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

Located/Co-located
A mental health service which is operated from within or on the immediate site of a general health service and which is managed through the same structure. For example, an acute inpatient psychiatric service would operate within a general hospital or a community mental health service would operate as part of a community health services.

Mainstream health services
Services provided by health professionals in a wide range of agencies including general hospitals, general practice and community health centres. Mental health services will be delivered and managed as an integral part of mainstream health services so that access to mental health services is no different than to other health services.

Mental disorder
A recognised, medically diagnosable illness that results in the significant impairment of an individual's cognitive, effective or relational abilities.

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

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

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

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

Performance indicators
The collection of statistical data, and measures of social, economic and clinical outcomes.

Reform and incentives contracts
Agreed contractual arrangements between the Commonwealth and States and Territories to support projects which will enable the setting of clear timeliness for reform in the mental health services.

Standards – Clinical and Service

- **Clinical practice standards** are agreed and defined clinical procedures and practices for the optimal treatment and care of persons with mental disorder.

- **Service standards** define what is required for a quality mental health service and are used to measure whether a service meets reasonable community expectations.

State Minister
Means the Minister of State of a State for the time being responsible for the administration of this Plan and includes the Minister of a State or other member of the State Executive Council acting on behalf of, or for the time being acting for, such Minister.

Territory Minister
Means the Minister of State of a Territory for the time being responsible for the administration of this Plan and includes the Minister of a Territory or other member of the Territory executive council acting on behalf of, or for the time being acting for, such Minister.

EXHIBIT 58

SUMMARY OF ACTIVITIES TO BE INITIATED DURING LIFE OF THE PLAN

DATE	EVENTS/TASK	BY WHOM	MEASURE
1 Oct 92	Establish National Performance Indicators of progress towards achievement of National Mental Health Policy objectives	all parties to Plan	endorsement by AHMAC MHWG
1 Oct 92	Agree to a National Mental Health Data Strategy (including a Minimum Data Set)	all parties to Plan	endorsement by AHMAC MHWG
1 Jan 93	Establish National Consumer Advisory Group with reps from each State, Territory and the Commonwealth	all parties to Plan	endorsement by AHMAC MHWG
30 April 93	Seek review of other government agency guidelines relevant to access for people with mental health problems and disorders	all parties to Plan	provide available data for inclusion in National Report by September 1993
1 July 93	Identify cross-border anomalies concerning treatment of people with mental disorders	States/Territories	report to AHMAC MHWG

ATTACHMENT A

EXHIBIT 58

DATE	EVENTS/TASK	BY WHOM	MEASURE
Sep 93 & annually thereafter	Provision of data for inclusion in the National Report	All parties to Plan	all parties shall provide the following data for inclusion in the National Report to be published in November 1993 and annually thereafter: consumer rights strategies and consumer input; strategies to achieve mainstreaming and integration; legislative reform and resolution of cross border anomalies; introduction of National Service Standards (from 1996) initiatives for carers and special needs groups (consultation strategies); quality assurance programs; activities of the AHMAC Working Group on Mental Health and related Committees/Working Parties; mental health expenditure and service utilisation data; benchmark data on National Minimum Data set;

EXHIBIT 58

DATE	EVENTS/TASK	BY WHOM	MEASURE
			agreed outcome measures, including efficiency and effectiveness measures;
			international developments in mental health;
			intersectoral linkages, and
			National Performance Indicators
1 Oct 93	Establish C'ttee to consider a range of policy issues relating to mental health workforce	AHMAC MHWG	c'ttee established and beginning to examine issues listed at 6B
Nov 1993 & annually thereafter	Publication of National Report	AHMAC MHWG	publication and distribution of the Report
1 July 95	Resolution of cross-border administrative and legislative inconsistencies	States/Territories	administrative and legislative changes in place to remove the major impediments to the movement of people with mental disorders across State/Territory borders
1 July 95	Evaluation of the Plan commenced	All parties to Plan	evaluation underway
1 April 96	Evaluation of the Plan completed	All parties to Plan	evaluation to be considered by Health Ministers

EXHIBIT 58

DATE	EVENTS/TASK	BY WHOM	MEASURE
By 1996	Introduction of National Mental Health Service Standards	States/Territories	Mental Health Service Standards adopted by Government funded mental health services
1 Jan 98	Ensure mental health legislation consistent with UN Resolution and Statement of Rights & responsibilities.	States/Territories	principles from both documents incorporated in all S/T mental health legislation

Second National Mental Health Plan

Australian Health Ministers

national mental health strategy

Second National Mental Health Plan

Australian Health Ministers

July 1998

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Additional copies of the report can be obtained from:

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Commonwealth Department of Health and Family Services
GPO Box 9848
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Facsimile: (02) 6289 8788
Website: http://www.health.gov.au/hsdd/mentalhe

Suggested reference:

Australian Health Ministers, Second National Mental Health Plan, Mental Health Branch, Commonwealth Department of Health and Family Services, July 1998.

