>Priority area 1: Social inclusion and recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome:</strong> The community will understand the importance and role of mental health and wellbeing, and recognise the impact of mental illness. People with mental health problems and mental illness will be embraced and supported by their communities to realise their potential, and live full and productive lives. Service delivery will be organised to deliver more coordinated care across health and social domains.</td>
</tr>
<tr>
<td><strong>Indicators for which data are currently available:</strong></td>
</tr>
<tr>
<td>• Participation rates by people with mental illness of working age in employment</td>
</tr>
<tr>
<td>• Participation rates by young people aged 16-30 with mental illness in education and employment</td>
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<tr>
<td><strong>Indicators requiring further development:</strong></td>
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<tr>
<td>• Rates of stigmatising attitudes within the community</td>
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<tr>
<td>• Proportion of front-line workers within given sectors who have been exposed to relevant education and training</td>
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<tr>
<td>• Percentage of mental health consumers living in stable housing</td>
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<td>• Rates of community participation by people with mental illness</td>
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<th>Priority area 2: Prevention and early intervention</th>
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<td><strong>Outcome:</strong> People will have a better understanding and recognition of mental health problems and mental illness. They will be supported to develop resilience and coping skills. They will be better prepared to seek help for themselves and others to prevent or intervene early in the onset of recurrence of mental illness. There will be greater recognition and response to co-occurring alcohol and other drug problems and physical health issues. Generalist services will have support and access to advice and specialist services when needed.</td>
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<tr>
<td><strong>Indicators for which data are currently available:</strong></td>
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<tr>
<td>• Proportion of primary and secondary schools with mental health literacy component included in curriculum</td>
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<td>• Rates of contact with primary mental health care by children and young people</td>
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<td>• Rates of use of licit and illicit drugs that contribute to mental illness in young people</td>
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<td>• Rates of suicide in the community</td>
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<td><strong>Indicators requiring further development:</strong></td>
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<tr>
<td>• Rates of understanding of mental health problems and mental illness in the community</td>
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<td>• Prevalence of mental illness</td>
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<th>Priority area 3: Service access, coordination and continuity of care</th>
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<td><strong>Outcome:</strong> There will be improved access to appropriate care, continuity of care and reduced rates of relapse and re-presentation to mental health services. There will be an adequate level and mix of services through population-based planning and service development across sectors. Governments and service providers will work together to establish organisational arrangements that promote the most effective and efficient use of services, minimise duplication and streamline access.</td>
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<td><strong>Indicators for which data are currently available:</strong></td>
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<tr>
<td>• Percentage of population receiving mental health care</td>
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<tr>
<td>• Readmission to hospital within 28-days of discharge</td>
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<td>• Rates of pre-admission community care</td>
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<td>• Rates of post-discharge community care</td>
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Indicators requiring further development:
- Proportion of specialist mental health sector consumers with nominated GP
- Average waiting times for consumers with mental health problems presenting to emergency departments
- Prevalence of mental illness among homeless populations
- Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities

Priority area 4: Quality improvement and innovation

Outcome:
The community will have access to information on service delivery and outcomes on a regional basis. This will include reporting against agreed standards of care including consumers’ experiences and perceptions. Mental health legislation will meet agreed principles and be able to support appropriate transfer of civil and forensic patients between jurisdictions. There will be explicit avenues of support for emerging and current leaders to implement evidence based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.

Indicators for which data are currently available:
- Proportion of total mental health workforce accounted for by consumer and carer workers
- Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards
- Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system

Indicators requiring further development:
- Proportion of consumers and carers with positive experiences of service delivery

Priority area 5: Accountability – measuring and reporting progress

Outcome:
The public will be able to make informed judgements about the extent of mental health reform in Australia, including the progress of this Plan, and have confidence in the information available to make these judgements. Consumers and carers will have access to information about the performance of services responsible for their care across the range of health quality domains and be able to compare these to national benchmarks.

Indicators for which data are currently available:
- N/A

Indicators requiring further development:
- Proportion of services publicly reporting performance data

Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders.

Accountability at the service delivery level will be strengthened by the introduction of systems of public reporting by service organisations on key performance measures. This will be progressed as part of broader initiatives to establish a culture of continuous quality improvement within service delivery systems that revolve around benchmarking and consumer and carer involvement. The aim will be to stimulate the development of informed mental health service delivery organisations that value positive results, strive for quality and are transparent to those they serve.

Introduction of these new arrangements will be achieved through incentives and supports to organisations seeking to participate in the new developments. This will include providing access to national benchmarking data, forums for interaction between peer organisations to share performance data and learn from each other and other leadership development opportunities. Web-based systems of reporting and benchmarking will be developed to better inform consumers, carers and the general community about local service performance.
Further develop mental health information including national mental health data collections that provide the foundation for system accountability and reporting

The solid information foundation developed over the past decade requires continuing collaborative effort between governments to keep data sources up to date, as well as fill gaps in current national collections. Key gaps in regularly available national data to be corrected over the course of the Fourth National Mental Health Plan are measures of consumers’ experiences of services, recovery-based outcome measures and collections that cover the growing specialised mental health non government sector. To guide the information development work, an updated National Mental Health Information Development Priorities document will be prepared in the first year of this Plan.

Conduct a rigorous evaluation of the Fourth National Mental Health Plan which makes use of data from a variety of sources and incorporates a range of perspectives.

The Fourth National Mental Health Plan has a strong commitment to evaluation. The monitoring and reporting activities described above, including the assessment of the achievements of the Plan against explicit indicators, will form the core of the evaluation. The evaluation will go beyond this. It will draw on a range of additional sources, in recognition of the fact that the indicators can only present a partial picture of progress. For example, the indicators are quantitative in nature, and the evaluation will ensure that qualitative information is captured too. In particular, the perceptions of consumers, families and carers, and the broader community will be sought through stakeholder consultations that employ qualitative data collection and analysis techniques. The emphasis here will be on the extent to which the mental health system and related sectors work together to promote recovery. Similar methods will be used to gauge workers’ views of the system, competencies and morale.

The evaluation of the Fourth National Mental Health Plan will involve the development of a clear framework at its outset that operationalises the aims of the Plan in a manner that enables them to be assessed. It will then use this information to determine any additional evaluative information that needs to be collected to examine the extent to which the aims of the Plan are achieved.

The evaluation will recognise the role of other sectors in mental health. Assessing the activities occurring in other sectors that may have an influence on the mental health of the community will be challenging, but the evaluation will incorporate an emphasis on these wherever possible.
Appendix 1: Consultation process

Summary of Consultation Process (to be developed once the process is completed)

- Developed from strong foundation of national consultation reports over the last five years including the Mental Health Council of Australia’s Not For Service and Time for Service Reports and reports from two separate national Senate Committee Inquiries into mental health services in Australia.

