Fourth National Mental Health Plan

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

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Foreword

One in five Australians continue to experience a mental illness in a given year. Confirmation of this comes at a time when significant investment and effort has been made by all governments to improve outcomes for people with mental illness, their families and carers. There has been significant reform in where and how mental health services are delivered—especially in recent years through growth of services in the community and in primary care.

Australia's leadership in mental health service development has been recognised internationally. Reform into the future must maintain the effort and build on the successes of the past, but recognise that new challenges require innovation and new ways of working together across systems and sectors.

A new *National Mental Health Policy* (the Policy) was endorsed by health ministers in December 2008. The Policy provides an overarching vision and intent for the mental health system in Australia and embeds the whole of government approach to mental health reform that formed the centrepiece of the *COAG National Action Plan on Mental Health*.

The Policy gave a vision for mental health in Australia:

> … *a mental health system that enables recovery, that 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 *Fourth National Mental Health Plan* (the Fourth Plan) has been developed to further guide reform and identifies key actions that can make meaningful progress towards fulfilling the vision of the Policy. The whole of government approach articulated within the Fourth Plan acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system.

On behalf of the Australian Health Ministers' Conference I would like to extend our appreciation to the Ministerial Advisory Councils outside of Health who have contributed their time and expertise to developing a Health Plan that is truly built within the whole of government partnership approach. Further, I encourage these councils to take up this Fourth Plan and use it as a basis for further work in their areas of responsibility. With the commitment of other sectors to progress the actions, indicators and outcomes identified in the Fourth Plan, we can make a real difference for people with a mental illness, their families and carers. Health ministers are committed to working with our cross sectoral colleagues towards this outcome.

The Fourth Plan comes at a time where there is significant focus on the roles and responsibilities of governments within the health system. We acknowledge this and accordingly have adopted a flexible approach to enable the Fourth Plan to respond to a rapidly changing environment. This will be achieved by monitoring and responding to developments in the broader health system and whole of government reforms over the next five years.

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. Some of the actions will require commitments of time and effort rather than financial investment to navigate the shared issues within and across sectors.

Robust accountability for both mental health reform and service delivery is central to the Fourth Plan, and progress in implementation will be reported annually. The Fourth Plan explicitly outlines indicators against which to measure progress. For some of these indicators, data are already available; for others, collaboration with other sectors and further developmental work may be required to achieve a suite of cross sectoral indicators that will robustly measure how progress in implementation of the Fourth Plan has changed the lived experience of people with a mental illness.

Specific targets have not yet been set for any indicators, but this will be given priority during the first year of the Fourth Plan. Collaboration between governments will be needed to fill data gaps and develop appropriate targets for data collection and reporting.

Health ministers are pleased to lead the implementation of the Fourth Plan and to work in conjunction with the Ministerial Advisory Councils outside of Health to progress the actions, indicators and outcomes identified in the Fourth Plan. The actions in the Fourth Plan will be progressed by governments both independently and nationally under the Australian Health Ministers' Advisory Council, but with the commitment of other sectors we can make a real difference for people with a mental illness, their families and carers.

The Fourth Plan has been built from an extensive national process of consultation and the time, effort and advice of the many people who have contributed to this Fourth Plan is acknowledged and appreciated. I encourage all of you to embrace and take forward this Fourth Plan and its actions towards a better mental health system for all Australians.

Ms Katy Gallagher MLA
Chair
Australian Health Ministers' Conference

Summary of priority areas, outcomes and actions

Priority area 1. Social inclusion and recovery	
Outcome	*Actions*
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 have improved outcomes in relation to housing, employment, income and overall health and are valued and supported by their communities. Service delivery is organised to provide more coordinated care across health and social domains.	Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy. Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs. Improve coordination between primary care and specialist mental health services in the community to enhance consumer choice and facilitate 'wrap around' service provision. Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models. Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community. Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage. Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Straits Islander *Social and Emotional Well Being Framework*.

Priority area 2. Prevention and early intervention	
Outcome	*Actions*
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, physical health issues and suicidal behaviour. Generalist services have support and access to advice and specialist services when needed.	Work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience. Implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations. Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services. Implement evidence based and cost effective models of intervention for early psychosis in young people to provide broader national coverage. Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors. Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them. Expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents with a mental illness. Develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma.

Priority area 3. Service access, coordination and continuity of care	
Outcome	*Actions*
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.	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 of funders, service providers, consumers and carers and other relevant stakeholders to develop local solutions to better meet the mental health needs of communities. Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models. Work with emergency and community services to develop protocols to guide and support transitions between service sectors and jurisdictions. Improve linkages and coordination between mental health, alcohol and other drug and primary care services to facilitate earlier identification of, and improved referral and treatment for, mental and physical health problems. Develop and implement systems to ensure information about the pathways into and through care is highly visible, readily accessible and culturally relevant. Better target services and address service gaps through cooperative and innovative service models for the delivery of primary mental health care.

Priority area 4. Quality improvement and innovation	
Outcome	*Actions*
The community has access to information on service delivery and outcomes on a regional basis. This includes reporting against agreed standards of care including consumer and carer experiences and perceptions. Mental health legislation meets agreed principles and, in conjunction with any related legislation, 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.	Review the *Mental Health Statement of Rights and Responsibilities*. Review and where necessary amend mental health and related 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 defines standardised workforce competencies and roles in clinical, community and peer support areas. Increase consumer and carer employment in clinical and community support 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. Expand and better utilise innovative approaches to service delivery including telephone and e-mental health services.

Priority area 5. Accountability—measuring and reporting progress	
Outcome	**Actions**
The public is able to make informed judgements about the extent of mental health reform in Australia, including the progress of the Fourth 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.	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*.

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* (the Fourth Plan) sets an agenda for collaborative government action in mental health for the next five years. It offers a framework to develop a system of care that is able to intervene early and provide integrated services across health and social domains. It provides guidance to governments in considering future funding priorities for mental health.

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 Fourth Plan recognises effective linkages must be formed between different sectors for this holistic response to work.

