Second National Mental Health Plan

Australian Health Ministers

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July 1998

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Terminology

For simplicity, the term *people with mental illness* is used throughout this document. In this context, *mental illness* refers to the full range of clinical diagnoses and is defined in the Glossary of Terms. As this second Plan also addresses prevention and early intervention, the term *mental health problem* is employed when referring to signs and symptoms, which do not meet the criteria for a diagnosis to be made. Where appropriate, the term *emotional and social well-being* is used to describe the holistic concept of mental health recognised by Indigenous people.

Foreword

This *Second National Mental Health Plan* is a joint statement by the health ministers of the Commonwealth, State and Territory governments of Australia. It is intended to provide a clear national framework for future activity in mental health reform. It extends the work undertaken through the first *National Mental Health Plan 1992* and operates within the agreed national vision articulated in the *National Mental Health Policy 1992.*

This second Plan builds on the achievements to-date and identifies additional areas for national activity. The views and recommendations of those with mental illness, their carers, mental health service providers and professional bodies were sought through consultation processes, and represent a major contribution to the identification of priority areas of activity. In developing this Plan, consideration was given to identifying issues and specific consumer needs which should be accorded greater attention than was achieved under the first Plan, and identifying gaps and duplication in the current mental health service delivery system.

The agreed national policy framework outlined in the *National Mental Health Policy* will be retained. It is important to emphasise that while attention must continue to be paid to the needs of people with the most serious and disabling mental illnesses, the needs of people with other mental illnesses, many of whom are not gaining access to appropriate services, must also be addressed. This Plan outlines better ways of responding to the mental health needs of Indigenous people, people from culturally diverse backgrounds and people living in country Australia, as well as identifying strategies targeted at specific populations.

Recent research has shown that the health burden of mental illness on Australian society is growing. In recognition of the impact that mental illness has on individuals, their families and the community, this Plan focuses on ways of promoting mental health, reducing the incidence of mental illnesses and addressing associated disability. To encourage the provision of a mix of health and welfare, employment and income support services, this Plan places major emphasis on the need to forge linkages and partnerships in collaboration with stakeholders and agencies providing health and community support. Consolidating and expanding on work undertaken in service reform will improve the quality, range and accessibility of services and enhance outcomes for individual consumers. Underpinning these themes is the need to collate and distribute information arising from National Mental Health Strategy activities so that good practice models of service delivery can be embraced and implemented.

Australian health ministers endorse this *Second National Mental Health Plan* as a commitment to the renewal of the National Mental Health Strategy. It will guide government activity in mental health service delivery and policy development within the national framework set out in the *National Mental Health Policy.* Implementation of this Plan by governments will contribute significantly to improved treatment, care and quality of life for Australians with mental illness, their families and the community in general.

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A Introduction

The **National Mental Health Strategy** was agreed by all health ministers in 1992, providing for the first time in Australia a national agenda for mental health reform. A number of documents comprised the National Mental Health Strategy. These are:

- the *Mental Health Statement of Rights and Responsibilities* 1991;
- the *National Mental Health Policy* 1992;
- the *National Mental Health Plan* 1992; and
- *Schedule F1 of the Commonwealth/State Medicare Agreements* 1993-98.

Since 1992, **substantial changes** have occurred in the delivery arrangements for mental health services across Australia. However, people with mental illness remain significantly disadvantaged through stigma, discrimination and lack of appropriate services. Variations in service type, quality and coverage continue to exist across States and Territories, between urban and rural areas, and in responsiveness to the needs of various client groups. Improving access to mental health services invariably results in increased demand on scarce resources and challenges fragile relationships within the network of service providers. Better targeting of resources and the strengthening of partnerships across service sectors therefore requires particular attention.

There is substantial evidence that the **burden of mental illness** on Australian society is growing. The *National Survey of Mental Health and Well-Being* 1997, conducted by the Australian Bureau of Statistics found that almost one in five Australians aged 18 years or more met criteria for a mental disorder at some time during the 12 months prior to the survey, but that only 38% of people with a mental disorder had used health services. This suggests a large unmet need for mental health services.

Through a **national approach,** health ministers have set the context for unprecedented cooperation to improve policy and service responses for consumers, through sharing of information, trialing innovative service initiatives and developing nationally consistent approaches. However, there is still a long way to go.

Ministers have therefore endorsed the reform agenda established under the *National Mental Health Policy* being further developed and have given a commitment to a national approach through this *Second National Mental Health Plan*.

Building on achievements and expanding into additional areas of reform

The **impetus for reform** generated by the existence of the National Mental Health Strategy should not be underestimated. The Strategy has provided a framework and direction that has maintained an agreed focus across Commonwealth, State and Territory jurisdictions. It has motivated the mental health sector to link with health and community service delivery systems to reduce the isolation of mental health from the mainstream health and welfare sectors.

The Strategy has also provided a basis for **improving consumer and carer participation** in decision making, advocacy and outcome measurement. An independent survey of consumers, carers, mental health professionals and general practitioners was conducted as part of the evaluation of the National Mental Health Strategy. Respondents believed that there had been substantial improvement during the life of the Strategy in consumer capacity to influence the services they receive. This continues to be a high priority area to be maintained and strengthened.

Given the size of the reform task, it has not been possible to achieve all the outcomes desired within the first five years of the Strategy. Gains have not been uniform across jurisdictions and the policy development and reform experience has been uneven.

However, as identified in the *National Mental Health Report 1996*, a considerable amount has been achieved within the existing policy and implementation framework. **Key achievements** are:

(1) Structural reform of mental health services

Changes in public sector mental health service mix have moved in the direction set by the National Mental Health Strategy and have resulted in:

- reduced reliance on stand alone psychiatric hospitals;
- expanded delivery of community based care integrated with inpatient care; and
- mainstreamed mental health services with other components of health care.