Terminology

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

Foreword

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

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

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

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

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

Australian Health Ministers

Contents

A Introduction

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

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

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

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

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

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

Building on achievements and expanding into additional areas of reform

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

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

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

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

(1) Structural reform of mental health services

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

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

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

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

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

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

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

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

(4) Improved service quality

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

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

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

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

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

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

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

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

B Scope of the Second National Mental Health Plan

The policy framework

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

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

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

An expanded focus

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

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

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

Thus the renewed National Mental Health Strategy will comprise the:

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

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

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

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

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

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

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

C Roles and responsibilities

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

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

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

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

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

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

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

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

State and Territory Governments

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

- organise and fund specialised public mental health services;
- plan for a comprehensive mix of mental health services, including the establishment of service delivery systems which ensure effective service networks and coordination of care are fostered, especially between the public, private and non-government sectors;
- manage the redirection of resources within mental health services to reflect national policies and responsiveness to local need and circumstances;
- establish mechanisms to facilitate consumer and carer input into decision making at all levels;
- ensure linkages at the State/Territory, area/regional and service delivery levels of mental health services and other general health and community care services;
- provide comprehensive data on mental health service delivery and reform activities for publication in annual National Mental Health Reports; and
- support mental health research and evaluation.

Commonwealth Government

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

- finance and administer programs, consistent with revised Commonwealth and State/Territory funding arrangements, where the nature of the service entitlement or program does not vary between States/Territories, and is more efficient for administration to be national (ie, Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and Social Security payments);
- ensure people with mental illness and their carers are not discriminated against in gaining access to general health, community support, accommodation, employment, training and other programs which are the responsibility of the Commonwealth Government;
- foster linkages with relevant national reform agendas and partnerships with national stakeholders;
- establish mechanisms to facilitate consumer and carer input into decision making at all levels;

- fund, and foster the development of, mental health research and service evaluation;

- in consultation with the States and Territories, seek to ensure an adequate supply of high quality mental health personnel through targeted education and training development; and

- act as a clearing house for information relating to significant developments in, and dissemination of, good practice models of mental health service delivery.

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

- provide a forum to promote the renewed National Mental Health Strategy and monitor the implementation of the *Second National Mental Health Plan* within the *National Mental Health Policy* framework;

- consider, and recommend on, emerging mental health issues and report to health ministers as appropriate;

- provide State and Territory, consumer and carer perspectives on priorities and approaches for national projects funded by the Commonwealth under the renewed National Mental Health Strategy;

- establish time-limited working parties to address specific issues; and

- consult regularly with national stakeholders and other relevant organisations, agencies and individuals as appropriate.

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

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

D. Priorities for Future Activity

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

The client focus

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

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

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

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

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

A focus on depression

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

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

Promotion and Prevention

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Outcomes

- Improved range, quality and effectiveness of public health strategies which promote mental health among the Australian population.
- The Australian population is more informed about mental health issues, of strategies to maintain their own mental health and to support people with mental illness.
- Reduced incidence and prevalence of mental illnesses and associated disability.
- Reduced number of suicides.
- Reduction in the incidence and prevalence of depression and associated disability.
- Reduction in inappropriate readmissions to inpatient services and a re-engagement with community based services.
- Consumers and carers more informed about signs of a first episode or a relapse of illness and how to respond.
- Increased consumer and carer satisfaction with clinicians' response to early warning signs.

Strategies

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

- Development of a national mental health promotion and prevention work program through the National Public Health Partnerships.

- Completion and evaluation of programs to reduce suicidal behaviour amongst groups with high rates of attempted and completed suicide, including those identified in the National Youth Suicide Prevention Strategy.

- Development and evaluation of risk-reduction programs for groups identified as vulnerable to the development of mental illnesses.

- Development and evaluation of programs with demonstrated efficacy in the prevention of mental health problems in infancy, childhood and adolescence, including programs targeting children vulnerable through parenting difficulties, family discord, family disruption, loss, trauma, maltreatment and abuse.

- Development of research programs that contribute to the compilation of an evidence base for population health approaches to mental illness prevention.

- Further development and evaluation of early detection programs, especially in relation to depression.

- Further development and evaluation of early intervention programs focusing on both first onset and relapsing mental illnesses.

- Continuation of successful community and setting specific education initiatives which aim to improve community understanding of mental illness and address the stigma and discrimination experienced by people with mental illness.

- In consultation with consumers and carers, further development and evaluation of education, training and professional development for all providers of services to people with mental illness.

- Compilation, production and dissemination of mental health literacy resources targeting key settings and occupational groups.

- Use of online technologies, such as the Internet, to disseminate information about initiatives already completed or underway.

Partnerships in Service Reform and Delivery

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Outcomes

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

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

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

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

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

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

- Improved coordination of services provided to consumers and carers.
- Increased community interest and involvement in mental health issues.