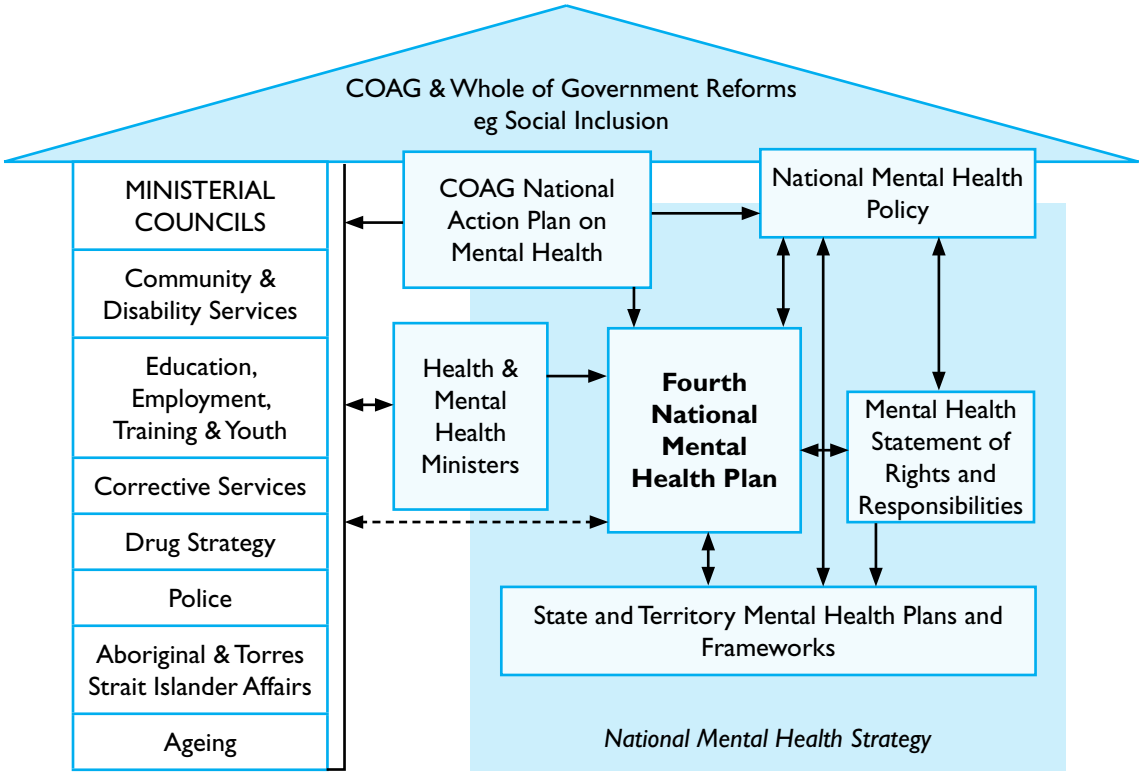
A whole of government approach

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 Fourth 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.

Ministerial Advisory Councils from beyond the health sector were involved in the development of the Fourth Plan. This enabled articulation of the current roles and responsibilities of other portfolios as they relate to improving mental health outcomes (see Appendix 1), 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 Fourth 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 Fourth Plan provides a basis for governments to emphasise mental health in a more



Fourth National Mental Health Plan and its relationship to the *National Mental Health Strategy* and a whole of government approach

Figure 1: A whole of government approach to mental health

integrated way, as represented in Figure 1. This figure shows how the Fourth Plan works within the existing *National Mental Health Strategy* and the new whole of government approach to mental health reform. At a basic level, it shows the relationship between areas of government and in doing so formally recognises that many sectors can contribute to better outcomes for people living with mental illness.

Scope and directions

The Fourth Plan targets the full spectrum of people living with mental health problems and mental illness, as well as their carers and families.

The Fourth Plan is underpinned by eight key principles (see Box 1) and focuses on the following five priority areas for national action, identified through a series of national consultations:

- 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 as well as 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.

Health ministers will lead implementation of the Fourth Plan. The actions will be progressed by governments both independently and nationally 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-focused funding.

Not all actions may be able to be fully implemented within a five year framework, but many will, particularly with the commitment of government and the 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 Fourth Plan explicitly outlines indicators against which to measure progress. For some of these indicators, data are already available; for others, further development work is required and will occur during the first 12 months of the Fourth Plan. Specific targets have not yet been set for any indicators, but this will also be given priority during the first year of the Fourth 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 (refer to definitions of recovery on page 26)—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 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. Mental health care for older people 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 health problems and mental illness

Mental health promotion, prevention and interventions need to include consideration of the spectrum from health and 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 is common or uncommon. Service options need to be responsive to the needs of different age groups, including young children and older people, 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 is widespread in Australia, as it is in other developed countries, and has substantial impact at the personal, social and economic levels. Results from the *2007 National Survey of Mental Health and Wellbeing*, conducted by the Australian Bureau of Statistics (ABS), indicate that one in five people aged 16 to 85 years experience one of the common forms of mental illness (anxiety, affective or mood disorders, and substance use disorders) in any one year. Prevalence rates vary across the lifespan and are highest in the early adult years, the period during which people are usually establishing families and independent working lives (Figure 2). Earlier surveys of children and adolescents aged 4–17, conducted in 1998, found 14% to have a mental illness.

Anxiety related and affective disorders are the most common, affecting approximately 14% and 6%, respectively, of adults each year, with about a quarter having more than one disorder. Collectively referred to as 'high prevalence' illnesses, these disorders include diverse conditions (e.g. post traumatic stress disorder, obsessive compulsive disorder, depression, bipolar disorder) that have different treatment requirements and outcomes.

Mental illness includes 'low prevalence' conditions such as schizophrenia and other psychoses that affect another 1 to 2% of the adult population that were not included in the ABS 2007 survey of adults. Although relatively uncommon, people affected by these illnesses often need many services, over a long period, and account for about 80% of Australia's spending on mental health care.

Mental illness impacts on people's lives at different levels of severity. Depending on definitions, an estimated 3% of Australian adults have severe disorders, judged according to the type of illness (diagnosis), intensity of symptoms, duration of illness (chronicity),