- Initial Stakeholder Forum 11 September 2008 convened by NSW and co-sponsored by Commonwealth.

- Establishment of Reference Group and Working Group through the Health Policy Priorities Principal Committee (a sub-committee of the Australian Health Ministers’ Advisory Committee)

- Jurisdiction-led consultations and Commonwealth consultations held throughout February and March 2009

- Consultations including presentations to many Ministerial Advisory Councils, National Advisory Council on Mental Health and Australian Suicide Prevention Advisory Council

- National Stakeholder Forum held in Melbourne 29 April 2009.
Appendix 2: A partnership approach

The National Mental Health Policy 2008 articulated the current mental health and broader policy environment. The Fourth Plan seeks to progress the relationships between these sectors and advisory structures towards a strategic, coordinated and collaborative approach to mental health across the service systems.

A partnership approach

An important first step towards the goal of greater whole-of-government responsibility articulated in the Policy has been the inclusion of Ministerial Advisory Councils on the Reference Group responsible for the development of this Plan. This has enabled the Plan for the first time to articulate the current roles and responsibilities of these non-health Portfolios in contributing to improved outcomes for people with mental illness.

The relationships between relevant portfolio areas must continue to be developed. It is envisaged that this Plan will provide a basis for governments to include mental health responsibilities into policy and practice in a more integrated way, as represented in Figure 1, to create better links between the work of national advisory committees.

It is recognised that the needs of people with mental illness, their families and carers, is not the core area of responsibility by these sectors. However, better integration and reciprocal service enhancements will benefit both the recipients of services, and result in more appropriate and effective use of services in all areas. The circumstances in which other sectors come into contact with individuals either directly or through the transition of people through service systems, provide valuable starting points for further collaboration and integration. There are already good examples or work across portfolios at a jurisdictional level, such as between police and mental health, or child protection services and mental health, but there is considerable opportunity to strengthen and expand these.

The Fourth National Mental Health Plan is guided by a recognition that good mental health, like good physical health, is determined by many factors – within the individual, and also within families and communities. How and where we live, our work, our access to education, and our relationships all influence mental health and wellbeing. Equally, when health services are needed, how and where these are provided influences our experience and the speed and extent of return to health and wellbeing. To lessen this will need action and commitment from all areas of government, and the community. Health Ministers and Mental Health Ministers at the State, Territory and Commonwealth level need to work with their ministerial colleagues in relevant portfolios to advocate for complementary policy and service development, including prioritising these in budget decisions.

Mental health reform operates in a dynamic environment. Early intervention strategies are important early in life, early in illness and early in episode, but each might involve different approaches and different components of the service system. Mental health awareness and promotion is just as important in treating environments as it is in schools and the workplace. Some reform areas are mutually dependent, for example housing, support and employment are important for ensuring well-being for people who suffer mental illness, but are often difficult to maintain when a person experiences symptoms of their illness. Likewise a person’s illness may become difficult to treat when they do not have secure housing, meaningful employment and personal support. Some issues will achieve the best outcome through nationally consistent approaches, while others will require actions tailored to address local imperatives.

There are also areas where further consideration of how services could or should respond is warranted. Some of the areas are primarily under the direction of the commonwealth government such as employment services, while others such as correctional services are primarily determined by policy at a State or Territory level. In each, there are areas for reform further development that will impact on mental health and mental health services. In some of these areas the State-based COAG Mental Health Groups, developed through the COAG National Action Plan on Mental Health 2006-
2011, have made some progress towards a whole-of-government approach and to foster stronger partnerships across service sectors. Providing staff in areas outside health with better skills to recognise mental health problems, and ensuring that they have knowledge about the mental health system and are able to access support through advice and referral will mean that all systems better respond to a person’s needs.

**Partnerships within the health system**

Like many physical illness, mental illnesses are frequently chronic and relapsing and require a multidisciplinary approach. Regrettably, there is still a gap in health outcomes of those with mental illness compared to the general population, largely because of the co-occurrence of physical ill health. We need to do more to lower the risk factors and improve the management of physical illness in those who suffer mental health problems. This includes health promotion, as well as prevention and intervention measures. A useful document which outlines areas for attention is the Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders, which was developed by experts during a conference in 2008. The Charter recognises the social and structural determinants of mental health and provides a framework for health promotion and prevention.

Mental health and physical health are interdependent. Partnerships across and within primary care and acute health system are important in developing a more holistic approach to health. Within government, greater recognition of areas such as preventative health (National Preventative Health Taskforce), and management of chronic disease have emphasised the importance of attention to social and medical domains.

**Primary care**

Primary care plays a central role in the treatment and care of those experiencing mental health problems and mental illness. General practitioners (GPs) are often the first point of entry to the care system. GPs are the route of access to psychologists and other appropriately trained professionals providing services through the Better Outcomes in Mental Health Care and Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiatives and the Mental Health Nurse Incentive Program. Their training, attitudes and knowledge of the service system positively influence peoples’ experiences of care and treatment outcomes. GPs are also ideally placed to identify comorbidities, including physical health and substance use problems. Increased awareness of the likelihood of mental health problems leads to earlier intervention and better support for carers. In many areas primary care has to be self-reliant as access to more specialist services is limited by distance or availability. Other practitioners who work in primary care such as maternal and child health nurses, and practice nurses, are also important in recognising and supporting those with mental health problems and mental illness. Developments such as Primary Care Partnerships or Networks are exploring better ways to link primary care with other relevant services to support coordinated and integrated care. In the context of the work by the National Health and Hospitals Reform Commission, there is currently an opportunity for further development of mental health in primary care, and its integration with the specialist sector.

**Emergency departments**

Another critical area is the hospital emergency department. In the context of concerns about the appropriateness of the emergency department environment for people who are often distressed and agitated, a number of service responses have been introduced. In recent years there has been the development of new models of care such as Psychiatric Emergency Care Centres, Short Stay Units, and dedicated mental health and drug practitioners within the emergency department. These provide a more immediate and specialised response to people presenting in crisis. Emergency departments may be the first point of contact with the mental health system, and need to be able to initiate treatment, especially if access to bed-based or community services is difficult.
Consultation-liaison services

Consultation-liaison services exist in many acute health services and there are also models of such support in primary care. These services recognise that mental illness may complicate the presentation and treatment of physical illness and vice versa. Mental illness is recognised as a common and significant complication in areas such as oncology, following cerebro-vascular accidents and after myocardial infarction. General hospital services need to be able to access expert advice and intervention, including support to nursing and medical staff to better manage people with physical illness complicated by psychological and behavioural problems.