Strategies

- Continuation of initiatives, which measure consumer and carer satisfaction with, services, taking account of age, gender and cultural issues.
- Further development of training programs, in consultation with consumers and carers, focusing on the attitudes of mental health service managers, staff and clinicians.
- Further development of structures and processes for the inclusion of consumers and carers in mental health decision making at all levels.
- Further development and evaluation of training courses, appropriately targeted to general practitioners, health and disability agencies and the non government sector, in consultation with consumers and carers.
- Further development of formal agreements and protocols between key stakeholders which clarify roles and responsibilities regarding services provided to consumers.
- Continued integration of community and inpatient services to provide continuity of care for consumers.
- Further development of strategic partnerships in programs which address the additional needs of particular client groups.
- Continued initiatives on behalf of people with psychiatric disability to ensure appropriate implementation of the Commonwealth/State Disability Agreement.
- Development and evaluation of strategic plans for Indigenous mental health at the State and Territory level which are consistent with the objectives of the *Aboriginal and Torres Strait Islander Emotional and Social Well-Being (Mental Health) Action Plan* being implemented at the national level.
- Further development and evaluation of funding models for mental health services.
- Development and evaluation of work based programs providing information on early intervention and appropriate referral mechanisms.

Quality and Effectiveness

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Population outcomes preferably using nationally agreed measures.

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

Outcomes

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

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

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

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

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

- Improved service responses and individual clinical outcomes for consumers.

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

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

Strategies

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

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

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

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

E Conclusion

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

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

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

F Glossary of Terms and Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The renewed National Mental Health Strategy will comprise:

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

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

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

Standards - Clinical and Service

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

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

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national mental health strategy

National Mental Health Plan 2003–2008

Australian Health Ministers, July 2003

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foreword

1992 represented an historic turning point for mental health policy and service delivery in Australia. Recognising the need for a unified, dedicated reform agenda, governments in Australia came together to endorse the principles and the plan for reform under a National Mental Health Strategy.

This commitment by the Australian Government and State and Territory governments to a national framework of reform has underpinned significant change in how services are provided to people with a mental illness, their families and communities. Since the first National Mental Health Plan in 1993, the mental health system has strengthened its capacity to respond to the needs of people with mental illness through major shifts in the settings and workforce that provide care. The development of national information and research has spearheaded improved understanding of mental illness, its causes and impact at a personal, social and economic level. Significant efforts have been made to combine mental health services within the general health system and a community-based system of treatment and support.

There has also been considerable development in the emphasis in mental health care, from a focus only on treatment to consideration of prevention, early intervention, rehabilitation and recovery.

The next five years provide an important opportunity to build upon the policy platform that has been put in place so firmly over the past decade. A whole-of-government, cross-sectoral approach will put the policies into practice, improving the mental health of the Australian community, and improving the care of people with mental illness across the lifespan.

In the National Mental Health Plan 2003–2008, four priority themes are addressed through 34 outcomes. These themes emphasise mental health promotion and prevention, increasing responsiveness to consumers and carers across all mental health and related services, strengthening quality, and fostering research and innovation across the sector for sustainable programs and services.

Ultimately, the Strategy seeks to engage all members of the community in a partnership to improve the mental health of the Australian community. The 2003–2008 Plan will see partnerships with other sectors such as housing, education, welfare, justice and employment, to assist with the recovery of those experiencing mental health problems and mental illness.

In seeking to achieve these goals, all Health Ministers have committed to working together through the National Mental Health Plan 2003–2008, building on the foundations of the last decade in improving the mental health of all Australians.

The Hon. Wendy Edmond
Chair, Australian Health Ministers' Conference 2003
Minister for Health, Queensland
August 2003

introduction

1

A vision for mental health

Good mental health is fundamental to the wellbeing of individuals, their families, and the whole population. Conversely, mental health problems and mental illness are among the greatest causes of disability, diminished quality of life, and reduced productivity. People affected by mental health problems often have high levels of morbidity and mortality, experiencing poorer general health and higher rates of death from a range of causes, including suicide. These conditions are significant in terms of prevalence and disease burden, and have far-reaching impacts for families, carers and others in the community.

Given our current state of knowledge, it is not reasonable to expect that everyone will experience good mental health all the time, nor that the population will ever be totally free of mental health problems and mental illness. However, all people in Australia – regardless of their age, gender, socioeconomic status, ethnicity or cultural background – have certain legitimate expectations regarding their mental health.

Mental health should be understood within a population health framework that takes into account the complex influences on mental health, encourages a holistic approach to improving mental health and wellbeing, and develops evidence-based interventions that meet the identified needs of population groups and span the spectrum from prevention to recovery and relapse prevention.

People's day-to-day environments, including their homes, schools and workplaces, should promote mental health, and not be detrimental to it.

When a person's mental health is at risk, service systems should be equipped to intervene early. Those who do experience mental health problems and mental illness, along with their families and carers, should have timely access to a range of high-quality and effective inpatient and community services, regardless of where they live. These services should provide continuity of care, adopt a recovery orientation and promote wellness. The mental health workforce should be equipped to deliver services in a manner that is respectful and meets consumers' and carers' needs.

The mental health system should take a lifespan approach to meeting the needs of the population. It should recognise the differing experiences of consumers and carers across the lifespan from childhood to old age. The needs of children with or at risk of mental health problems and children of parents with a mental illness should be afforded the same attention as adult consumers and carers.