Figure 2: Prevalence of selected mental illnesses by age group

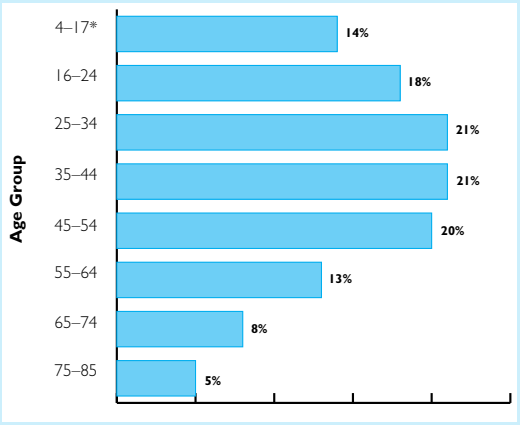
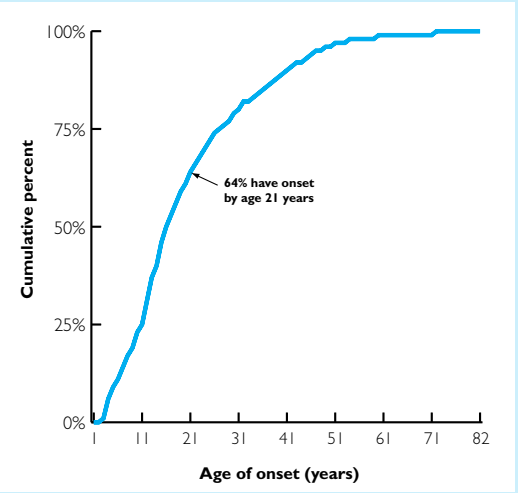


Figure 3: Age of onset for the most common mental illnesses (anxiety and affective disorders)



Notes:
Figure 2: Ages 16–85 based on supplementary analysis of data collected in the Australian Bureau of Statistics (ABS) *2007 National Survey of Mental Health and Wellbeing*. Prevalence estimates exclude counts of persons with drug and alcohol disorders for whom there is no other co-existing mental illness (3% of adults). Prevalence data for ages 4–17 are based on the 1998 child & adolescent component of the first National Survey of Mental Health and Wellbeing.

Figure 3: Based on supplementary analysis of data collected in the ABS *2007 National Survey of Mental Health and Wellbeing*.

Sources:

Australian Bureau of Statistics (2008). National Survey of Mental Health and Wellbeing 2007: Summary of results. ABS Cat. No 4326.0. Australian Bureau of Statistics: Canberra.

*Sawyer, MB et al. (2000). The mental health of young people in Australia. Commonwealth Department of Health and Aged Care: Canberra.

and the degree of disability caused. This group represents approximately half a million Australians. About 50% have a psychotic illness, primarily schizophrenia or bipolar affective disorder. The remainder mainly comprise individuals with severe depression or severe anxiety disorders.

For most people, the mental illness they experience in adult life has its onset in childhood or adolescence. For example, of those who will experience an anxiety or affective disorder, two thirds will have had their first episode by the time they are 21 years of age (Figure 3).

Because many illnesses affect the individual's functioning in social, family, educational and vocational roles, the early age of onset can have long term implications. Mental illnesses are the largest single cause of disability in Australia, accounting for 24% of the burden of non-fatal disease (measured by total years of life lived with disability, Figure 4). This has a major impact on youth and people in their prime adult working years.

People who live with a mental illness are also more at risk of experiencing a range of adverse social, economic and health outcomes. Analysis by the Productivity Commission found that of six major health conditions (cancer, cardiovascular, major injury, mental illness, diabetes, arthritis), mental illness is associated with the lowest likelihood of being in the labour force. For those affected by severe illnesses, particularly those with psychotic disorders, average life expectancy is shorter and is second only to Indigenous Australians, due mainly to high levels of untreated comorbid physical illness.

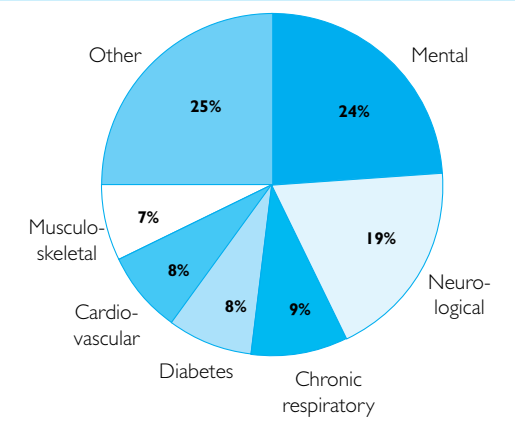
People with mental illness are also over represented in the homeless and prison populations. Australian data suggests that up to 75% of homeless adults have a mental illness and, of these, about a third (approximately 29,000 people) are affected by severe disorders. Additionally, Australian studies have found that around 40% of prisoners have a mental illness and that 10–20% are affected by severe disorders.

The economic costs of mental illness in the community are high. Outlays by governments and health insurers to provide mental health services in 2006–07 totalled $4.7 billion, representing 7.3% of all government health spending. Mental health as a share of overall government spending on health has remained stable over the 15 year course of the *National Mental Health Strategy*.

These figures reflect only the cost of operating the specialist mental health service system and do not indicate the full economic burden of mental illness and costs to government. Because of the disability often associated with mental illness, many people depend on governments for assistance that extends beyond specialist mental health treatment. They require an array of community services including housing, community and domiciliary care, income support, and employment and training opportunities. The *National Mental Health Report 2007* most recently analysed these costs and estimated that outlays by government on mainstream support for people with mental illness substantially exceed the costs of specialist mental health care (Figure 5).

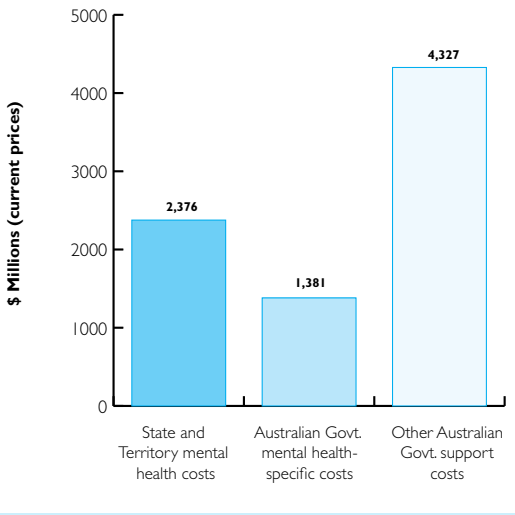
In addition to outlays by government, mental illness impacts on the broader economy by reducing workforce participation and impairing the productivity of those who are in employment. Estimates of the annual costs of the productivity losses attributable to mental illness range from $10 to $15 billion.

Figure 4: Burden of mental illnesses relative to other disorders, in terms of years lost as a result of disability



Source: Begg S et al. (2007). The burden of disease and injury in Australia 2003. PHE 82. Australian Institute of Health and Welfare: Canberra.

Figure 5: Comparing the direct and 'indirect' cost to governments of mental illness, 2004–05



Source: Department of Health and Ageing (2007). *National Mental Health Report 2007*. Commonwealth of Australia: Canberra.