The *National Mental Health Report 1996* shows that compared with the baseline year (1992-93) by 1995-96:

- Spending on community mental health had grown by 55% and community based services had expanded their share of the total State/Territory expenditure to 42%;
- The number of psychiatric beds located in general hospitals increased by 17% with the proportion of acute psychiatric beds located in general hospitals now being 64%;
- The number of beds in stand alone psychiatric hospitals decreased by 31% and the proportion of the total national mental health budget directed to these hospitals fell from 51% to 35%; and
- The resources previously invested in psychiatric hospitals have been transferred to community-based services and general hospitals.

(2) Improved consumer and carer participation in decision making and advocacy

- improved participation of consumers and carers in decision making at the national and State/Territory level;
- established the National Community Advisory Group on Mental Health and State/Territory Consumer Advisory Groups to advise on the implementation of the National Mental Health Strategy; this produced a unique partnership between consumers and carers;
- developed tools and training programs for consumers and carers to enhance their skills in consultation forums, advocacy and media performance; and
- improved consumer and carer involvement in the development of education and training curricula, especially for health professionals.

(3) Collection and analysis of mental health information, development of data systems, accountability and monitoring mechanisms

- improved information and data systems at the national level;
- conducted an analysis of the prevalence of mental illness, the disability associated with it and service utilisation of those affected;
- published a series of annual *National Mental Health Reports*;
- developed performance indicators and targets; and
- examined the feasibility of individual consumer outcome measures.

(4) Improved service quality

- developed and field tested national service standards;
- examined the optimum use of the specialist medical workforce in psychiatry;
- commenced education and training initiatives for mental health professionals; and
- examined ways of improving the attitudes of health professionals.

(5) Improved linkages between sectors, governments and external stakeholders

- improved links with stakeholders, particularly consumers, carers and non-government service providers;
- worked towards improved links with the housing and disability sectors;
- developed model legislation to assist in achieving consistency in State/Territory legislative reform and a Rights Analysis Instrument to assess the extent to which Australian mental health legislation is meeting international obligations; and
- contributed to the development of the *Aboriginal and Torres Strait Islander Emotional and Social Well-Being (Mental Health) Action Plan*.

(6) Improved understanding of mental illness, its prevention and mental health promotion

- improved community awareness about mental illness and advocated positive community attitudes to mental illness and people affected by it;
- developed mental health promotion and primary prevention frameworks in partnership with public health approaches; and
- collaborated with the National Youth Suicide Prevention Strategy on initiatives that address the mental health of young people.

(7) Identification, development and trialing of innovative service and funding models

- initiated the development of funding models across the full pathway of care, from inpatient to community care;
- developed innovative and enhanced service models for Indigenous people, those from culturally and linguistically diverse backgrounds and people living in rural and remote communities; and
- developed guidelines for best practice in early intervention for children and young people.

Many of these initiatives are well underway and at critical points in development or implementation. State and Territory governments are at different stages in the reform process and vary in their ability to incorporate new directions into current practices. It is vital to maintain the momentum for reform, to build on these achievements, and expand into additional areas of reform outlined in this Plan.

B Scope of the Second National Mental Health Plan

The policy framework

This *Second National Mental Health Plan* has been developed within the existing policy framework specified in the *National Mental Health Policy.* The objectives are:

- to promote the mental health of the Australian community;
- to, where possible, prevent the development of mental disorder;
- to reduce the impact of mental disorder on individuals, families and the community; and
- to assure the rights of people with mental disorder.

These policy objectives provide a sufficiently broad scope to enable **consolidation of existing reform activity and an expansion into additional areas of reform**. While the policy framework remains relevant, the needs of a number of client groups have been identified for particular attention in light of international research and national reform initiatives within the health and community services sectors.

An expanded focus

In renewing the National Mental Health Strategy, it is considered that the *National Mental Health Policy* and the *Mental Health Statement of Rights and Responsibilities* should be retained to provide an on-going policy framework.

The first *National Mental Health Plan* provided an agreed five-year implementation strategy, which ceased in June 1998. *Schedule F1 of the Medicare Agreements 1993-98* outlined bilateral agreements between the Commonwealth and each State and Territory government on funding targets and performance measures, accountability and reporting mechanisms. The provision of recurrent funding to State and Territory governments by the Commonwealth through Schedule F1 of the Medicare Agreements has significantly contributed to the successful outcomes of the National Mental Health Strategy.

Commonwealth funding to State and Territory governments such as that provided under *Schedule F1 of the Medicare Agreements 1993-98*, is being considered through the broader renegotiation of the Australian Health Care Agreements (formerly Medicare Agreements).

Thus the renewed National Mental Health Strategy will comprise the:

- *Mental Health Statement of Rights and Responsibilities* 1991;
- *National Mental Health Policy* 1992; and
- *Second National Mental Health Plan 1998*.

The second Plan **is relevant for the whole system of mental health service delivery**, both public and private, and includes policy and service delivery provided by the Commonwealth and State/Territory departments responsible for health.

The Plan also recognises that people with mental illness access support systems and services administered by other government agencies. While the ambit of the second Plan does not directly include matters more properly covered by existing Commonwealth/State agreements (eg disability and housing agreements) or programs delivered by other agencies (eg income support, employment services), it seeks to influence the policy framework and delivery of those services and support systems in a manner consistent with the objectives of the *National Mental Health Policy* through emphasising the importance of improved links across agencies and tiers of government. This Plan also recognises **the importance of fostering partnerships** in collaboration with mental health clinicians and the broader health and community sector, in particular with general practitioners.