Partnerships with other government areas of responsibility

A number of areas outside Health provide services to similar populations within our community. Policy, service planning and delivery in these areas need to be mindful of developments in the mental health area and vice versa. Examples of cross portfolio committees, include the state-based COAG mental health committees, and inter-departmental liaison committees. A national focus on areas such as social inclusion, or development of a Mental Health and Disability Employment Strategy provides opportunity to further engage across government and community areas.

The following sections illustrate non-health portfolio areas in which a collaborative approach to policy and service development will benefit service recipients across sectors.

Aboriginal and Torres Strait Islander Partnerships

Overview

Cultural respect and awareness of the importance of a holistic approach across the continuum of mental health and wellbeing to mental illness are critical in the delivery of services to Aboriginal and Torres Strait Islander (ATSI) people. While some services are provided through Aboriginal Community Controlled Health Services, mainstream services need to be culturally proficient so that ATSI people feel confident to seek assistance when required.

Interface and future directions

Services need to be aware of issues of cultural safety and respect in how services are provided, and the impact of life events such as incarceration. They need to be aware of the importance of family, family dynamics and how cultural beliefs may impact on the presentation and management of mental illness. The impact of trans-generational trauma needs to be taken into account when planning and delivering services. In rural and remote communities, health and community workers need to be aware of mental health issues, and of the risks that co-morbid substance abuse or physical ill-health brings to mental wellbeing. ATSI specific services will need to support and inform workers in mainstream services how to provide the most appropriate interventions to Indigenous people.

Particular challenges that face service improvement in ATSI health include the diverse nature of the needs of ATSI people, and the ongoing development of the ATSI health workforce. The needs of urban ATSI people may be very different from those in remote communities, but the aim of promoting mental health and wellbeing just as relevant. The Indigenous workforce needs to have confidence that they have access to advice and back-up when required.
Ageing

Overview

The proportion of the older people in Australia is increasing with as is life expectancy. While many remain in their own homes, others require the additional support of hostel or nursing home placement. Older people have an increased risk of mental health problems – through pre-existing illness, the recent onset of illness such as depression, and age specific illness such as dementia. They are also more likely to experience chronic physical health problems. They may be reliant on family or friends for support and have difficulty accessing some services because of limited mobility. They access specialist psychiatric services less than younger people. The delivery of services to ageing people in the community, and in aged care facilities is complicated by the frequent co-existence of mental health and physical problems, sometimes with associated challenging behaviours.

Interface and future directions

Services for aged people are often delivered in partnership across health and community sectors. Care coordination is particularly important in such situations where general practice, multiple support agencies and clinical specialists are involved. While it is not expected that aged care staff will have the level of clinical skill that may be required for detailed assessment and treatment, workers from aged care and community sectors need to be aware of the risk of mental health problems, and should be able to screen, and where appropriate support referral to more specialised services for mental health treatment and care.

Likewise, specialist aged persons mental health services should develop improved capacity to support generic services, provide additional training and consultation to support the person remaining at home or in a mainstream facility. This may involve ‘in-reach’ of clinical services to the person’s home or residential facility. Where admission to an inpatient service is indicated, discharge planning needs to incorporate advice and support to those involved in ongoing care, including family members.

Alcohol and other drug services

Overview

There is a complex and multifactorial association between mental health problems, mental illness and excessive use of alcohol and illicit substances. Use of some substances such as cannabis and psycho-stimulants, is causally associated with mental health problems and mental illness. Those at increased risk for developing a mental illness or mental disorder, such as people who have experienced major disruptions during childhood, or exposure to trauma, are also at increased risk of developing substance dependence. This is especially so for those with ‘high prevalence’ problems such as depressive illness, and anxiety disorders including post traumatic stress disorder. Children of parents with a substance abuse problem have an increased risk of developing mental health problems.

Interface and future directions

Until fairly recently, there was little engagement between mental health services and alcohol and other drug (AOD) services. There is now considerable effort in a number of jurisdictions to better coordinate service delivery and to improve mutual understanding and respect between the sectors. Screening for mental health problems and staff training in their recognition and management leads to earlier identification and support to access appropriate services. Establishing linkages with mental health services, transfer of information and the development of joint care plans for people with multiple and complex needs will lessen duplication and discontinuity of care and support early intervention and sustained recovery.
At a state/territory and Commonwealth level there has been investment to support workforce development, but further work is required to determine best practice in delivery of services to people with co-morbid mental health problems and substance abuse. The interface between mental illness and mental health problems, and presentation to AOD services warrant an investigation of new service delivery and care models. These may involve co-location, or one arm of service taking a lead in particular areas. For example, services focusing on psychotic disorders could provide interventions for cannabis and amphetamine users, while services for AOD have arrangements for anxiety and affective disorders available. Headspace is one example of combined service delivery to young people. Future directions should support an improved response to mental health problems and to AOD dependency through comprehensive assessment, referral and treatment models.

The courts, police and other law enforcement officials are frequently faced with decisions regarding behavioural disturbance and its attributions. It can be difficult to distinguish at times the effects of intoxication from those of acute mental illness, and therefore to determine the most appropriate intervention and treatment. Collaboration between the courts, police, mental health services, AOD services and emergency department staff can make a significant difference to the immediate and longer term outcomes for the person involved.

**Children in Care and Youth Justice**

**Overview**

Children and their families who have contact with child protection services may present in the context of a particular crisis or be exposed to more enduring disadvantage and distress. Young people who come to the attention of the youth justice system often have multiple problems and challenges. These include increased risk of mental health problems, often experience of abuse or trauma, and exposure to illicit substances.

**Interface and future directions**

Contact with these services presents an opportunity for intervention. Such intervention may directly address mental health issues, or indirectly improve mental health outcomes via services such as speech therapy or assistance at school. Intervention should work in ways that increase the young person’s self-confidence and resilience. Providing additional clinical and non-clinical support to parent(s), (e.g. via support for AOD issues) may be the most appropriate way to support children in the family and minimise risk. It is important that the staff working in these areas are aware of areas of vulnerability, and to adequately assess and supported to assist the young person and his or her family.

There is sometimes a tension between the aims of child protection and youth justice services in relation to safety and risk minimisation, and those of mental health services in delivering treatment and care in the least restrictive environment. Greater effort is needed to improve understanding of the roles, responsibilities and limitations of each sector, and to develop models of service collaboration which include relevant information sharing and cross-sector support.

**Community services**

**Overview**

Community services and mental health services often provide services to shared clients. Community services cover a diverse cross section of support services, generally provided by not for profit organisations which operate with a combination of charitable and government funding. Services include:

- family support;
- alcohol and other drug services;
- aged care;
- out-of-home care;
• personal support;
• vocational and employment services;
• homelessness services;
• sexual assault services;
• disability services;
• women’s services;
• recreational services;
• carer respite; and
• multicultural services, including assistance to victims of torture and trauma.