The National Mental Health Strategy

The *National Mental Health Strategy* has guided mental health reform in Australia since 1992, the year in which Australian health ministers agreed to the original National Mental Health Policy and the first five-year National Mental Health Plan. Two further National Mental Health Plans followed in 1997 and 2003, and complementary action was guided by the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011. The original National Mental Health Policy was recently revised (see below for more detail). The Fourth Plan is set in the context of the updated Policy, and builds on the work of previous plans. Like its predecessors, it is underpinned by the *Mental Health Statement of Rights and Responsibilities*.

The *National Mental Health Strategy* has steered a changing reform agenda over time, and understanding this agenda helps to set the context for the Fourth Plan. The *First National Mental Health Plan* (1993–98) represented the first attempt to coordinate mental health care reform in Australia, through national activities. It focused on state/territory based, public sector, specialist clinical mental health services and advocated for major structural reform, with particular emphasis on the growth of community based services, decreased reliance on stand alone psychiatric hospitals, and 'mainstreaming' of acute beds into general hospitals.

The *Second National Mental Health Plan* (1998–2003) consolidated ongoing reform activities and expanded into additional areas of focus. It built on the First Plan by adding a focus on the promotion of mental health and the destigmatisation of mental illness, with the Commonwealth Government and selected state and territory governments providing funding for major initiatives like *beyondblue*. It attended to the question of how

the public mental health sector could best dovetail with other government and non-government areas (e.g., private psychiatrists, general practitioners, general health services, and community support services) to maximise treatment outcomes and opportunities for recovery. Whereas the First Plan focused largely on severe and disabling low prevalence illnesses that are principally the responsibility of the states and territories, the Second Plan expanded the emphasis to include the more common illnesses such as depression and anxiety disorders that are treated in primary health care settings.

The *Third National Mental Health Plan 2003–2008* set out to consolidate the achievements of the First and Second Plans, by taking an explicit population health approach and reaffirming an emphasis on the full spectrum of services that are required to assure the mental health of Australians. It focused on mental health promotion and mental illness prevention, improving service responsiveness, strengthening service quality, and fostering innovation.

Both the Second and Third Plans recognised 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. The *COAG National Action Plan on Mental Health 2006–2011* was developed between governments to provide further impetus to mental health reform and sharpen the focus on areas that were perceived by stakeholders to have not progressed sufficiently under the various National Mental Health Plans. The *COAG National Action Plan* emphasised the importance of governments working together, and the need for more integrated and coordinated care. It also committed governments to a significant injection of new funds into mental health, including the expansion of the Medicare Benefits Schedule to improve access to mental health care delivered by psychologists and other allied health professionals, general practitioners and psychiatrists. The *COAG National Action Plan* led to increased investment by states and territories in community based mental health services, enabling them to better respond to consumers with severe and persistent mental illnesses, and their carers and families. It also increased investment in services delivered outside the health sector that are needed by people who live with mental illness, including employment, education and community services.

Alongside these national activities, states and territories have developed their own specific mental health plans or strategies which help set the context for the Fourth Plan. Consistent with the *COAG National Action Plan*, state and territory plans and strategies have 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 programs operating outside the health system, 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.

Progress of mental health system reform in Australia

The last decade and a half of mental health system reform under the *National Mental Health Strategy* has led to significant change. Public sector specialist mental health services are now staffed by a significantly larger mental health workforce. Nationally, the number of state and territory employed professionals who work directly with consumers in specialist

Figure 6: Growth in the state and territory clinical workforce 1993 to 2007

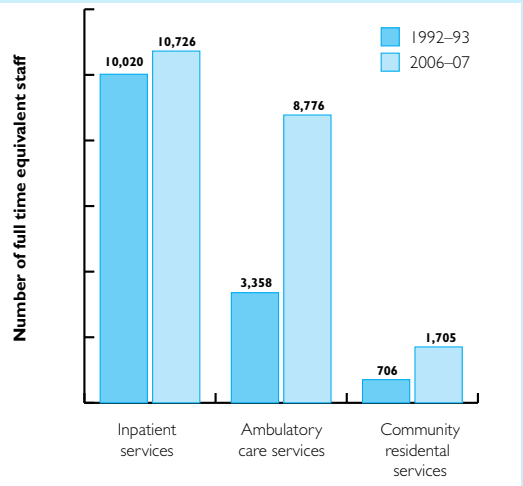
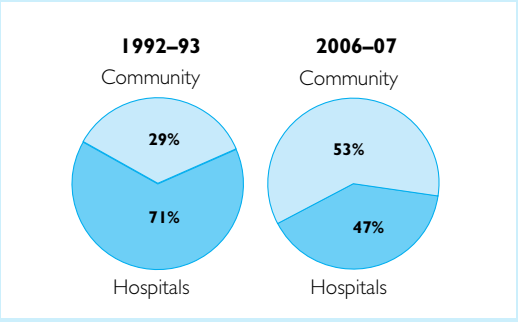


Figure 7: Community based services as percentage of total state and territory spending on mental health services, 1992–93 and 2006–07



Sources:

Figure 6 and Figure 7: Australian Government Department of Health and Ageing.

mental health settings grew by 51% between 1993 and 2007 (Figure 6). This workforce is complemented by employed consumer consultants and peer workers who did not previously exist as a professional group but are now growing in number.

Care is now delivered primarily in community settings, compared with the previous heavy reliance on inpatient services that characterised Australia's mental health system. 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% (Figure 7). There has also been an increased emphasis on the safety, quality and outcomes of care, as evidenced by activities like the routine measurement of clinician rated and consumer rated outcomes in all services.

Access to mental health care in primary care settings has been substantially increased as a result of changes to the Medicare Benefits Schedule at the end of 2006, with more than 1.3 million mental health treatment plans developed by general practitioners, and 4.95 million services provided by psychologists and other allied health professionals through Medicare subsidised services.

The *2007 National Survey of Mental Health and Wellbeing* provided evidence of the impact of these changes, with the finding that the percentage of those with a mental illness who saw a mental health professional in 2007 was almost double those who did so in 1997 (Figure 8).