This second Plan provides a five-year framework (1998-2003) for activity at the national and State/Territory levels. It has a focus consistent with the need to consider mental health reform within the broader health reform context and in light of recent research findings. It builds on achievements to date and identifies **further priority areas for reform** within three key themes:

- **promotion/prevention;**
- **the development of partnerships in service reform; and**
- **the quality and effectiveness of service delivery.**

Certain activities will be progressed under more than one theme. For example, aspects of mental health promotion activity and the identification of priority groups for particular attention are relevant to all three themes.

In addition, this Plan does not seek to specify projects to be funded within these themes but rather to identify priority areas of work within an agreed policy framework. It clarifies Commonwealth and State/Territory government roles and responsibilities as a basis for a national approach to mental health reform and provides an agreed nationally consistent framework for future activity at all levels of government.

C Roles and responsibilities

This Plan provides a framework for a **coordinated national approach** to mental health service and policy reform within which all jurisdictions will work. It recognises existing state based reform frameworks and broader national health and welfare reform agendas and seeks to influence those agendas in a manner consistent with National Mental Health Strategy policy objectives. Primarily, it seeks to do this through the development of intersectoral and intrasectoral links and through partnerships in collaboration with consumers and carers and with providers of services. In addition, it aims to identify key areas of national activity to which all jurisdictions will contribute and does so within the three broad themes: promotion and prevention; partnerships in service reform and delivery; and quality and effectiveness.

A total of $1.997 billion was spent on specialised mental health services across Australia in 1995-96. Of this amount, 58% ($1.158 billion) was spent by State and Territory governments. The Commonwealth Government spent 33% ($661 million) through the Medicare Benefits Schedule, the Pharmaceutical Benefits Scheme, payments to veterans and National Mental Health Strategy national projects, with the remaining 9% ($178 million) directed to psychiatric patients in private hospitals.

In the 1997-98 budget, the Commonwealth Government committed $28 million for three years (commencing in July 1998) for the renewed National Mental Health Strategy.

The Commonwealth is now making available a total of $300 million (indexed) for mental health service activity throughout the five years of the *Second National Mental Health Plan*. Of this, $250 million will be broadly allocated on a per capita basis to States and Territories for continued service reform.

Fifty million dollars (indexed) will also be made available over the five years for targeted reform in the following areas:

- developing service delivery arrangements to enhance coordination and integration of public and private sector mental health services;
- introducing routine consumer outcome measurement in mental health services;
- further developing and implementing a national mental health Casemix classification system;
- developing and implementing national service quality indicators for mental health services; and
- further development and implementation of clinical information systems.

This second Plan represents a commitment by the Commonwealth Government to facilitate reform in areas of national significance.

This Plan is a commitment by State and Territory governments to apply mental health funding provided at the State/Territory level and by the Commonwealth through the Australian Health Care Agreements, in a manner consistent with the objectives of the renewed National Mental Health Strategy.

State and Territory Governments

In reaffirming a commitment to a national policy and implementation framework, **State and Territory governments undertake to**:

- organise and fund specialised public mental health services;

- plan for a comprehensive mix of mental health services, including the establishment of service delivery systems which ensure effective service networks and coordination of care are fostered, especially between the public, private and non-government sectors;

- manage the redirection of resources within mental health services to reflect national policies and responsiveness to local need and circumstances;

- establish mechanisms to facilitate consumer and carer input into decision making at all levels;

- ensure linkages at the State/Territory, area/regional and service delivery levels of mental health services and other general health and community care services;

- provide comprehensive data on mental health service delivery and reform activities for publication in annual National Mental Health Reports; and

- support mental health research and evaluation.

Commonwealth Government

In reaffirming a commitment to a national policy and implementation strategy framework, **the Commonwealth Government undertakes to**:

- finance and administer programs, consistent with revised Commonwealth and State/Territory funding arrangements, where the nature of the service entitlement or program does not vary between States/Territories, and is more efficient for administration to be national (ie, Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and Social Security payments);

- ensure people with mental illness and their carers are not discriminated against in gaining access to general health, community support, accommodation, employment, training and other programs which are the responsibility of the Commonwealth Government;

- foster linkages with relevant national reform agendas and partnerships with national stakeholders;

- establish mechanisms to facilitate consumer and carer input into decision making at all levels;

- fund, and foster the development of, mental health research and service evaluation;
- in consultation with the States and Territories, seek to ensure an adequate supply of high quality mental health personnel through targeted education and training development; and
- act as a clearing house for information relating to significant developments in, and dissemination of, good practice models of mental health service delivery.

As specified in the first Plan, and to ensure that ongoing priority is accorded to mental health issues, **a working group will be established which will oversee implementation of the renewed National Mental Health Strategy.** In particular, it will:

- provide a forum to promote the renewed National Mental Health Strategy and monitor the implementation of the *Second National Mental Health Plan* within the *National Mental Health Policy* framework;
- consider, and recommend on, emerging mental health issues and report to health ministers as appropriate;
- provide State and Territory, consumer and carer perspectives on priorities and approaches for national projects funded by the Commonwealth under the renewed National Mental Health Strategy;
- establish time-limited working parties to address specific issues; and
- consult regularly with national stakeholders and other relevant organisations, agencies and individuals as appropriate.

The Working Group will comprise representatives from the Commonwealth and each State and Territory government and will include consumer and carer representation. It will meet at least twice a year and will report annually on its activities. The Commonwealth will provide secretariat support to the Working Group.

This *Second National Mental Health Plan* commences on 1 July 1998 and will terminate in respect of all parties on 30 June 2003. Progress in achieving objectives will be subject to ongoing monitoring by the Commonwealth, State and Territory governments and publicly reported annually through an agreed mechanism. A formal evaluation will be completed by 31 December 2002.