Services provided in these areas include counselling, accommodation, employment assistance, education and social activities.

Interface and future directions

Often workers in these services are at the frontline, and will be involved in identifying people experiencing mental health issues, providing support to them, and promoting good mental health generally. While mental health clinical services focus on assessment and treatment, specialist and generic community services offer greater focus on opportunities that build resilience, community involvement and support that helps prevent escalation and relapse of mental illness. A partnership between the community sector and specialist mental health programs is critical to improving the mental health and well being of a large number of Australians across a diverse range of cultures, locations and ages. Because of this, workers in all areas of community services need to be aware of mental health problems, including early identification and mental health first aid, the concerns faced by those with mental illness, and the needs of their carers.

Community services staff need to be aware of mental health issues to respond appropriately to people with mental illness, their families and carers. They also need an extensive knowledge of other support services that complement mental health services to facilitate local referrals between services to ensure timely and equitable access to appropriate care.

People with mental health as well as other health problems need to have their mental health needs addressed as well as their other health needs. For example, people with intellectual disability are at increased risk of experiencing a mental illness, yet this is often overlooked and access to appropriate treatment for both disabilities is limited.

Carer respite services also need training to recognise mental illness and knowledge of other support services to offer support and early intervention to people with mental illness and their carers.

Correctional services and Justice

Overview

People who come into contact with the criminal justice system – through courts, prisons and community corrections are more likely to have mental health problems or mental illness than the general community. They are also more likely to have alcohol and/or substance use problems. Incarceration can result in loss of contact with family, loss of accommodation and employment, and exacerbation or onset of mental illness. Indigenous people can be particularly at risk of mental health problems within a custodial environment.

Interface and future directions

Screening people for mental health problems at courts, and where possible diverting them to services in the community supports an early intervention and prevention approach. Treatment and care within the custodial environment, and support to link with community services at the point of release will reduce the risk of relapse of illness and is also likely to reduce the risk of recidivism. A significant proportion of those found guilty of an offence will also be managed in the community at some point – under parole or on community-based orders.
Improving linkages between community correctional staff and the primary and specialist mental health service sector through better information exchange and staff training will lessen the risk of people falling between services. A particular challenge for correctional case managers is working within service criteria that fail to give sufficient weight to the complex needs of offenders. While there is a shared interest in community safety objectives, particularly where that is informed by assessment of the risk to self or others, there is less alignment between other health and corrections objectives. Offenders with apparently stable or sub-acute conditions may still require mental health support. Repeated involvement with the criminal justice system can exacerbate symptoms of mental illness. These issues are also relevant to the youth justice system. Cultural awareness and respect are particularly important in supporting ATSI people in the justice system.

It is recognised that the development of a consistent approach to the management of people with mental health problems in custody is complicated by the fact that models for the delivery of assessment and treatment services vary across jurisdictions. In some States and Territories, mental health service provision is the responsibility of Health, while in others it is overseen by the Justice portfolio, or is a hybrid of both. Different legislative frameworks also apply. While there is general clarity with regard to the most appropriate management of offenders who have a mental illness, there is sometimes a tension regarding the management of offenders with behavioural disturbance in the context of a personality disorder. The manifestations of the most severe of these disorders continue to pose a major challenge in the correctional domain with a need for the development of specialist expertise and interventions. The National Forensic Mental Health Principles covered a number of these areas, but have not been fully embraced across the service system. Court diversion programs, and the development of mental health liaison staff with in prisons are examples of collaborative joined up interventions.

**Culturally and linguistically diverse groups**

**Overview**

The Australian community includes people from many different ethnic and cultural backgrounds. A number of issues relevant to mental health confront people who have come to Australia from other countries and cultures. They may have experienced trauma or torture in their country of origin or during the journey to Australia. They may be isolated, lacking community support and facing additional barriers because of language and cultural differences.

**Interface and future directions**

Mental health services need to make use of professional interpreting services and to be aware of particular sensitivities associated with different religions and cultures. They need to be aware of the impact of exposure to traumatic events and of loss on the presentation of mental health problems and their treatment. This includes issues related to gender sensitivity. They need to support and nurture a bilingual workforce. Likewise, agencies who come into contact with new arrivals, or who provide community and support services to people from other countries need to include consideration of their mental health needs, and establish pathways for referral or advice.

Future developments could include greater access to information in other languages, and support for multicultural community groups that recognise issues of particular concern or prevalence in a given community. The amenity of bed-based and community services should include consideration of the needs of different religious groups, including issues related to gender.

**Emergency services – Police, ambulance and fire authorities**

**Overview**

Police, ambulance officers and fire-fighters provide frontline services. They are exposed to difficult and potentially dangerous situations, which sometimes involve those experiencing mental illness. With the shift to community-based care and shortened inpatient episodes of care in less restrictive
settings there has also been increased expectation on police and others in the community to respond to people who experience mental illness and mental disorders.

**Interface and future directions**

Some mental illnesses are associated with a risk of functional disability and at times difficult behaviour. Co-morbidity is common in such situations, particularly intoxication with alcohol and/or illicit substances. At such times there needs to be a close working relationship between mental health services and emergency services. Emergency service personnel have reported feeling that they were the “meat in the sandwich”, and that their concerns were given insufficient attention by those in the mental health sector.

Over the past decade, emergency services have responded to give staff greater training and support and to encourage local engagement. Transport of people experiencing mental illness has been an area of particular concern. Although ambulances are the preferred means of transport of mentally ill people, police will also be involved in transport in situations where there has been alleged offending behaviour, or when the risk of harm to the person or to others is very acute.

Emergency services should ensure their staff have adequate training in the recognition and early management of people in mental health crisis, and knowledge of the service system and how to access it. Respectful communication, patience and reassurance can defuse a situation and avert a tragic outcome. But police and ambulance staff also need to be able to access specialist services rapidly, and to have sufficient information transfer to allow them to do their job.

**Employment**

**Overview**

There has been increasing recognition of the importance of employment or occupation in supporting good mental health, and of the impact of mental illness on absenteeism and subsequent loss of productivity. Mental health problems and mental illness often become evident in the work situation, particularly more common illnesses such as depression and anxiety disorders.

**Interface and future directions**

Workplace policies and practices designed to support people to remain employed or to return to employment, have been implemented in some areas, but are not yet common. Likewise, support to find suitable employment, and support through the early stages of vocational placement can be very effective in assisting a person who has experienced a mental illness to rejoin the workforce. The development of policies at government level to promote more inclusive practice in support to find and keep employment is an important aspect of the recovery focus included in the Mental Health Plan. While some models are in place, they are still relatively new and untested. Some rely on partnerships between clinical service providers, community support agencies and employment support agencies. Centrelink and employment support agencies are responsible for facilitating and supporting models which improve the placement and retention of those who are at risk of mental health problems. Staff in these agencies need to have access to information about what type of employment and support needs may be required. Clinical and community mental health services should work in ways that assist people with mental illness to seek or retain employment.