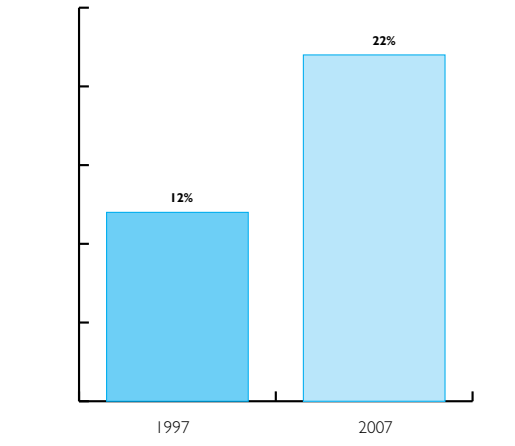
Community mental health literacy has also improved during the life of the *National Mental Health Strategy*, indicating that the substantial investment in mental health promotion initiatives—particularly those driven by *beyondblue*—are bearing fruit. Research undertaken by the University of Melbourne has demonstrated an increase in awareness of depression and the issues associated with

it (e.g. discrimination) between 1995 and 2004, which was most pronounced in states and territories that contributed funding to *beyondblue*.

The broader, cross sectoral activities are gaining traction too. Across most states and territories, work in the housing sector has begun to recognise the needs of those with mental illness when planning social housing initiatives. Similarly, developments in the justice sector have seen diversionary programs developed for people with mental illness or substance dependency. In other areas, state and territory cross portfolio COAG Mental Health Groups are beginning to take forward whole of government initiatives and foster stronger partnerships.

These achievements have led to Australia being regarded as a world leader in mental health system reform, but the Fourth Plan acknowledges that there is still much to be done. While the directions of each of the previous plans have been broadly supported, the pace of reform has varied, often considerably, across jurisdictions. 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 illness receive mental health services each year. Major disparities continue between different states and territories in the mix and level of services. Demand for mental health care—particularly for acute and emergency care—continues to outstrip supply. Challenges in recruiting, retaining and supporting a workforce with appropriate competencies also continue to compromise the quantity and quality of care available. Consumers and carers still report that they experience difficulties in accessing the right care at the right time, and that they experience discrimination from within the mental health system, from other sectors with which they come into regular contact, and from the general community.

Figure 8: Percentage of people with a current mental illness who consulted a mental health professional, 1997 and 2007



Sources:

Figure 8: Based on supplementary analysis of data collected in the Australian Bureau of Statistics 1997 and 2007 National Surveys of Mental Health and Wellbeing.

The Fourth Plan extends 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 the three previous National Mental Health Plans, and it gives particular consideration to a collaborative approach that will foster complementary programs that deliver responsive services.

The new National Mental Health Policy

As noted, the original National Mental Health Policy marked the beginning of the *National Mental Health Strategy* in 1992. A revised *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* 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 of 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 2008* are to:

- promote the mental health and wellbeing 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.

The Fourth 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 2008*, the Fourth Plan acknowledges our indigenous heritage and the unique contribution of Indigenous people's culture and heritage to our society.

Furthermore, it recognises Indigenous people's distinctive rights to status and culture, self determination and the land. It acknowledges that this recognition and identity is fundamental to the wellbeing of Indigenous Australians It recognises that mutual resolve, respect and responsibility are required to close the gap on indigenous disadvantage and to improve mental health and wellbeing.

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 have improved outcomes in relation to housing, employment, income and overall health and are valued and supported by their communities. 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.
- Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.
- Improve coordination between primary care and specialist mental health services in the community to enhance consumer choice and facilitate 'wrap around' service provision.
- Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.
- Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community.
- Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage.
- Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Strait Islander *Social and Emotional Well Being Framework*.

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 and the arts.

Indicators for monitoring change

- 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
- Rates of stigmatising attitudes within the community *
- Percentage of mental health consumers living in stable housing *
- Rates of community participation by people with mental illness *

** These indicators require further development*

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—key elements of social inclusion—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. 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 significant developments in these areas, including establishment of a national Social Inclusion Board, 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, and 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/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.

Within current service delivery, a recovery focus has mainly been championed by the non-government community support sector and consumer advocacy bodies. This Fourth 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

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 the *SANE StigmaWatch* program 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

Definitions of recovery

The definition provided in the *National Mental Health Policy 2008* is:

> *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.*

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 New Zealand Mental Health Advocacy Coalition in *Destination Recovery* is:

> *… a philosophy and approach to services focusing on hope, self determination, active citizenship and a holistic range of services.*

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 destigmatisation. 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.

Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.

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 Queensland Centre for Mental Health Research) that, for people with 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.

Related to this action, a *National Mental Health and Disability Employment Strategy* has been developed by the Australian Government to address barriers to employment faced by people living with disability, including mental illness.

Improve coordination between primary care and specialist mental health services in the community to 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 general practitioner. 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.

Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.

Elements of this approach include targeted workforce development, establishment of an effective peer support workforce, and expansion of opportunities for meaningful involvement of consumers and carers.

From the perspective of people with emotional, physical, sensory or intellectual differences, they overwhelmingly report their experience as being one of social exclusion. The link between disability and social exclusion is well documented. Meaningful and diverse means of addressing structural barriers that exist for people excluded because of emotional and psychosocial experiences need to be developed to begin to expand opportunities for enhanced participation of consumers and carers.

Consumer and carer leaders need to actively promote, lobby and encourage an approach that introduces and acknowledges best practice in policy and activity. This approach should promote the individual's value and strengths, encourage participation and relevant and equitable service provision. Best practice models that promote the development of a certified peer specialist workforce accountable to peers and to funders are elements of a recovery oriented framework of service provision.

Develop integrated programs between mental health support services and housing agencies to provide tailored assistance 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 cooperation 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. There is good evidence that, when clinical treatment and community support co-exist, they complement each other and promote better outcomes for consumers, their families and carers. Such outcomes include tenancy stability and greater capacity to seek employment and

other community participation. While there has been considerable attention to this area at a national level and through state/territory and Commonwealth partnerships, nationally consistent models to match support to a person's needs require further development.

Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people 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.

Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Straits Islander Social and Emotional Well Being Framework.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* (the Framework) was developed to respond to the high rates of social and emotional wellbeing problems and mental illness experienced by Aboriginal and Torres Straits Islander (ATSI) people and communities.

The Framework was designed to complement the *National Mental Health Plan* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003–2013). It was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 2004. The Framework 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 effort. This work will need to take into account other recent developments through COAG and other sectors relevant to a social and emotional wellbeing approach.

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 wellbeing and emotional wellbeing, as this is critical to all efforts that aim to give Indigenous Australians the same health status as other Australians.

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, physical health issues and suicidal behaviour. Generalist services have support and access to advice and specialist services when needed.

Summary of actions

- Work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience.
- Implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations.
- Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services.
- Implement evidence based and cost effective models of intervention for early psychosis in young people to provide broader national coverage.
- Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.
- Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors.
- Expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents with a mental illness.
- Develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma.