Mental health, mental health problems and mental illness

Mental health is a complex domain where diverse views exist and where terms are used in different ways, which can sometimes lead to misunderstandings. The National Mental Health Plan 2003–2008 uses certain central terms in the following ways.

Mental health is a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential.[1] It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities.[2] Mental health is not simply the absence of mental illness. Its measurement is complex and there is no widely accepted measurement approach to date. The strong historical association between the terms 'mental health' and 'mental illness' has led some to prefer the term 'emotional and social wellbeing', which also accords with holistic concepts of mental health held by Aboriginal peoples and Torres Strait Islanders and some other cultural groups,[3] or alternatively, the term 'mental health and wellbeing'.

Mental health problems and mental illness refer to the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people. The term mental illness is synonymous with mental disorder. The term mental illness is used throughout the Plan, as it is the term preferred by many consumers. Use of the word 'illness' emphasises that people with mental illness have legitimate health care rights and needs, equivalent to those afforded to consumers of health care for physical illnesses.

A mental illness is 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, Fifth Edition (DSM-IVR)[4] or the International Classification of Diseases, Tenth Edition (ICD-10).[5] These classification systems apply to a wide range of mental disorders (for the DSM-IV) and mental and physical disorders (for the ICD-10).

Not all the DSM-IV mental disorders are within the ambit of the National Mental Health Plan 2003–2008. In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and have a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their comorbidity with mental illness.

Mental health problems also interfere with a person's cognitive, emotional or social abilities, but to a lesser extent than a mental illness. Mental health problems are more common mental health complaints and include the mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental illnesses, but may develop into mental illness. The distinction between mental health problems and mental illness is not well defined and is made on the basis of severity and duration of symptoms.

Recognising that mental health and mental illness are on a continuum, the National Mental Health Plan 2003–2008 considers ways to improve mental health, as well as ways to reduce the prevalence and burden of mental health problems and mental illnesses.

The human rights of all people in Australia should be respected. Individuals should not be discriminated against in housing, law, employment or education. Mental health problems and mental illness should not be stigmatised in the media, by the general community or by mental health services themselves.

Politicians, policy-makers, planners, managers and service providers – across a range of sectors – should put mental health high on the agenda, and consumers, families and carers should be able to genuinely participate as equal partners in national, State/Territory and local decision-making that affects their quality of life.

The National Mental Health Strategy

The National Mental Health Plan 2003–2008 builds on the work of two previous Plans. In 1992, Australian Health Ministers agreed to a National Mental Health Policy,[6] implemented under a five-year National Mental Health Plan.[7] This represented the first attempt to coordinate mental health care reform through national activities. The Plan focused on State/Territory-based public sector, specialist mental health services. It increased the emphasis on community-based care, decreased reliance on stand-alone psychiatric hospitals, and 'mainstreamed' acute beds into general hospitals.[8] At the end of 1997, Australian Health Ministers endorsed the further development of the original reform agenda under the Second National Mental Health Plan.[9] The Second Plan was developed within the framework of the existing National Mental Health Policy, and was designed to consolidate ongoing reform activities and expand into additional areas of focus. It built on the First Plan by adding a focus on mental health promotion and mental illness prevention, and attending to the question of how the public mental health sector could best dovetail with other sectors (e.g. private psychiatrists, general practitioners, the general health sector) and beyond (e.g. emergency services, non-government organisations) to maximise treatment outcomes and opportunities for recovery. Whereas the First Plan focused largely on severe and disabling low-prevalence illnesses, particularly psychoses, the Second Plan expanded the emphasis to include high-prevalence illnesses such as depression and anxiety disorders.

The Policy[6] and the First and Second Plans were outlined in separate documents,[7,9] and were underpinned by the Mental Health Statement of Rights and Responsibilities.[2] Funding from Schedule F1 of the Medicare Agreements supported the First Plan, and Schedule B funds from the Australian Health Care Agreements assisted the implementation of the Second Plan. Together, these are known as the National Mental Health Strategy. The broad aims of the National Mental Health Strategy remain consistent. They are:

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

Priority areas under the First and Second National Mental Health Plans

Priority areas under the First National Mental Health Plan were:

- Consumer rights
- The relationship between mental health services and the general health sector
- Linking mental health services with other sectors
- Service mix
- Promotion and prevention
- Primary care services
- Carers and non-governmental organisations
- Mental health workforce
- Legislation
- Research and evaluation
- Standards
- Monitoring and accountability

Additional priority areas under the Second National Mental Health Plan were:

- Promotion and prevention
- The development of partnerships in service reform
- The quality and effectiveness of service delivery

Evaluations were undertaken at the end of each of the previous Plans. These involved a number of components, including widespread community consultation, commentary by international experts, and data from the National Mental Health Report. Together, these evaluations suggest that substantial reform has been achieved and the shape of mental health services has been irrevocably altered. The mental health system has strengthened its capacity to respond to the needs of people with mental illness by moving towards the provision of mental health care within the mainstream health system and through community care. Furthermore, the nature of the workforce providing mental health care has changed substantially: the role of primary care, which includes general practice, is acknowledged as a critical area complementing the specialist mental health workforce. The mental health agenda has been broadened from a focus on treatment to incorporating the entire spectrum of interventions, including mental health promotion, the prevention of mental health problems and mental illness, early intervention, and rehabilitation and recovery.