**Housing**

**Overview**

Safe, secure and affordable housing is critical for all, but particularly those with mental health problems. As such, it is important that appropriate services and support is available to all people, regardless of their housing tenure. There has been considerable attention to this area in recent years. The Homelessness White Paper considers a range of areas relevant to mental health, including a statement that people should not be discharged from health services into homelessness.
But this may not always be feasible. A given person may not accept the accommodation offered. There is also pressure on services to admit very unwell people, and accommodation options are sometimes limited. Recognition of the importance of stable accommodation to the recovery process has led to greater integration across services, but further improvement in the coordination and collaboration between housing services and mental health services is still needed.

**Interface and future directions**

Homelessness may be both a cause and an effect of mental illness and mental health problems. Engagement with services is difficult for those who are homeless, but can be improved by services being available at homeless shelters or drop in centres. This engagement can then support movement into more secure and appropriate accommodation. Admission to an inpatient unit can precipitate homelessness and discharge planning should include consideration of accommodation and support on discharge. Some people with mental illness may need long term supported accommodation. Others may require only transitional support.

There are a number of models for the provision of housing and support. These have demonstrated better outcomes, including sustained recovery from mental illness and return to employment. Planning for social housing developments should include consideration of the needs of people with mental illness and mental health problems, such as the proximity of clinical and support services, location and size of accommodation. Allocations made by social housing providers should also consider the needs of people with mental illnesses when offering properties, based on advice provided by mental health service providers where the person is linked with mental health services. Clinical and non-clinical mental health services should work with Housing agencies to ensure tenancies are sustainable through the provision of suitable models of treatment and support.

**Schools and education**

**Overview**

Kindergarten, primary and secondary education are accessed by nearly all young people. They thus provide a universal platform where mental health promotion, prevention and early intervention activities should be fostered. Identification, early intervention and, where appropriate, referral to more specialised services can make a significant difference in a child’s welfare and outcome. A number of mental health problems such as anxiety and mood disorders, eating disorders and challenging behaviour may first come to notice in the school environment.

**Interface and future directions**

Programs which address areas such as mental health and emotional wellbeing, bullying, challenging behaviours, healthy eating, and drug and alcohol education, are in place in some areas but could be expanded. We also need greater consistency in the range of programs provided, informed by evidence of what works best. School teaching staff and counsellors should have access to relevant training, and advice and support from the mental health specialist sector in relation to individuals or school programs.

Engagement between schools, community-based mental health services, and child protection services should be supported by shared service agreements developed at a local or regional level. Transition from early childhood services to school and from primary to secondary school may represent a time of increased stress. It is during these times that staff need to be most alert to those who are at risk of dropping out of school.
Appendix 3: Social inclusion principles

Social inclusion principles for Australia

The Australian Government’s Principles for Social Inclusion in Australia were developed with advice from the Australian Social Inclusion Board to guide individuals, business and community organisations, and government on how to take a socially inclusive approach to their activities.

Aspirational principles

1. Reducing disadvantage

_Making sure people in need benefit from access to good health, education and other services_

Funding and service delivery should promote equitable access to universal benefits and services for Australians in all their diversity, and invest more intensively in those at risk of, or experiencing, social exclusion.

2. Increasing social, civil and economic participation

_Helping everyone get the skills and support they need so they can work and connect with community, even during hard times_

Maximum participation in economic, social and community life is a defining characteristic of an inclusive society. Achieving this outcome for all Australians means delivering policies and programs which support people to learn and strengthen their ability to participate actively in the labour market and in their communities. Over time people’s opportunities and capabilities are formed through their experience of family life and their participation in the communities, economies and institutions around them. People with well-established social networks and institutional connections are more likely to deal successfully with personal crisis and economic adversity. Policy design should be mindful of costs and benefits and the evidence about returns for investments. Resources should be weighted towards tailored approaches for those most in need while maintaining universal access and participation in services and community life. Services should be responsive to the diverse attributes, circumstances and aspirations of their clients. A key aspect of boosting participation is capacity building – supporting individuals’ personal capacity to address the issues that arise over the course of their lives, and supporting people to take independent decisions and to negotiate priorities through participation in their workplaces, their neighbourhoods and their communities. This is especially true for communities struggling with intergenerational disadvantage.

3. A greater voice, combined with greater responsibility

_Governments and other organisations giving people a say in what services they need and how they work, and people taking responsibility to make the best use of the opportunities available_

Achieving social inclusion depends on the active involvement of the entire community. Providing opportunities for citizens and communities to identify their needs and give feedback about the design and delivery of policies and programs will be important. Individuals and service users must have a say in shaping their own futures and the benefits and services that are offered to them. Detailed feedback from users and community members and genuine and inclusive consultation are important sources of information to improve policy settings and service delivery. Where people are part of a democratic community and able to access opportunities, benefits and services, they also have an obligation to use their best efforts and take personal responsibility for taking part and making progress. Organisations – both government and non-government - also have responsibilities to listen and respond, and to make sure their policies, programs and services help to build social inclusion.
**Principles of approach**

**4. Building on individual and community strengths**

*Making the most of people’s strengths, including the strengths of Aboriginal and Torres Strait Islander peoples and people from other cultures*

Taking a strength-based, rather than a deficit-based, approach means respecting, supporting and building on the strengths of individuals, families, communities and cultures. Assuming, promoting and supporting a strong and positive view of Aboriginal and Torres Strait Islander identity and culture will be particularly important ways to reduce social exclusion for Indigenous Australians, working in parallel with specific initiatives to improve their health, education, housing and employment prospects. Recognising the varied and positive contributions of people from culturally and linguistically diverse backgrounds will also be an important feature of the social inclusion approach.

**5. Building partnerships with key stakeholders**

*Governments, organisations and communities working together to get the best results for people in need*

All sectors have a role to play in building a more socially inclusive Australia and the approach will rely on encouraging and supporting the diverse contribution of all. Strong relationships between government and these other stakeholders are key to achieving the joined up approach required for sustainable outcomes and to sharing expertise to produce innovative solutions. Building effective partnerships to tackle shared priorities is essential to improving social inclusion over time. Whether in forming city wide plans to reduce homelessness, or strengthening service provision in parts of the community sector, or jointly investing in new social innovations, policy on social inclusion needs to advance work through a diverse range of cross sector partnerships.