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 monitoring change

- 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
- Proportion of front-line workers within given sectors who have been exposed to relevant education and training *
- Rates of understanding of mental health problems and mental illness in the community *
- Prevalence of mental illness *

** These indicators require further development*

The importance of promotion, prevention and early intervention (PPEI) in mental health has been recognised in previous plans. *Promotion, Prevention and Early Intervention for Mental Health: A Monograph* and the 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 outcomes.

National actions

Work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience.

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 between mental health, maternal and child health services, schools and other related organisations.

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.

Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug 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 Internet based technology, and joining up 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 focused services that are relevant and accessible and support better engagement. There should be close links between youth focused 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.

Implement evidence based and cost effective models of intervention for early psychosis in young people to provide broader national coverage.

Early intervention is critical in minimising the impact of mental health problems over the life of a person. Effective and accessible clinical and non-clinical intervention for young people with early psychoses will improve their capacity to manage their illness over their life (and reduce their risk of social exclusion and homelessness) and reduce the cost to the community and the health system.

About 50,000 Australians experience severe and persistent mental illness including psychosis, and of these it is estimated that up to 10,000 young people would benefit from early psychosis interventions. For young adults, mental illness accounts for almost half of their total ill health, and young people in their teens and twenties lose over three times as many disability adjusted life years per person to mental illness compared to the rest of the population.

Provide education about mental health and suicide prevention to front line workers in 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, including individuals who may be suicidal. Supporting these groups to better understand and recognise mental illness and to know how to react to individuals during an acute episode of illness or suicidal behaviour will improve earlier intervention and bring better outcomes for individuals and their families. Workers that are particularly important 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. Other similar programs have been developed by organisations such as *beyondblue* and Lifeline. For example, Lifeline has developed a two-day, practical interactive workshop in suicide first aid called *Applied Suicide Interactive Skills Training (ASIST)* that helps people recognise when someone may be at risk of suicide, explores how to connect with them in ways that understand and clarify that risk, increase their immediate safety and link them with further help. Again, while education regarding mental health problems should incorporate those issues and problems which are common, front line 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. Those who are responsible for developing and providing training to front line workers need to be competent in the area of mental health and suicide prevention, or ensure that appropriate training staff are available to provide such input.

Education and training should also include consideration of the impact of substances such as alcohol, prescribed medication and illicit substances. It should also include education about the relationship between mental illness, substance abuse and increased risk of suicidal behaviour, and training should emphasise the role that various workers should play in recognising and responding to people at higher risk of suicide.

Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.

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.

Specific support mechanisms should be developed to help people at high risk of suicide including the development of a nationally consistent set of suicide risk assessment tools for use in primary and community care appointments for all persons who have significant risk factors such as mental health problems including depression or substance abuse disorders. In addition, policies and practices should be developed and implemented that promote improved continuity of care for individuals who are at higher risk of suicide following discharge from inpatient psychiatric hospitalisation or from emergency departments following a suicide attempt. There should also be greater availability of a range of after hours services in the community for people who are at risk of suicide.

Expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents 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 a 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, general practitioners 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 and young people who have experienced physical, sexual or emotional abuse, or other trauma.

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 general practitioners and other health professionals working with families with young children.

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 of funders, service providers, consumers and carers and other relevant stakeholders to develop local solutions to better meet the mental health needs of communities.
- Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models.
- Work with emergency and community services to develop protocols to guide and support transitions between service sectors and jurisdictions.
- Improve linkages and coordination between mental health, alcohol and other drug, and primary care services to facilitate earlier identification of and improved referral and treatment for mental and physical health problems.
- Develop and implement systems to ensure information about the pathways into and through care is highly visible, readily accessible and culturally relevant.
- Better target services and address service gaps through cooperative and innovative service models for the delivery of primary mental health care.

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 monitoring change

- 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
- Proportion of specialist mental health sector consumers with nominated general practitioner *
- 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 *

* These indicators require further development

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 General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative. These initiatives recognised that people commonly present to their general practitioner 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 national 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 between and within sectors. Within the specialised mental health system, 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 better coordination between the range of service sectors providing treatment and care, 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 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.

A national service planning framework will include acute, long stay, 'step up/step down' and supported accommodation services, as well as ambulatory and community based services. It will take account of the contribution of public, non-government sectors and private mental health service providers, and clearly differentiate between the needs of children and young people, adults and older people. Indicative 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. The framework needs to be supported by flexible funding models that allow innovation and service substitution to meet specified targets in different delivery contexts.

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.

Most importantly, development of a national service planning framework for mental health services needs to be based on sound epidemiological data that quantifies the prevalence and distribution of the various mental illnesses, as well as evidence based guidelines that identify the treatment required for the range of conditions. Construction of the service framework needs to translate this knowledge about illness prevalence and

required treatments into resources, measured in terms of the workforce and service components required to establish an adequate service system. Australia is fortunate to have a body of internationally recognised mental health researchers and expert clinicians who have established the groundwork in these areas.

Establish regional partnerships of funders, service providers, consumers and carers and other relevant stakeholders 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 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 the 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 and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models.

A key impediment to seamless, joined up services and cooperation between service providers is 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 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 responsiveness.

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 mental health, alcohol and other drug, and primary care services to facilitate earlier identification of, and improved referral and treatment for, mental and physical health problems.

Many people who seek help for mental health problems or for problems associated with use of alcohol or other drugs will do so through their general practitioner. 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, or 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 the pathways into and through care is highly visible, readily 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 better information referral systems or portals 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 and innovative service models for the delivery of primary mental health care.

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 develop and support 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*, a 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. Consultation with local communities and service providers is required to accurately identify and prioritise unmet need and facilitate coordination between primary, specialist and non-government services to improve access and continuity of care for consumers.

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 consumer and carer experiences and perceptions. Mental health legislation meets agreed principles and, in conjunction with any related legislation, 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 and related 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 defines standardised workforce competencies and roles in clinical, community and peer support areas.
- Increase consumer and carer employment in clinical and community support 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 Frameworks*.
- Develop a national mental health research strategy to drive collaboration and inform the research agenda.
- Expand and better utilise innovative approaches to service delivery including telephone and e-mental health services.

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 monitoring change

- 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
- Proportion of consumers and carers with positive experiences of service delivery *

** These indicators require further development*

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 professions 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 wellbeing 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 actions

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 and related 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 scope opportunities to overcome such barriers.