D. Priorities for Future Activity

Commonwealth, State and Territory governments have endorsed the three key themes that form the basis of this Plan. These themes (promotion/prevention, partnerships in service reform and quality and effectiveness) received overwhelming support through all aspects of the consultation process and it is considered that identified priority activities can be conducted within this framework. In addition, a number of client groups have been identified as priorities for future activity recognising that it is also critical to provide programs across the lifespan from infancy to old age.

The client focus

One of the key principles of the *National Mental Health Policy* was that priority should be given to people with severe mental health problems and mental disorders. This promoted a strong focus on structural reform of services for this target group. While significant reform has been achieved, particularly at the State and Territory level, it has been acknowledged that improvement in services has been variable across jurisdictions. It is important to reaffirm the broad thrust of the original policy that priority must continue to be accorded to services and support for people with the most serious needs.

There was no attempt to define this target group in the *National Mental Health Policy* or first Plan resulting in variable local interpretations of the *Policy's* intent. An unforeseen consequence of this has been that some public mental health services have excluded people seen as having less serious conditions and have erroneously equated severity with diagnosis rather than level of need and disability. The *National Survey of Mental Health and Well-Being* estimates that over half of all people with mental illness do not receive services and treatment from the health system. It is therefore important to acknowledge the problems created by an overly narrow interpretation of the original policy which can result in consumers not gaining access to services early in their illness or its recurrence. This Plan will focus on definitional issues at a national level to encourage national consistency in policy interpretation across all jurisdictions.

This Plan seeks to identify the range of services directly or indirectly funded by government which can be further mobilised **to improve treatment and care for a broader range of people with high level needs** while continuing service reform for existing client groups.

Better ways of meeting the mental health needs of Indigenous people, people from culturally and linguistically diverse backgrounds and those living in rural and remote areas will require special attention. Despite the priority accorded to these groups in the first Plan, there is still a lack of appropriate responses at the service level.

There is a range of target groups for whom improved service access and better service responses are essential. These include: children and adolescents, older people, people with mental illness and intellectual disability or problems with drug and alcohol misuse, forensic populations and people with severe personality disorders.

A focus on depression

The World Health Organisation and the World Bank have identified that the burden of mental illness, while responsible for little more than 1 per cent of all deaths, accounts for almost 11 per cent of disease burden world wide. It is estimated that this will rise to 15 per cent by 2020. Among all mental illness, depression is expected to contribute the greatest disease burden in the developing world and to rank second world wide by 2020.

The National Health Priority Areas initiative, which is a collaborative effort between Commonwealth, State and Territory governments, has targeted depression as a primary focus, directed to achieving gains across the continuum of this disorder. Mental health activity under the National Public Health Partnerships will also include a focus on depression.

Promotion and Prevention

Mental health promotion and illness prevention is one of the three priority areas identified for the *Second National Mental Health Plan*. This theme broadly includes mental health promotion, community education, prevention of mental illnesses, and early intervention. In the interests of clarity, the prevention of mental illnesses will be distinguished from community education and promotion activities to reflect differences in aims, objectives and methodologies.

Mental health promotion is action to maximise mental health and well-being among both populations and individuals. With respect to population based mental health promotion, there is strong support for this to be further integrated with broader public health promotion activity, while incorporating mental health expertise. This would ensure access to public health expertise and avoid the risk of population based promotion activity being marginalised. Joint planning through the National Public Health Partnerships will support this approach. Promotion of mental health in individuals accessing mental health services is part of the core business of these services.

Within the public health framework, promotion activity will focus on settings (such as family, schools, and workplaces) and on life stages. Strategies will aim at building resilience and enhancing coping mechanisms for dealing with stresses across the life span, especially at points of transition. This would include projects in educational settings such as healthy schools, anti-bully and protective behaviours campaigns, and life stage programs aimed at improving parenting skills, promoting healthy workplaces, preparing for retirement, and healthy ageing. Because of the association between the terms *mental health* and *mental illness*, the term *promotion of emotional and social well-being* may be preferred to the term *mental health promotion.*

Under the first *National Mental Health Plan* , **community education** focused largely on increasing public awareness of the extent of mental illness and promoting destigmatisation. Priorities identified for this second Plan include changing the often stigmatising attitudes to people with mental illness held by clinicians, including mental health professionals and increasing mental health literacy in key settings and amongst key groups in the community. Mental health literacy here refers to knowledge of early warning signs, how to respond and where to turn for professional help.

Examples of **key settings** for mental health promotion and community education are:

- family
- schools and other educational institutions
- primary health care facilities including mother and baby health centres
- disability support services provided by non-government agencies
- community support services
- employment and income support agencies
- public housing and private supported residential services
- workplaces
- courts.

Key groups of workers to be targeted for mental health promotion and community education include:

- teachers and school counsellors
- general practitioners and community nurses
- workers in government and non-government service agencies
- staff of emergency services including police, ambulance and emergency departments of general hospitals.

It is considered that the best framework to guide **illness prevention** is a modified form of the threefold typology of universal, selective and indicated preventive measures, which is compatible with a public health framework. This is believed to be more valuable than the categories of primary, secondary and tertiary prevention, although there are strong conceptual parallels.

Universal preventive measures refer to strategies targeting the whole population or population groups, whereas **selective preventive measures** are those aimed at groups or individuals identified as being asymptomatic but at risk of developing mental illness. **Indicated preventive measures** are those targeted at people with early symptoms and defined as high risk in terms of developing more severe illnesses.

For mental illness, it is often difficult to clearly differentiate between prevention and treatment. Early intervention in first onset and relapsing mental illness can avert recurrence or at least markedly reduce the impact on the person and their immediate family. There is value in encouraging a preventive culture in specialist mental health services, using this framework.