**6. Developing tailored services**

*Services working together in new and flexible ways to meet each person’s different needs*

*For some members of the Australian population experiencing, or at immediate risk of, significant exclusion, mainstream services may not be sufficient or appropriate to mitigate against exclusion*

Deep, intensive interventions tailored at an individual, family or community level are one way to support those experiencing deep and complex social exclusion, by helping them tackle their actual problems. Different service providers may need to link together to do this. For example, linking health and family support services may make the most difference to parents of children at risk. Linking employment preparation effectively with drug or alcohol treatment may be necessary as a pathway out of homelessness. Successfully overcoming social exclusion may also involve learning to change deeply held attitudes and behaviours, for example through anger management or family counselling, in order to access new opportunities. Overcoming the fragmentation of government service systems for people at high risk of social exclusion, and in relation to important milestones in the lifecycle, such as transitions from adolescence to adulthood or the end of working life, is a priority.

**7. Giving a high priority to early intervention and prevention**

*Heading off problems by understanding the root causes and intervening early*

It is important to tackle the immediate problems of social exclusion that many face, such as homelessness. But in the longer term it is clearly preferable to prevent such problems arising in the first place. Identifying the root causes of disadvantage and the connections between different types of disadvantage allows interventions to be designed to prevent the occurrence of problems and provide more effective support to those who are vulnerable before the disadvantage becomes entrenched. This is particularly important in preventing intergenerational transmission of disadvantage. Universal services such as schools and hospitals provide a range of opportunities to identify those at risk of disadvantage at an early stage. Giving priority to early intervention and
prevention means focusing on children and young people, on the early identification of potential problems, and on taking effective action to tackle them.

8. Building joined-up services and whole of government(s) solutions

Getting different parts and different levels of government to work together in new and flexible ways to get better outcomes and services for people in need

The multifaceted nature of social exclusion means that the services offered by any one agency can only go so far in meeting the complex needs of a person or groups of people. Separate silos of funding, policy-making and service delivery can be systemic barriers to providing effective support. Flexibility and cooperation across agencies, both between Commonwealth agencies and across levels of government, is one key to comprehensively address social exclusion. Integration, transparency and collaboration between Commonwealth, State and Territory governments are particularly important. Priorities include:

- taking a 'people-first' view of what people and communities need, using evidence about their actual experiences and life outcomes;
- developing policy through integrated, problem-solving projects which draw together all relevant agencies and knowledge; and
- developing programs within a comprehensive social inclusion framework, researching and understanding the links between programs operating on the ground, and working across all levels of government, including through COAG, to join up service delivery in strategic as well as practical ways.

9. Using evidence and integrated data to inform policy

Finding out what programs and services work well and understanding why, so you can share good ideas, keep making improvements and put your effort into the things that work

Progress towards social inclusion must be accompanied by better information, faster learning and better use of knowledge to improve outcomes. As far as possible, interventions should draw on:

- practical experience of community and other delivery organisations;
- existing research and the evidence base on what works; and
- monitoring and evaluating strategies as they develop, focusing on outcomes as well as processes.

To the extent that interventions are experimental, they should be designed and evaluated in a way which builds on this evidence base. It will also be important for government to report regularly on progress in social inclusion, using clear indicators and reporting from the perspective of the individual, the family, the neighbourhood or the community affected. Indicators should be responsive to effective policy interventions and identify the essence of the problem and have a clear and accepted interpretation.

10. Using locational approaches

Working in places where there is a lot of disadvantage, to get to people most in need and to understand how different problems are connected

Evidence show that different kinds of disadvantage can be concentrated in particular locations in Australia. Focusing effort on building social inclusion in particular locations, neighbourhoods and communities can ensure that they are not left behind, and help us learn how planning, economic development, community engagement and service delivery can be integrated to achieve better overall outcomes.
11. Planning for sustainability

*Doing things that will help people and communities deal better with problems in the future, as well as solving the problems they face now*

Policies and programs should be focused on long-term sustainable improvement. To do this, it is important to ensure that interventions build an individual’s capacity and develop protective factors that will enable them to self-manage through life-course events. For the government, it will be important to establish benchmarks and adopt formal quantified targets that are ambitious but attainable, measurable and time specific, focus on long term policy goals, and integrate long term social inclusion objectives in broader reform efforts, such as budgetary reform and reforms being pursued through COAG.
# Appendix 4: Technical notes on indicators to monitor the Fourth National Mental Health Plan