Develop and commence implementation of a National Mental Health Workforce Strategy that defines standardised workforce competencies and roles in clinical, community and peer support areas.

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 postgraduate 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 for the Mental Health Workforce*.

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 community support 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 is a key tool for promoting quality improvement in health care. The *National Mental Health Performance Benchmarking 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 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, 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.

Expand and better utilise innovative approaches to service delivery including telephone and e-mental health services.

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 illness, 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 the Fourth 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 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 Plan.

Indicators for monitoring change

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

** This indicator requires further development*

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 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 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 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 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.

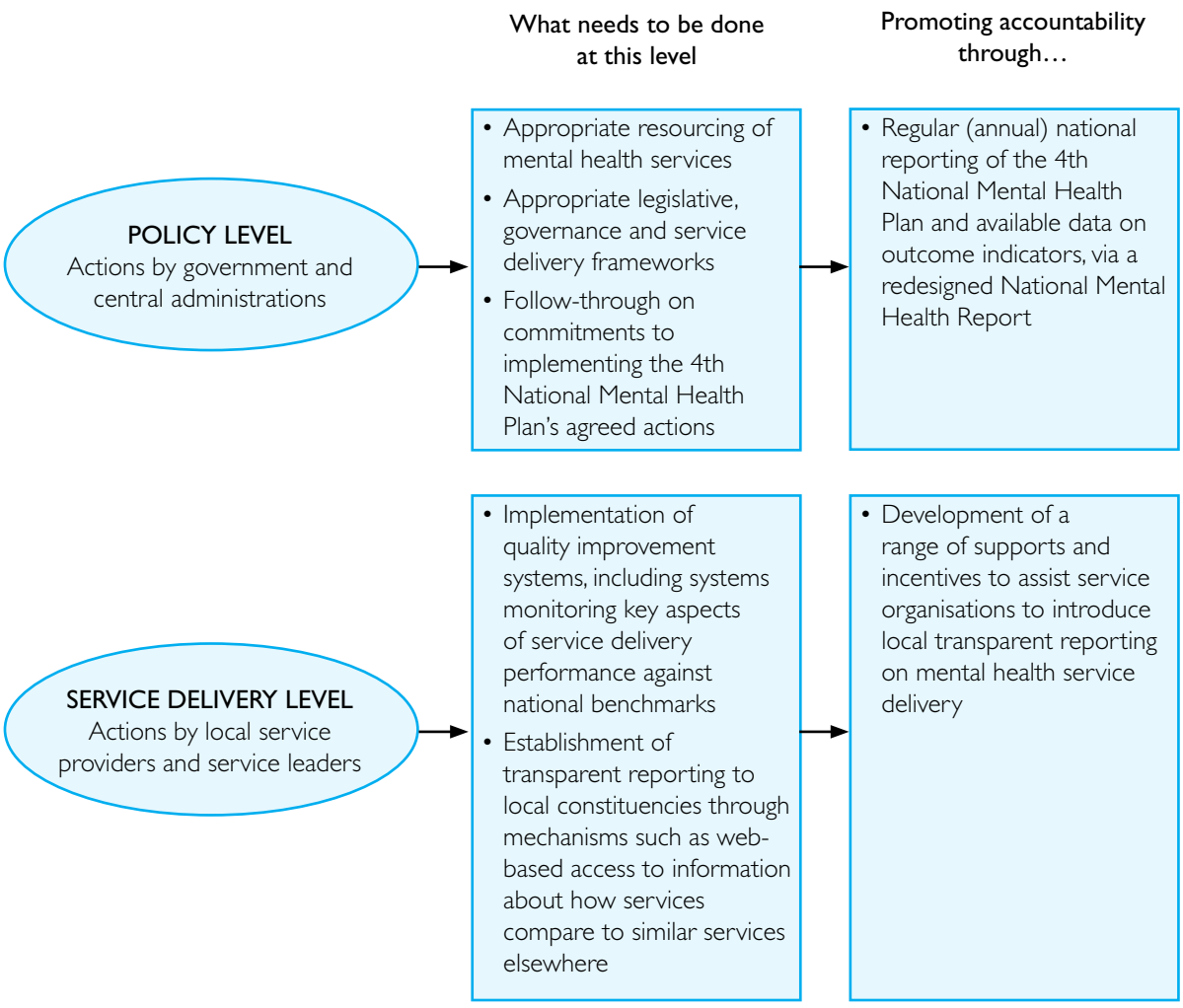
Australia's mental health sector has been a world leader in reporting on indicators of mental health reform, and has a longer and stronger history of doing so than many other sectors. The process began with the original *National Mental Health Plan* in 1992, when health ministers imposed on themselves 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 delivery. 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.

Figure 9: Multi-level approach to building an accountable and transparent mental health system



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 to 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 9 summarises the approach.

National actions

Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs.

The Fourth 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 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 2008* for services to people with mental illness in Australia.

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

Title	*Purpose*	*Prepared/ Released by*	*How the report will be developed 2009–14*	*Frequency*
National Mental Health Report	Principal report for monitoring progress of mental health reform in Australia. Presents analysis of reform against specified indicators.	Australian Government, for AHMC	Focus to be on reporting progress and outcomes of Fourth 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.	Annual
Mental Health Services in Australia	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.	Australian Institute of Health and Welfare, funded by Australian Government	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	Annual
COAG Action Plan on Mental Health Annual Progress Report	Serves as the key accountability instrument for the Action Plan—summarises progress in the Action Plan's implementation and available data on outcomes.	Prepared under auspice of AHMC for COAG	Report scheduled to conclude at end of Action Plan in 2011. Progress indicators are incorporated in indicators developed for Fourth Plan and will be published in National Mental Health Report.	Annual to 2011

Indicators to be used to monitor the success of the Fourth 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 Fourth Plan, and details on data sources for these indicators are provided in Appendix 2. 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 progressed during the first twelve months of the Fourth 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

Priority area 1: Social inclusion and recovery

Outcome:

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.

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
- Percentage of mental health consumers living in stable housing
- Rates of community participation by people with mental illness

Priority area 2: Prevention and early intervention

Outcome:

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.

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:

- Proportion of front line workers within given sectors who have been exposed to relevant education and training
- Rates of understanding of mental health problems and mental illness in the community
- Prevalence of mental illness

Priority area 3: Service access, coordination and continuity of care

Outcome:

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.

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 general practitioner
- 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 consumer and carer experiences and perceptions. Mental health legislation will meet agreed principles and, in conjunction with any related legislation, 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 able to make informed judgements about the extent of mental health reform in Australia, including the progress of this Fourth 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. Internet 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 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 the Fourth Plan.