While preventive approaches in the mental health field have been slow to develop, comprehensive reviews point to the efficacy of preventive approaches aimed at reducing risk factors for mental illnesses and providing scope for action, especially amongst children and adolescents. Further basic research on the causes of particular illnesses will continue to be necessary for identifying cost-effective preventive measures. Preventive projects aimed at reducing suicidal behaviour amongst young people and older males have been supported and are underway in some jurisdictions.

Useful strategies for the prevention of mental illness include those targeting high-risk groups, using selective and indicated preventive measures. Through the consultation process, particular groups have been identified as being at risk and requiring specifically targeted preventive action. Additional groups may also emerge from international, national and state projects already underway in relation to the community prevalence of mental illnesses and associated disability.

Focusing first on selective prevention, groups identified as warranting attention are the children of parents with mental illness, children subject to abuse and neglect and adult survivors of childhood sexual, emotional or physical abuse. Aboriginal and Torres Strait Islander people, particularly those removed as children from their families, are a core group whose vulnerability has been identified in the Human Rights and Equal Opportunity Commission report into the separation of Aboriginal and Torres Strait Islander children from their families entitled *Bringing Them Home*. Responses for these groups that lessen the risk of developing mental illnesses, especially depression, need further development, refinement and evaluation.

Indicated preventive measures have particular relevance for the early detection of depressive disorders. Early detection is designed to identify those at risk of developing more severe disorders with the aim of taking appropriate action to lessen this risk. Groups relevant to this approach would include women (for example, during adolescence and following childbirth), young men (particularly in rural and remote areas) and older men (especially following retirement or after the loss of a life partner).

One focus of **early intervention** has been on first onset of psychosis in young people. This should be broadened to include first onset of other mental illness. A wider range of age groups will need to be encompassed to acknowledge differential patterns across gender and illnesses. In relation to relapsing illnesses, consumers and carers continue to express concern about inadequate responses from clinicians to the early signs of recurring illness. Consumers, families and other carers strongly support the development of early intervention strategies to avoid or reduce the impact of a repeat episode of illness.

Outcomes

- Improved range, quality and effectiveness of public health strategies which promote mental health among the Australian population.

- The Australian population is more informed about mental health issues, of strategies to maintain their own mental health and to support people with mental illness.

- Reduced incidence and prevalence of mental illnesses and associated disability.

- Reduced number of suicides.

- Reduction in the incidence and prevalence of depression and associated disability.

- Reduction in inappropriate readmissions to inpatient services and a re-engagement with community based services.

- Consumers and carers more informed about signs of a first episode or a relapse of illness and how to respond.

- Increased consumer and carer satisfaction with clinicians' response to early warning signs.

Strategies

National strategies will be developed to progress prevention and promotion activity, especially through the National Public Health Partnerships. In developing national promotion and prevention strategies, an emphasis on identifying intervention points which maximise the potential for positive consumer outcomes is essential. Promotion and prevention initiatives being progressed through the National Mental Health Strategy will be evaluated to inform the development of future initiatives. Strategies include:

- Development of a national mental health promotion and prevention work program through the National Public Health Partnerships.
- Completion and evaluation of programs to reduce suicidal behaviour amongst groups with high rates of attempted and completed suicide, including those identified in the National Youth Suicide Prevention Strategy.
- Development and evaluation of risk-reduction programs for groups identified as vulnerable to the development of mental illnesses.
- Development and evaluation of programs with demonstrated efficacy in the prevention of mental health problems in infancy, childhood and adolescence, including programs targeting children vulnerable through parenting difficulties, family discord, family disruption, loss, trauma, maltreatment and abuse.
- Development of research programs that contribute to the compilation of an evidence base for population health approaches to mental illness prevention.
- Further development and evaluation of early detection programs, especially in relation to depression.
- Further development and evaluation of early intervention programs focusing on both first onset and relapsing mental illnesses.
- Continuation of successful community and setting specific education initiatives which aim to improve community understanding of mental illness and address the stigma and discrimination experienced by people with mental illness.
- In consultation with consumers and carers, further development and evaluation of education, training and professional development for all providers of services to people with mental illness.
- Compilation, production and dissemination of mental health literacy resources targeting key settings and occupational groups.
- Use of online technologies, such as the Internet, to disseminate information about initiatives already completed or underway.

Partnerships in Service Reform and Delivery

The main challenge in service reform and delivery is to achieve an appropriate and coordinated system of care that meets the needs of individual consumers across the life span. To achieve this, **consumers should have a key role** in planning and evaluating the services they use and must be able to influence the way in which their service needs are met.

Specialised mental health services can only meet **some** of the needs of people with mental illness. Consumers have the same needs as other people for general health care, stable housing, home support, recreation, employment, education and friendship. When their illness results in disability they require non discriminatory access to disability support services.

There is a need to **formally entrench partnership arrangements** at both the system and service levels through policies, procedures, protocols and funding. Any such arrangements must identify relative responsibilities and resolve issues that may impede effective interventions.

Key strategic alliances will vary according to individual consumer need and preference. However, important partnerships will include:

- **Consumers, families and carers** who are key stakeholders and must be in a position to influence decisions on all aspects of mental health services and be adequately resourced and assisted to do so. Although significant progress has been made in this area, it has not extended to consumers of all ages and across the spectrum of mental health services.

- **General practitioners** who are major service providers for people with mental illness and who assume even greater responsibility in areas of geographic isolation or cultural sensitivity. Productive partnerships are dependent on identifying and addressing funding issues, sharing consumer information, and education and training.

- **Private psychiatrists and the private mental health sector** who provide treatment and support for a range of people with mental illness and are often unable to access disability and related support services or public mental health services for their clients.