The complexity of the reform process has become increasingly evident. To reform, reshape and redefine mental health care in Australia is an ambitious undertaking. The first ten years of reform have seen an impressive start in terms of policy, but there is much still to be achieved in terms of implementation. The impetus for action with regard to consumer rights has moved from concern over open human rights abuses to awareness of problems of neglect. While formal mechanisms for consumer and carer participation have been put in place, these do not comprise the meaningful participation that is required. Community expectations are now higher regarding access to quality mental health care, and have moved beyond the basic hopes held at the time of the adoption of the National Mental Health Policy in 1992. Australians now expect a timely, respectful, individualised and holistic approach to their mental health care, coordinated within the mainstream health system and delivered in accord with cultural and developmental needs. There is much yet to be done in terms of funding, researching, planning, delivering and reporting on mental health care to realise this expectation.

The evaluation of the First National Mental Health Plan recommended the Second Plan. The evaluation of the Second Plan found support for the renewal of the National Mental Health Strategy, in the form of the development of a third National Mental Health Plan.

The National Mental Health Plan 2003–2008

The National Mental Health Plan 2003–2008 consolidates the achievements of the First and Second Plans, addresses gaps identified in both, and takes the National Mental Health Strategy forward with restated and new directions. It can be viewed as an ongoing agenda for service and community development that sets priorities for 2003–2008. It represents a partnership between the key stakeholders in mental health.

scope of the national mental health plan 2003–2008

2

Renewing the National Mental Health Strategy: the policy framework

The overarching aims of the National Mental Health Strategy outlined in the previous section have not changed, and guide the National Mental Health Plan (2003–2008). The policy aims are sufficiently broad in scope to allow for the consolidation of existing reform activities and for strengthening the focus in areas of particular significance.

Like its predecessors, the Plan also encompasses the seminal principles contained in the Mental Health Statement of Rights and Responsibilities.[2] This embodies the values of the United Nations Resolution 98B (Resolution on the Protection of Rights of People with Mental Illness) and outlines the philosophical underpinning of the National Mental Health Strategy on civil and human rights.

As noted, the First and Second National Mental Health Plans were, in part, operationalised through Schedule F of the Medicare Agreements (1993–1998) and Schedule B of the Australian Health Care Agreements (1998–2003), respectively. These bilateral funding agreements between the Commonwealth and each State and Territory have provided crucial financial support for the Plans, and have contributed to the successful outcomes of the National Mental Health Strategy to date.

Striking the optimal balance

The National Mental Health Plan (2003–2008) builds on the priorities of both the First and Second Plans. It consolidates existing reforms, begun under the first two Plans, which have been regarded as consistent with international best practice. At the same time, it strengthens the focus in areas of particular significance. Strong commitment to the national agenda by the Australian and State/Territory governments is necessary to capitalise on earlier achievements and to address identified priorities, so that all Australians can benefit. It recognises that some initiatives will bear fruit within the next five years, while others will lay the groundwork for achievements that may take much longer. The new Plan does not seek to specify projects to be funded within the new reform agenda, but rather to identify priority areas of work within an agreed policy framework. It also does not provide details of all the developments and initiatives that have taken place in the last decade, as these are contained in other documents.[10,11]