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<thead>
<tr>
<th>Priority area</th>
<th>Outcome</th>
<th>Indicators</th>
<th>Technical notes re. indicators</th>
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<tbody>
<tr>
<td>1. Social inclusion and recovery</td>
<td>The community has a better understanding of the importance and role of mental health and wellbeing, and recognises the impact of mental illness. People with mental health problems and mental illness are valued and supported by their communities to realise their potential, and live full and productive lives. Service delivery is organised to deliver more coordinated care across health and social domains.</td>
<td>Participation rates by people with mental illness of working age in employment&lt;sup&gt;1&lt;/sup&gt; Participation rates by young people aged 16-30 with mental illness in education and employment&lt;sup&gt;1&lt;/sup&gt; Rates of stigmatising attitudes within the community&lt;sup&gt;2&lt;/sup&gt; Proportion of front-line workers within given sectors who have been exposed to relevant education and training&lt;sup&gt;3&lt;/sup&gt; Percentage of mental health consumers living in stable housing&lt;sup&gt;4&lt;/sup&gt; Rates of community participation by people with mental illness&lt;sup&gt;5&lt;/sup&gt;</td>
<td>1. Several data sources exist that could provide baseline data against which these indicators could be monitored, including the National Survey of Mental Health and Wellbeing, the Survey of Disability, Ageing and Carers, and the Household, Income and Labour Dynamics in Australia Survey. Consideration will need to be given to issues around the re-administration of these surveys. 2. No existing data sources are available to monitor this indicator, and a large-scale population-based survey would be required. It might be possible to adapt Jorm’s mental health literacy survey for this purpose. 3. No existing data sources are available to monitor this indicator. New ways of quantifying exposure to education and training in different service sectors will need to be explored. 4. Existing data sources do not yet enable this indicator to be monitored. Amendments will be needed to the various National Minimum Data Sets covering state and territory services to routinely capture the relevant information. 5. Various instruments exist which could be adapted to inform this indicator. For example, New South Wales mental health services are developing an instrument known as the ‘Activity Participation Questionnaire’ which assesses involvement in a range of social and vocational activities. Such instruments could be routinely administered in mental health services, or could form part of a community-based survey which also assessed mental health problems.</td>
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<td>2. Prevention and early intervention</td>
<td>People have a better understanding and recognition of mental health problems and mental illness. They are supported to develop resilience and coping skills. People are better prepared to seek help for themselves and to support others to prevent or intervene early in the onset or recurrence of mental illness.</td>
<td>Proportion of primary and secondary schools with mental health literacy component included in curriculum&lt;sup&gt;1&lt;/sup&gt; Rates of contact with primary mental health care by children and young people&lt;sup&gt;2&lt;/sup&gt;</td>
<td>1. Routinely-collected data through the MindMatters and KidsMatter national initiative can be used to inform this indicator. 2. Numbers of GP Mental Health Care Plans provided for children and young people, identified from Medicare data, could be used to inform this indicator. 3. Data relevant to this indicator are collected at regular intervals via the National Drug Strategy Household Survey.</td>
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<td>mental illness.</td>
<td>Rates of use of licit and illicit drugs that contribute to mental illness in young people&lt;sup&gt;3&lt;/sup&gt;</td>
<td>4. Routinely-collected data on suicide published by the Australian Bureau of Statistics are used to inform this indicator.</td>
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<td>There is greater recognition and response to co-occurring alcohol and other drug problems and physical health issues. Generalist services have support and access to advice and specialist services when needed.</td>
<td>Rates of suicide in the community&lt;sup&gt;4&lt;/sup&gt;. Rates of understanding of mental health problems and mental illness in the community&lt;sup&gt;5&lt;/sup&gt;. Prevalence of mental illness&lt;sup&gt;6&lt;/sup&gt;.</td>
<td>5. Jorm’s mental health literacy survey could provide baseline data against which this indicator could be monitored. Consideration will need to be given to issues around the re-administration of this survey.</td>
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<td>3. Service access, coordination and continuity of care</td>
<td>There is improved access to appropriate care, continuity of care and reduced rates of relapse and re-presentation to mental health services. There is an adequate level and mix of services through population-based planning and service development across sectors. Governments and service providers work together to establish organisational arrangements that promote the most effective and efficient use of services, minimise duplication and streamline access.</td>
<td>Percentage of population receiving mental health care&lt;sup&gt;1&lt;/sup&gt;. Readmission to hospital within 28-days of discharge&lt;sup&gt;2&lt;/sup&gt;. Rates of pre-admission community care&lt;sup&gt;2&lt;/sup&gt;. Rates of post-discharge community care&lt;sup&gt;2&lt;/sup&gt;. Proportion of specialist mental health sector consumers with nominated GP&lt;sup&gt;3&lt;/sup&gt;. Average waiting times for consumers with mental health problems presenting to emergency departments&lt;sup&gt;4&lt;/sup&gt;. Prevalence of mental illness among homeless populations&lt;sup&gt;5&lt;/sup&gt;. Prevalence of mental illness among people who are remanded or newly sentenced to</td>
<td>1. Numerator and denominator data for this indicator can be calculated at national and local levels from service contact data and census data. The indicator is currently reported in annual progress reports on the COAG National Action Plan on Mental Health. Data from the National Survey of Mental Health and Wellbeing could be used to further inform the question of who in the population is receiving mental health care.</td>
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<td>Prevalence of mental illness among people who are remanded or newly sentenced to</td>
<td>2. Routinely-collected data from the Admitted Patient Mental Health Care and the Community Mental Health Care National Minimum Data Sets can be used to inform these indicators.</td>
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<td>Prevalence of mental illness among people who are remanded or newly sentenced to</td>
<td>3. Existing data sources do not yet enable this indicator to be monitored. Consideration will need to be given to novel ways of capturing relevant information (e.g., incorporating new fields into routinely-collected data sets, auditing files from a representative sample of services)</td>
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<td>Prevalence of mental illness among people who are remanded or newly sentenced to</td>
<td>4. Existing data sources do not yet enable this indicator to be monitored. Average waiting times could be calculated in many emergency departments, but it is not possible accurately differentiate waiting times for people with and without mental health problems. Consideration will need to be given to new ways of</td>
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<td>adult and juvenile correctional facilities (^6)</td>
<td>capturing this information.</td>
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<td>Proportion of total mental health workforce accounted for by consumer and carer workers (^1)</td>
<td>5. The Supported Accommodation Assistance Program (SAAP) provides crisis accommodation and related support services to people who are homeless or at imminent risk of becoming homeless. The SAAP program has been incorporated into the National Affordable Housing Agreement. Data sources linked to this include data on whether clients have mental health problems, including through a special purpose survey to explore the same issue. These data sources could inform this indicator.</td>
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<td>Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards (^2)</td>
<td>6. The Prisoners Health Information Group (a group established in 2004 by the Australian Health Ministers' Advisory Council) has undertaken a range of activities designed to enable regular monitoring of the health status of Australia's prison population. Stemming from this work, a one week census of new entrants to Australian prisons is scheduled to take place in July 2009, as a precursor to more regular national data collection.</td>
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<td>Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system (^3)</td>
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<td>Proportion of consumers and carers with positive experiences of service delivery (^4)</td>
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4. Quality improvement and innovation

The community has access to information on service delivery and outcomes on a regional basis. This includes reporting against agreed standards of care including consumers' and carers' experiences and perceptions.

Mental health legislation meets agreed principles and is able to support appropriate transfer of civil and forensic patients between jurisdictions.

There are explicit avenues of support for emerging and current leaders to implement evidence based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.

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<tr>
<td></td>
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<td>Proportion of total mental health workforce accounted for by consumer and carer workers (^1)</td>
<td>1. Data relating to this indicator are available in part through the Mental Health Establishments National Minimum Data Set, which provides information on the size of the total workforce and the numbers comprising particular workforce groups. NGO coverage is not included and will require new data collection.</td>
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<td></td>
<td></td>
<td>Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards (^2)</td>
<td>2. Data relating to this indicator will be available as a by-product of routine reporting against the National Mental Health Standards, again through the Mental Health Establishments National Minimum Data Set.</td>
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<td></td>
<td></td>
<td>Mental health outcomes for people who receive treatment from State and Territory services and the private hospital system (^3)</td>
<td>3. Data relating to this indicator are reported routinely through the National Outcomes and Casemix Collection.</td>
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<td>Proportion of consumers and carers with positive experiences of service delivery (^4)</td>
<td>4. Initiatives being taken by several jurisdictions to regularly monitor consumer perceptions of care will be reviewed, with a view to identifying a standard measure. Similarly, work on available measures of carer well-being, burden and perceptions of care will be consolidated to identify or develop an appropriate measure or set of measures to be used across services.</td>
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<td>5. Accountability – Measuring and reporting progress</td>
<td>The public is able to make informed judgements about the extent of mental health reform in Australia, including the progress of this Plan, and has confidence in the information available to make these judgements. Consumers and carers have access to information about the performance of services responsible for their care across the range of health quality domains and are able to compare these to national benchmarks.</td>
<td>Proportion of services publicly reporting performance data(^1)</td>
<td>1. As public reporting of performance information is not yet the norm, no existing datasets are available to collect data related to this indicator. Consideration will need to be given to systematic means of monitoring progress against this indicator.</td>
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\(^1\) As of 2023, performance data was not publicly available for all services.
Glossary

[To be completed once plan is endorsed and all terms are identified. The Glossary of the National Mental Health Policy 2008 is provided as a basis for initial reference]

Acute services/treatment: Specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The treatment effort is focused upon symptom reduction with a reasonable expectation of substantial improvement.