- **Emergency services**, including police, ambulance officers and staff of emergency departments in general hospitals, who are often the first point of contact for people with mental illness at times of crisis or acute need.

- **The wider health sector** which through the mainstreaming of mental health services has taken on responsibility for the management and provision of mental health services in all States and Territories. Partnerships in collaboration with maternal and child health, geriatric and paediatric services, public health and health promotion agencies must be pursued by mental health services.

- **Other government services** including the criminal and juvenile justice systems, the welfare sector and drug/alcohol services, many of which are particularly relevant to people with mental illness.

- **Non-government agencies** both generic and specialist, which provide disability support and other services to people with psychiatric disabilities, their families and other carers, including day and residential psychosocial rehabilitation programs, supported housing, and respite care.

- **Community support services** including housing, home help, recreation, family support, employment and education which are essential elements in improving the quality of life of people with mental illness and psychiatric disability. These services are funded and provided by a wide range of government and non government organisations and require information, training, support networks and clear linkages with mental health services.

- **The broader community** including employers, service organisations and community leaders who, with increased understanding of mental health issues, can help reduce stigma, encourage timely referral of people in need and provide support to people within their setting.

In States and Territories, partnerships must be established at both a policy and program level and at a local service level by building on established regional networks. In recognition of this, most State and Territory governments have increased funding for the non government sector to increase choice and introduce new perspectives in service provision.

At the Commonwealth level, **improved strategic alliances** can be achieved through linkages with other reform agendas including general practitioner reform initiatives, private health insurance initiatives, National Public Health Partnerships, National Health Priority Areas and Commonwealth/State agreements relating to housing and disability services. There is also an opportunity to advance the second Plan through partnerships in collaboration with national stakeholder groups such as consumer and carer groups, professional associations and non-government organisations.

The report of the National Consultancy on Aboriginal and Torres Strait Islander Mental Health entitled *Ways Forward* documents the policy framework for Indigenous mental health. An essential principle in achieving progress for Indigenous people is to ensure that they play a central role in determining acceptable partnerships for service reform. At the national level, an Action Plan has been developed and there is now a need for each State and Territory to develop a mental health policy and strategic plan which identifies priorities for action at a local level.

Framework Agreements between Commonwealth and State/Territory ministers, the Aboriginal and Torres Strait Islander Commission and Indigenous health councils are now in place in most States and Territories. These Agreements provide the implementation framework for service coordination and development.
Priority partnerships for Indigenous mental health services are likely to include:

- general health and primary care services
- Indigenous networks and organisations
- rural and remote health services
- adult and juvenile justice systems
- drug and alcohol services.

In rural and remote areas, where specialised mental health services are scarce or non existent, services cannot be delivered without strong networking with general practitioners, community health services, the Royal Flying Doctor Service, and Indigenous health workers. Innovative strategies, such as consultation through telepsychiatry need further development.

While it is recognised that access to a broad range of services enables people to live as independently as possible, it is evident that **discrimination still exists** and that consumers and their families are not receiving equitable access to the range of support which they need.

Particular difficulties exist in relation to accessing **disability support services** for people with a psychiatric disability. This is an area where people with mental illness are significantly disadvantaged and where further efforts must be directed in order to ensure that policy decisions translate into actual resources at the service level. Other areas of ongoing concern include housing, income support, employment and domiciliary care.

Funding systems are undergoing change and mechanisms must ensure that there are no financial disincentives to general practitioners, consultation/liaison services and other health professionals participating fully in the mental health care system.

Better linkages at all levels will improve service responses for consumers. Clarifying the roles and responsibilities of service providers, removing barriers to funding and eligibility, developing referral strategies and agreeing accountability and reporting mechanisms will enhance linkages. This collaborative approach is essential to achieving a coordinated system of care.

Outcomes

- Improved consumer and carer satisfaction with their participation in all areas of mental health service delivery ranging from their relationship with individual service providers to their involvement in the planning, delivery and evaluation of services.

- Increased participation of a wide range of health, welfare and disability professionals and organisations in the provision of services to people with mental illness.

- Increased access to and participation by mental health consumers in disability support programs.

- Improved coordination of care between all services providing support for people with mental illness.

- Increased knowledge and understanding of mental health and mental illness and an awareness of the specific needs of people with mental illness among management and staff of health and human service agencies.

- Improved attitudes of health and human service managers, staff and clinicians to people with mental illness.

- Improved coordination of services provided to consumers and carers.

- Increased community interest and involvement in mental health issues.

Strategies

- Continuation of initiatives, which measure consumer and carer satisfaction with, services, taking account of age, gender and cultural issues.

- Further development of training programs, in consultation with consumers and carers, focusing on the attitudes of mental health service managers, staff and clinicians.

- Further development of structures and processes for the inclusion of consumers and carers in mental health decision making at all levels.

- Further development and evaluation of training courses, appropriately targeted to general practitioners, health and disability agencies and the non government sector, in consultation with consumers and carers.

- Further development of formal agreements and protocols between key stakeholders which clarify roles and responsibilities regarding services provided to consumers.

- Continued integration of community and inpatient services to provide continuity of care for consumers.

- Further development of strategic partnerships in programs which address the additional needs of particular client groups.

- Continued initiatives on behalf of people with psychiatric disability to ensure appropriate implementation of the Commonwealth/State Disability Agreement.

- Development and evaluation of strategic plans for Indigenous mental health at the State and Territory level which are consistent with the objectives of the *Aboriginal and Torres Strait Islander Emotional and Social Well-Being (Mental Health) Action Plan* being implemented at the national level.

- Further development and evaluation of funding models for mental health services.

- Development and evaluation of work based programs providing information on early intervention and appropriate referral mechanisms.