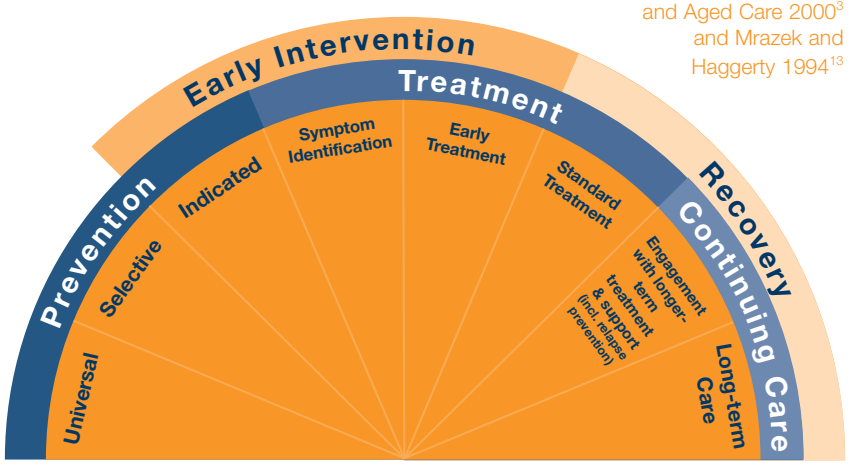
Adopting a population health framework

The National Mental Health Plan 2003–2008 adopts a population health framework. This framework is based on an understanding that the influences on mental health occur in the events and settings of everyday life. It recognises that health and illness result from the complex interplay of biological, psychological, social, environmental and economic factors at all levels – individual, family, community, national and global. The determinants of mental health status, at the population level, comprise a range of psychosocial and environmental factors, including income, employment, poverty, education and access to community resources, as well as demographic factors. The population health framework recognises the importance of mental health issues across the lifespan, from infancy to old age, and across diverse groups within the population. It recognises the contribution of physical health to mental wellbeing and the effect of mental health on physical health. It also recognises the effect of mental illnesses occurring comorbidly with drug and alcohol problems and other conditions. The corollary of this is that a population mental health approach recognises that effective linkages must be forged with other sectors in order to achieve collaborative planning in a way that builds capacity and takes account of local needs and circumstances.[3,12]

The framework also stresses the importance of monitoring mental health and mental illness within populations – both at single points in time and longitudinally – in order to describe the epidemiology of given mental illnesses and to provide information to match the level and type of interventions to population needs. This recognises the importance of mental health issues across the lifespan and in those with diverse and complex needs.[12] This epidemiological information is crucial to determining the impact of policies and programs on rates of mental health problems and mental illness and their associated disability. In addition, it provides a picture of unmet need for services. It is essential, within a population health approach, that interventions are supported by an appropriate evidence base, and informed by ongoing monitoring and evaluation. In order for this to occur, it is necessary to develop an overarching research and evaluation agenda and to build capacity in research and evaluation at a local level.

Within the population health framework, the Plan recognises that interventions to promote mental health and reduce the impact of mental health problems and mental illness must be developed relevant to the needs of population groups. These interventions must be comprehensive, encompassing the entire spectrum of interventions from prevention to recovery and relapse prevention (see Figure 1). They should be viewed as complementary. Prevention and promotion efforts are necessary complements to, and not substitutes for, core clinical and community support services. Only a balance of interventions across the entire spectrum can meet the diverse needs of population groups and thus impact on incidence, prevalence, morbidity, mortality and other factors associated with mental health problems and mental illness.

Figure 1. Spectrum of interventions for mental health
Source: adapted from Commonwealth Department of Health and Aged Care 2000[3] and Mrazek and Haggerty 1994[13]



Aims

The aims of the National Mental Health Strategy remain an appropriate guide to change. To reiterate, these aims are:

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

Principles

The following principles underpin the reform process and are fundamental to realising the above aims.

All people in need of mental health care should have access to timely and effective services, irrespective of where they live

Australia's universal health care system guarantees access to basic health care (including mental health care) as a fundamental right. Individuals in need of care should not only have timely access to such care, but the services they receive should be of a quality that is at least consistent with other developed countries, if not better. Access to and quality of care should be equitable, and people should not be disadvantaged by, for example, being on a relatively low income, having particularly complex needs or living in a rural area. These principles of access and equity require governments to take responsibility for planning and regulating mental health care, providing services through a mixture of public and private delivery and financing systems.

The rights of consumers, and their families and carers, must shape reform

The rights of consumers and carers in policy, planning and delivery of mental health services should be protected. Consumers, and their families and carers, should be empowered to fully and meaningfully participate at all levels, including in individual treatment plans, service delivery, planning and policy. Sometimes the approach required to address the rights of consumers and carers will be uniform across both groups. At other times, tailored approaches will be required for each group, or for subgroups within them, such as children and adolescents who either are experiencing mental health problems themselves or have a parent with a mental illness.

Mental health care should be responsive to the continuing and differing needs of consumers, families and carers, and communities

Mental health care should be responsive to needs as they vary across the lifespan, recognising that the needs of children and adolescents differ from those of adults, which differ from those of older people. It should be responsive to the needs of consumers as they vary across the course of an illness. It should be culturally appropriate and safe. It should be responsive to the unique needs of specific population groups, including people who live in rural and remote communities, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and people with complex needs.

The quality and safety of mental health care must be ensured

Monitoring of and accountability for the quality and safety of mental health care is essential to ensuring the rights of consumers, families and carers, and the community. Priority should be given to implementing the National Mental Health Standards,[14] and operationalising data collection systems that can inform decisions related to quality and safety. Furthermore, information and information systems need to be available, and outcome measures should be developed that are agreed on in consultation with all those individuals and groups likely to be affected.

A recovery orientation should drive service delivery

Recovery has been defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and, or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability'[15]. Recovery is both a process and an outcome and is essential for promoting hope, wellbeing, and a valued sense of self-determination for people with mental illness. A recovery orientation emphasises the development of new meaning and purpose for consumers and the ability to pursue personal goals. Mental health service providers should operate within a framework that supports recovery.

Investment in the workforce is essential

The nature of the workforce providing mental health care in Australia has changed substantially over the last decade. The specialist mental health sector, including public and private providers, still has a crucial role to play, but the primary care sector is now acknowledged as a critical element. In terms of professional groups, the workforce is now diverse, and includes psychiatrists, nurses, psychologists, social workers, occupational therapists, other allied health providers, general practitioners and Aboriginal and Torres Strait Islander health workers.