Conduct a rigorous evaluation of the Fourth National Mental Health Plan

The Fourth Plan has a strong commitment to evaluation. The monitoring and reporting activities described above, including the assessment of the achievements of the Fourth 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 Plan will involve the development of a clear framework at its outset that operationalises the aims of the Fourth 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 Fourth 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: 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 Fourth Plan. This has enabled the Fourth 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 the Fourth 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 of 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 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, and how and where these are provided, influences our experience and the speed and extent of return to health and wellbeing. To improve 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 wellbeing 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 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 illnesses, 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 systems 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 implementation of the National *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 comorbid 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 is just as relevant. The Indigenous workforce needs to have confidence that they have access to advice and backup when required.

Ageing

Overview

The proportion of older people in Australia is increasing, 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 is 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 mental health services for older people 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, 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 comorbid 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 could 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 can adequately assess and be 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;
- carer respite;
- personal support;
- vocational and employment services;
- homelessness services;
- sexual assault services;
- disability services;
- women's services;
- recreational services;
- arts based services; 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 front line, 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 wellbeing 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 Statement of Principles for Forensic Mental Health covered a number of these areas, but has not been fully embraced across the service system. Court diversion programs and the development of mental health liaison staff

within 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 front line 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.

Interface and future directions

Some mental illnesses are associated with a risk of functional disability and at times difficult behaviour. Comorbidity 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 Fourth 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 2: Technical notes on indicators to monitor the Fourth National Mental Health Plan

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
1. Social inclusion and recovery	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.	Participation rates by people with mental illness of working age in employment[1] Participation rates by young people aged 16–30 with mental illness in education and employment 1 Rates of stigmatising attitudes within the community[2] Percentage of mental health consumers living in stable housing[3] Rates of community participation by people with mental illness[4]	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 (1997) for this purpose. 3. 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. 4. 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.

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
2. Prevention and early intervention	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.	Proportion of primary and secondary schools with mental health literacy component included in curriculum[1] Rates of contact with primary mental health care by children and young people[2] Rates of use of licit and illicit drugs that contribute to mental illness in young people[3] Rates of suicide in the community[4] Rates of understanding of mental health problems and mental illness in the community[5] Prevalence of mental illness[6] Proportion of front line workers within given sectors who have been exposed to relevant education and training[7]	1. Routinely collected data through the national *MindMatters* and *KidsMatter* initiatives 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 4. Routinely collected data on suicide published by the Australian Bureau of Statistics are used to inform this indicator. 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. 6. Baseline data relevant to this indicator are available for the Australian population aged 16–85 from the *2007 National Survey of Mental Health and Wellbeing*. The survey could be re-administered to provide a subsequent cross sectional picture of prevalence. It should be noted, however, that to collect meaningful comparative data in this way is an expensive undertaking as the survey is considerably more complex than other health related surveys conducted in Australia. 7 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.

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
3. Service access, coordination and continuity of care	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.	Percentage of population receiving mental health care[1] Readmission to hospital within 28 days of discharge[2] Rates of pre-admission community care[2] Rates of post-discharge community care[2] Proportion of specialist mental health sector consumers with nominated general practitioner[3] Average waiting times for consumers with mental health problems presenting to emergency departments[4] Prevalence of mental illness among homeless populations[5] Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities[6]	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. 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. 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) 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 to accurately differentiate waiting times for people with and without mental health problems. Consideration will need to be given to new ways of capturing this information.

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
			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 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 took place in July 2009, as a precursor to more regular national data collection.

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
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.	Proportion of total mental health workforce accounted for by consumer and carer workers[1] Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards[2] Mental health outcomes for people who receive treatment from state and territory services and the private hospital system[3] Proportion of consumers and carers with positive experiences of service delivery[4]	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. 2. Data relating to this indicator will be available as a by-product of routine reporting against the National Standards for Mental Health Services, again through the Mental Health Establishments National Minimum Data Set. 3. Data relating to this indicator are reported routinely through the National Outcomes and Casemix Collection. 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 wellbeing, burden and perceptions of care will be consolidated to identify or develop an appropriate measure or set of measures to be used across services.

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
5. Accountability—measuring and reporting progress	The public is able to make informed judgements about the extent of mental health reform in Australia, including the progress of the Fourth 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.	Proportion of services publicly reporting performance data[1]	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.

Glossary of key terms

Acute mental health services: Acute mental health services provide 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. In general, acute services provide relatively short term treatment.

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: A person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the consumer and carer.

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

Consumer: A person who uses or has used a mental health service.

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.

E-mental health: Mental health services or information delivered or enhanced through the Internet and related technologies. E-mental health can include mental health promotion, prevention, early intervention, treatment, relapse maintenance and emergency services. E-mental health solutions can also facilitate professional training for the mental health workforce.

Forensic mental health services: Refers to mental health services that principally provide assessment, treatment and care of people with a mental illness who are in the criminal justice system, or who have been found not guilty of an offence because of mental impairment. Forensic mental health services are provided in a range of settings, including prisons, hospitals and the community.

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

Mental health services: Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.

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 illness and their families and carers. 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 their carers, or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, pre-vocational 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 heath condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis.

Performance indicator: Refers to a quantitative measure that is used to judge the extent to which a given objective has been achieved. Indicators are usually tied to specific goals and serve simply as 'yardsticks' by which to measure the degree of success in goal achievement. Performance indicators are usually expressed as a rate, ratio or percentage.

Prevalence: The proportion of individuals in a particular population who have an 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 privately managed hospitals, for which private health insurers pay benefits, and some services provided in general hospital settings.

Psychiatric disability: Refers to the impact of a mental illness on a person's 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.

Recovery: See the various definitions that have been described on page 26.

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

Step up/step down: These are clinically supported services which are delivered through staffed residential facilities and offer short term care to manage the interface between inpatient and community settings. They provide an alternative to hospital admission (pre-acute) and provide bridging support following discharge from hospital (post-acute).

Supported accommodation: Safe, secure 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.

Targets: A target (or benchmark) refers to the desired standard of performance to be achieved on a given performance indicator. Whereas performance indicators are the measurement tools used to gauge the extent to which a goal is met, targets represent the 'marks' on those indicators that define the desired levels of performance. Targets may be set on the basis of objective evidence, expert consensus, values or simple averages.

Wrap around services: The term refers to individualised and integrated services provided through a single coordinated process to comprehensively meet the needs of a person with a mental illness.