Quality and Effectiveness

The third key theme in the *Second National Mental Health Plan* focuses on the quality and effectiveness of mental health services with a particular emphasis on improved consumer outcomes across the life span. While the impetus for structural reform of the service delivery system must be maintained, attention must be paid to the impact of this system on outcomes for consumers and carers.

Quality and effectiveness are obviously closely linked. Identification and agreement on **standards** is a critical first step. Standards act as a yardstick for monitoring and evaluating the quality and effectiveness of services and clinical practice. Standards cover two areas - service delivery and clinical practice.

Development of the **national standards for mental health services** to pilot stage was an important achievement of the first *National Mental Health Plan*. Following field testing and refinement, these standards will provide a basis for the accreditation of services. In addition they will be reviewed and updated over time to ensure currency.

The preparation and dissemination of **clinical standards** will also enhance mental health practice. This includes guidelines for best practice in relation to particular mental illnesses and clinical cohorts, such as the clinical practice guidelines for young people with depression issued by the National Health and Medical Research Council.

Establishing **benchmarks** and identifying **models of best practice** are also important for continuous quality improvement and the encouragement of service excellence. Benchmarking the best service mix for consumers and carers should include the availability of community-based care as an alternative to hospital admission, access to both acute and extended care beds and respite care options.

It has become evident that impetus must be given to better ways of meeting the mental health needs of Indigenous people, people from culturally and linguistically diverse backgrounds and people living in rural and remote areas. Additionally, the first *National Mental Health Plan* focused largely on reform of services for adults. The second Plan provides an important opportunity to extend this focus to other age groups.

Further development and evaluation of appropriate service models is also essential for groups of clients with additional needs. The most frequently cited examples are people with mental illness who are parents, people with mental illness and intellectual disability or with drug and alcohol misuse, forensic populations and people with severe personality disorders. Improved service access and more refined models of treatment and care are required for these groups.

Use of **evidence-based practice** is being encouraged in all health service delivery, including mental health service provision. This approach has raised concerns about its reliance on randomised controlled trials as benchmarks and ethical issues about withholding non-proven treatment from some clients. These criticisms are not insurmountable. They can lead to use of research and evaluation methodologies which are rigorous but better suited to particular service settings, and to the provision of incentives to encourage innovative clinical practice.

Another important way of improving quality and effectiveness is ensuring adequate dissemination of information and knowledge about research findings and examples of best practice. There is strong support for use of online technologies such as the Internet to improve dissemination.

Service reform initiated by the first *National Mental Health Plan* has been particularly challenging for staff. It has highlighted the importance of ensuring staff can acquire and maintain the skills to deliver services in new ways. The increased focus on community treatment and care requires upskilling for some mental health professionals as well as workers in the disability support sector and in generalist community services.

Education and training includes university courses at both undergraduate and postgraduate level, TAFE certificate and diploma courses, post-graduate university courses (which are often interdisciplinary), and in-service training. Strategies for extending and refining staff skills can also cover supervision on-the-job or from an external consultant, modelling of new practices, and staff rotation through different elements of a mental health service. There is strong support for consumer and carer input into the design and delivery of staff and worker training, and also the education of consumers and carers to allow them to participate effectively in mental health service reform.

It is critical that the curricula of pre-service courses include material on current best practice models and strategies, especially in relation to early intervention for first onset and relapsing mental illnesses. In addition, there are a number of clinical staff now working in community-based services whose training and experience has largely been undertaken in stand-alone psychiatric institutions.

Through in-service training and other processes, staff can be provided with the opportunity to develop and refine skills relevant to community mental health practice, such as making the links with necessary government, non government and private sector health, support and other social services consumers require and engaging with clients in a wide range of settings. Training should also be made available for both inpatient and community based staff in the prevention and management of aggression.

Paying attention to quality is designed to enhance effectiveness. The development and refinement of **measures of effectiveness** at the population, service and individual consumer levels is a key goal of the *Second National Mental Health Plan*. To achieve this, further development is required of measures which indicate the clinical benefits to consumers and their satisfaction with the services they receive. In addition, outcomes at the population level, such as reduced rates of suicide and prevalence of mental illness, must be monitored. The extent to which outcomes have been achieved will be considered in relation to the following:

- National policy goals in relation to service reform.
- Key performance indicators for services as detailed in service agreements.
- Satisfaction with service performance. Consumers and carers are the primary focus but with satisfaction ratings also being sought from service providers such as general practitioners.

- Consumer outcomes which reflect an increased emphasis on individualised service plans and on quality of life measures taking account of a range of non-clinical needs and consumer preferences.

- Population outcomes preferably using nationally agreed measures.

A national minimum data set based on consistent data definitions allows information on mental health service performance to be collated and reported annually as agreed between the Commonwealth, State and Territory governments. This would build on the existing reporting mechanisms of the *National Mental Health Reports*, a positive feature of the first Plan.

Outcomes

- Improved mental health and well-being of the Australian population.

- Improved emotional and social well-being of Indigenous populations.

- Better mental health outcomes for people from culturally and linguistically diverse backgrounds.

- Improved service access and better mental health outcomes for children and adolescents, young adults and older people with mental illness and people living in rural and remote areas.

- Improved responsiveness of services to the needs of consumers and carers across the life span.

- Improved service responses and individual clinical outcomes for consumers.

- Consumer and carer satisfaction with what and how services are provided.

- Improved service responses and individual clinical outcomes for client groups with additional needs.

Strategies

- Finalisation of the *National Standards for Mental Health Services* for use in accreditation of services for all age groups.

- Identification and introduction of service initiatives for improving Indigenous mental health.

- Further development of ways to meet the mental health needs of people from culturally and linguistically diverse backgrounds.