The supply, distribution and composition of the mental health workforce are fundamental to quality services. Not only should the overall size of the workforce match community needs, its distribution must be right. Balancing the composition of the mental health workforce is important. This should aim for an appropriate mix of medical, nursing and allied health professionals, providers from the specialist mental health sector and the primary care sector, public and private sector providers, and inpatient and community workers. These providers should represent an optimal mix of professions and skills, and should foster a team approach to service provision.

Beyond this, consideration must be given to who comprises the workforce and how the workforce is used. This requires new and innovative perspectives on who can best contribute to improving mental health.

The attitudes, knowledge and skills of the mental health workforce are also fundamental to the improvement of mental health services. A mental health workforce that actively works against stigma and discrimination is fundamental. The workforce should be prepared to work within genuine partnership models, particularly with consumers and carers. The workforce also needs to be highly skilled and knowledgeable and be able to work within a shared understanding of best practice and evidence.

Addressing workforce issues is important for the mental health of the workforce itself. It is important to strive for a workforce that is equipped to provide the services demanded of it, is not stretched beyond its capacity, and is valued by consumers, carers and the community.

Innovation must be strongly encouraged and supported

There is much yet to learn about the causes and treatment of mental health problems and mental illness and the delivery of mental health care. High priority should be given to research into the aetiology of mental illness, new treatments (biological, psychological and social), and ways to reduce risks for mental health problems and increase resilience. New models of service delivery and improved interventions that are more responsive to diversity of need should also be developed and evaluated for their effectiveness and cost-effectiveness.

Sustainability of effective interventions must be ensured

Approaches that are evidence-based in methodologically sound evaluations should be sustained and replicated in other settings (tailored to local need as appropriate). Conversely, approaches that are not based in evidence should not continue to be supported. This cycle of innovation, research/evaluation and sustainability will contribute to building an evidence base to inform best practice.

Resources for mental health must recognise the impacts of mental health problems and mental illness

Mental health warrants a resource base that reflects the impacts of mental health problems and mental illness on individuals, their families and carers, and the community. Resources are necessary to support the reduction of these impacts, and should be related to defined need. Resources should be directed at services and interventions – across the spectrum from mental health promotion and mental illness prevention to recovery and relapse prevention – for which there is evidence of effective outcomes. Strategies to manage demand and increase service efficiency and effectiveness need to be developed.

Mental health reforms must occur in concert with other developments in the broader health sector

There is a complex interplay between mental and physical health and responsibility for mental health should extend beyond the mental health sector. For example, reforms that relate to improving access to mental health services for Aboriginal and Torres Strait Islander people should be aligned with the Social and Emotional Wellbeing Framework being developed by the Social Health Reference Group, which deals with Aboriginal and Torres Strait Islander-specific services as well as general mental health services and services in other sectors.

Mental health reforms require a whole-of-government approach

Improving the mental health of Australians cannot be achieved within the health sector alone. A whole-of-government approach is required which brings together a range of sectors that impact on the mental health of individuals, such as housing, education, welfare and justice. Together, these sectors have an important role to play in promoting the mental health and wellbeing of the general population, and assisting with the recovery of those experiencing mental health problems and mental illness. Partnerships with these other sectors must be fostered, in order to develop a broader, whole-of-government approach to mental health that promotes positive reforms. As an example, the mental health sector should provide targeted support to other sectors to develop mental health impact statements for given initiatives.

Priority themes

The new Plan is guided by four priority themes:

- Promoting mental health and preventing mental health problems and mental illness
- Increasing service responsiveness
- Strengthening quality
- Fostering research, innovation and sustainability

roles, responsibilities and accountability

3

Roles and responsibilities

The National Mental Health Plan (2003–2008) provides a national policy and implementation framework for a coordinated national approach to improving Australia's mental health. It represents a commitment to this framework by all Health Ministers. It recognises that a number of areas within given Australian Government and State/Territory health departments have responsibilities for mental health, and have key roles to play. In addition, it represents an acknowledgement by Health Ministers that they need to work with their counterparts in other portfolios in order to achieve the aims stated in the Plan. The policies of other sectors, such as housing, employment, justice, welfare and education, can have a significant mental health impact. Agencies responsible for promoting human rights, such as the Human Rights and Equal Opportunity Commission and State/Territory anti-discrimination authorities, also have an important role to play. This Plan is seeking to improve Australia's mental health through linkages with these other areas of public policy, including with areas aimed at promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

This Plan represents a commitment by the Australian Government to take forward the mental health agenda within the Federal jurisdiction. It also represents a commitment by the Australian and State/Territory governments to apply mental health funding to develop services in a manner consistent with the aims of the renewed National Mental Health Strategy.