Advocacy: Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support to enable them to represent themselves.

Carer consultants: People who have experience of caring for a person with a mental illness. They are employed by public mental health services, and have a good knowledge of the mental health system and the issues that are faced by families and other carers. Carer consultants provide emotional support, information and referral advice for families and carers. They also work with mental health staff in developing service responsiveness to the needs of carers and families.

Community controlled services: Aboriginal Community Controlled Health Services are primary health care services initiated, operated and controlled by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management). Services form a network, but each is autonomous and independent both of one another and of government.

Community mental health teams: Teams which may include: social workers, community psychiatric nurses, consumer and carer consultants, peer support workers, occupational therapists, psychologists and psychiatrists and Aboriginal mental health workers. Community mental health teams provide a range of services in the community including: individual treatment programs; family interventions; short and long term support and psycho-education.

Consumer consultants: Consumers who are employed to advise on and facilitate service responsiveness to people with a mental health problem or mental illness and the inclusion of their perspectives in all aspects of planning, delivery and evaluation of mental health and other relevant services.

Criminal justice system: Explicit rules (laws) created by political authorities and designated officials such as police, lawyers and judges to make, interpret and enforce rules, and the provision for punishment for those who offend and commit acts against the rules and society at large.

Cultural competence: A set of behaviours, attitudes and a culture within a system that respects and takes into account the person’s cultural background, cultural beliefs, and their values and incorporates it into the way healthcare is delivered to that individual.

Cultural respect and safety: Cultural respect and safety is the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples and other cultural groups.

Day programs: Programs providing individual or group centre-based activities on a whole or part-day basis. They include but are not limited to: assessment, assertive life skills training, activities programs, diversional therapy and pre-vocational training.

Disability: The effects of mental illness which severely impair functioning in different aspects of a person’s life such as the ability to live independently, maintain friendships, maintain employment and to participate meaningfully in the community.
**Diversion**: A process which diverts mentally ill offenders away from the criminal justice system to the health and social care sectors. Diversion can occur at any stage of the criminal justice process: before arrest, after proceedings have been initiated, in place of prosecution, or when a case is being considered by the courts.

**Emotional resilience**: A feature of personality which contributes to mental health and well-being. In situations of significant adversity, emotional resilience enables a person to pursue their goals, to solve problems and to quickly regain emotional equilibrium. It also enables a person to cope more confidently and effectively in day-to-day life and to handle stress better than those who are less emotionally resilient.

**Forensic mental health services**: Services providing assistance to people who experience mental illness and are in contact with the adult criminal and juvenile justice systems.

**Incidence**: The proportion of individuals in a particular population who have a newly developed mental illness during a specific time period.

**Key performance indicators**: Achievable, measurable targets, used for goals and monitoring of performance.

**Meaningful participation**: The capacity of a person to engage in personal, educational, employment, social, political and other activities within their community in such a way that they are able to fully realise their potential and to feel socially valued and personally validated.

**Mental health problem**: Diminished cognitive, emotional or social abilities but not to the extent that the criteria for a mental illness are met.

**Mental illness**: A clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the *Diagnostic and statistical manual of mental disorders* (DSM) or the *International classification of diseases* (ICD).

**Non-government mental health sector**: Private, not-for-profit, community-managed organisations that provide community support services for people affected by mental health problems and mental illness. Non-government organisations may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness and carers or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, prevocational training, residential services and respite care.

**Peer support**: Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis.

**Population health framework**: An understanding that the factors which impact on the mental health of individuals and populations are complex and occur in the events and settings of everyday life. A population health approach encourages a holistic approach to improving mental health and well-being. Interventions span the spectrum from prevention to recovery and relapse prevention across the lifespan.

**Prevalence**: The proportion of individuals in a particular population who have a mental illness during a specific period of time.

**Primary care services**: Community based services which often constitute the first point of contact for people experiencing a mental health problem or a mental illness and their families. The primary care sector includes general practitioners, emergency departments and community health centres.
Private sector specialist mental health services: The range of mental health care and services provided by psychiatrists, mental health nurses and allied mental health professionals in private practice. Private mental health services also include inpatient and day-only services provided by private hospitals, for which private health insurance funds pay benefits, and some services provided in general hospital settings.

Public sector specialist mental health services: The range of specialist mental health services provided by government locally, regionally and state-wide. Services include child and adolescent mental health services, adult mental health services and aged persons’ mental health services and specialist state-wide services (e.g. forensic services).

Psychiatric disability support services: Services provided by the non-government sector including: physical health care, assertive outreach, advocacy services, peer support services, consumer-operated services, and programs addressing areas such as living skills, vocational training, accommodation support and respite care.

Quality assurance: Activities designed to evaluate, monitor and improve the quality of mental health services. Activities include monitoring of performance indicators, clinical audit including medical record audit, peer review, customer surveys, observational studies, quality reviews and quality improvement projects.

Recovery: A personal process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources.

Respite care: Services for carers enabling them to ‘take time out’ from the role of direct carer. Respite may occur in the home and outside the home. Services include centre-based respite, recreational respite, cottage-style residential respite and one-on-one respite.

Social inclusion: Contemporary concepts of disadvantage often refer to social exclusion. Social inclusion refers to policies which result in the reversal of circumstances or habits which lead to social exclusion. Indicators of social inclusion are that all Australians are able to secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and have their voices heard.

Social and emotional well-being: An holistic Aboriginal definition of health that includes: mental health; emotional, psychological and spiritual well-being; and issues impacting specifically on well-being in Aboriginal and Torres Strait Islander communities such as grief, suicide and self-harm, loss and trauma.

Supported accommodation: Decent, safe, and affordable community-based housing combined with non-clinical and clinical supports and services which enable people with mental health problems and mental illness to live independently in the community. This also applies to people who may need 24 hour clinical support in a residential (long-stay inpatient) setting rather than an institutional setting.

Whole-of-government, whole-of-community: Public service agencies working across portfolio boundaries and in partnership with, non-government organisations, private service agencies and individuals, and with the community at large to achieve a shared goal and an integrated response to particular mental health issues. Approaches can be formal and informal. They can focus on policy development, program management and service delivery.
References
(To be completed).