- Improved service models for people with mental illnesses living in rural and remote areas.
- Further development of services for children and adolescents, young adults and older people.
- Development and evaluation of models of best practice and service benchmarks for client groups with additional needs.
- Introduction of education and training initiatives to ensure an appropriately skilled workforce.
- Further refinement and introduction of population based outcome measures to assess the mental health and wellbeing of the Australian community.
- Further refinement and introduction of outcome measures to monitor service performance.
- Further development of individual clinical outcome measures including quality of life and measures to assess consumer and carer satisfaction with services.
- Evaluation of activity in order to identify better approaches for information dissemination across jurisdictions.
- Further development of nationally consistent definitions, including those identified as requiring attention in this Plan.
- Further development and establishment of clinical information systems across all jurisdictions.
- Use of online technologies such as the Internet to disseminate information about service developments, practice evaluations and outcome measurement.

E Conclusion

The *Second National Mental Health Plan* provides the framework to progress mental health reform through the five years to June 2003.

It does not provide detailed strategies. These must be developed by State and Territory governments to address local needs and by the Commonwealth to provide overarching directions. However, it does articulate an agenda for action which encourages a national, coordinated approach and allows more to be achieved through cooperation and collaboration.

It is worth restating that the aim of the National Mental Health Strategy is to improve the mental health and well-being of the Australian community, and to improve the treatment, care and quality of life for people with mental illness of all age groups. The next five years provide an important opportunity to build on current gains.

F Glossary of Terms and Definitions

Advocate
A person who has been given the power by a consumer to speak on her or his behalf, who represents the concerns and interests of the consumer as directed by the consumer, and provides training and support to enable consumers to better represent themselves.

Case Management
The mechanism of ensuring access to and coordination of the range of services necessary to meet the identified needs of a person within and outside the integrated mental health service. People with mental illness requiring case management are usually living in the community and have long term needs necessitating access to health and other relevant community services.

Carer
A person whose life is affected by virtue of a close relationship and a caring role with a consumer.

Clinical Indicator
A measure of clinical management and outcome of care; a method of monitoring care and services, which attempts to identify problem areas, evaluate trends and so direct attention to issues requiring further review.

Co-located Service
A mental health service which is operated from within or on the immediate site of a general health service, such as an acute inpatient psychiatric service operating within a general hospital.

Consumer
A person utilising, or who has utilised, a mental health service.

Continuity of care
Integration and linkage of components of individualised treatment and care across health service agencies according to individual needs.

Emotional and Social Well-being
The holistic concept of mental health recognised by Indigenous people.

Forensic Populations
People in contact with the adult criminal and juvenile justice systems who also experience mental illness.

Government
Includes all Australian State and Territory governments, the Commonwealth Government and local governments.

Indigenous
Includes people of Aboriginal and Torres Strait Islander descent and other native islander communities within Australia.

Integrated mental health services
A network of specialised mental health service components within the general health system coordinated across inpatient and community settings, to ensure continuity of care for consumers. These components can encompass assessment, crisis intervention, acute care, extended care, treatment, rehabilitation, specialised residential and housing support services, and domiciliary care services. The network can be coordinated through area/regional management and uses a case management system across service components.

Integration
The process whereby components of a mental health service, across inpatient and community settings, become coordinated as a single, specialist network and include mechanisms which link intake, assessment, crisis intervention, and acute, extended and on-going treatment using a case management approach to ensure continuity of care.

Intersectoral linkages
Collaboration between mental health services and other relevant Commonwealth, State/Territory and local government programs and the private and community sector to ensure the overall needs of people with mental illness are effectively addressed.

Intrasectoral linkages
Collaboration between mental health policy/program areas within a government department and other relevant policies/programs/services within that department.

Jurisdictions
Used within this document to describe the area for which the Commonwealth Government and each State and Territory government is responsible.

Mainstream health services
Services provided by health professionals in a wide range of agencies including general hospitals, general practice and community health centres. Mental health services will be delivered and managed as an integral part of mainstream health services so they can be accessed in the same way as other health services.

Mental health
The capacity of individuals and groups to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of cognitive, affective and relational abilities, and the achievement of individual and collective goals consistent with justice.

Mental health problem
A disruption in the interactions between the individual, the group and the environment, producing a diminished state of mental health.

Mental health services
Specialised health services which are specifically designed for the care and treatment of people with mental illness.

Mental illness
Used in this document to describe the full range of recognised, medically diagnosable illnesses that result in significant impairment of an individual's cognitive, affective or relational abilities. Using the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders - fourth edition* (DSM IV) terminology, it encompasses all disorders on Axis I & II of that classification system.

Multi-disciplinary clinical team
The identifiable group of mental health personnel comprising a mix of professionals responsible for the treatment and care of people with mental illness.

National Mental Health Strategy
Endorsed by Australian health ministers in 1992, the National Mental Health Strategy comprised the following documents:

- the *Mental Health Statement of Rights and Responsibilities 1991*;
- the *National Mental Health Policy 1992*;
- the *National Mental Health Plan 1992*; and
- *Schedule F1 of the Commonwealth/State Medicare Agreements 1993-98.*

The renewed National Mental Health Strategy will comprise:

- the *Mental Health Statement of Rights and Responsibilities 1991*;
- the *National Mental Health Policy 1992*; and
- this *Second National Mental Health Plan 1998.*

Outcome
A measurable change in the health of an individual, or group of people or population, which is attributable to an intervention or series of interventions.

Performance indicators
Measures of change in the health status of populations and in service delivery and clinical practice in order to improve outcomes for individual consumers.

Standards - Clinical and Service

Clinical practice standards are defined and agreed clinical procedures and practices for the optimal treatment and care of people with mental illness.

Service standards define what is required for a quality mental health service.

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