In reaffirming a commitment to the National Mental Health Strategy, State and Territory governments undertake to:

- Work with the private and non-government sectors, and with consumers and carers, to plan for, organise, fund and either deliver or purchase a comprehensive mix of mental health services and/or programs that:
  - reflect the spectrum of care from mental health promotion and mental illness prevention to rehabilitation and recovery;
  - provide access to a range of appropriate inpatient and community services;
  - are culturally appropriate and safe; provide continuity of care across the lifespan, catering for children and adolescents, adults and older people;
  - promote access for all people in Australia; and cater for specific population groups, including people who live in rural and remote communities, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and people with complex needs
- Manage resources within mental health services and/or programs to reflect national and State/Territory policies and responsiveness to local need and circumstances
- Strengthen mechanisms to facilitate the genuine participation of consumers, families and carers in decision-making at all levels
- Ensure linkages at the State/Territory, area/regional and service delivery levels of mental health services and/or programs and other general health and community initiatives
- Provide comprehensive data on mental health service delivery and reform activities for national reporting
- Support mental health research and evaluation, with a view to developing a sound evidence base

In reaffirming a commitment to the National Mental Health Strategy, the Australian Government undertakes to:

- Finance and administer programs, consistent with Commonwealth and State/Territory funding arrangements (e.g., Medicare Benefits Schedule, Pharmaceutical Benefits Schedule, the Australian Health Care Agreements and income support payments)
- Ensure people with mental health problems and mental illness and their families and carers are not discriminated against in gaining access to health care, community support, justice, employment and training opportunities, and other programs which are the responsibility of the Australian Government
- Foster linkages with relevant national reform agendas and partnerships with national stakeholders
- Strengthen mechanisms to facilitate the genuine participation of consumers, families and carers in decision-making at all levels
- Foster the development of mental health research and evaluation, with a view to developing a sound evidence base, and disseminate information regarding good practice models of mental health service delivery
- In consultation with the States and Territories, seek to ensure an adequate supply of high-quality mental health personnel through targeted education and training development

In addition to these specific undertakings within their own jurisdictions, the Commonwealth and States/ Territories will work with each other, and with consumers, their families and carers, and the community to further the mental health agenda in Australia.

Consistent with the First and Second National Mental Health Plans, and to ensure that ongoing priority is accorded to mental health issues, a Working Group will be established which will oversee implementation of the renewed National Mental Health Strategy. The Working Group will include consumer and carer representation, and its remit will be to:

- Provide a forum to promote the renewed National Mental Health Strategy and monitor the implementation of the Plan
- Consider and make recommendation on, emerging mental health issues, and report to Health Ministers as appropriate
- Provide key stakeholder perspectives on priorities and approaches for national projects funded by the Commonwealth under the renewed National Mental Health Strategy
- Involve national stakeholders and other relevant organisations, agencies and individuals as appropriate
- Initiate action to evaluate the Plan

Accountability

Clear and transparent accountability regarding resource use and service quality is essential. This was a major theme emerging from the evaluation of the Second National Mental Health Plan,[16] particularly from consultations conducted by the Mental Health Council of Australia.[17] Appropriate mechanisms are required to ensure accountability for the expenditure of mental health resources, for the processes of service development, and for the achievement of outcomes. These mechanisms need to straddle sectors at both the Commonwealth and the State/Territory level, as well as at the service delivery level, and should be part of a process of continuous quality improvement.

National monitoring is important, and should occur through continued national reporting, and through independent evaluation of the Plan, described later. At the same time, States and Territories should develop their own monitoring systems, relevant to their responsibilities.

Specific and measurable indicators of achievement in each of the four priority themes identified in the Plan should be agreed on early in its life. Methods should be established whereby national and State/Territory data can be collected to inform progress against these criteria, focusing on the broad outcomes identified.

At a service delivery level, greater transparency is required in order for consumers, carers and the community to be regularly informed about the quality, effectiveness and cost-effectiveness of care. Indicators need to regularly report on critical aspects of services, such as waiting times and consumer and carer experiences of service delivery. Public reporting of a range of indicators should be encouraged as part of the accountability process. Other approaches to increasing accountability at a service delivery level include ongoing implementation of consumer outcome measures that can be used routinely, and the full implementation of the National Mental Health Standards.[14]

priority themes

4

As noted earlier, the activities of the National Mental Health Plan (2003–2008) are guided by four priority themes:

- Promoting mental health and preventing mental health problems and mental illness
- Increasing service responsiveness
- Strengthening quality
- Fostering research, innovation and sustainability

For each priority theme, outcomes and key directions for achieving these outcomes are identified. These outcomes and key directions represent agreed areas of focus to be addressed by governments. In some cases, the responsibility for the achievement of the outcomes lies with the Australian Government; in others, it lies with State/Territory governments. This reflects the complexity of mental health care delivery in Australia, where the Australian Government is responsible, for example, for funding private psychiatrists and general practitioners, and the State/Territory governments are responsible, for example, for the provision of public sector mental health services. Often the achievement of given outcomes will be dependent on the Australian and State/Territory governments working with each other, as well as with service providers, consumers, their families and carers, communities and other key stakeholders.

In outlining these outcomes and key directions, the Plan recognises that different jurisdictions have already progressed the mental health agenda, but have done so at different paces and in different areas. The Plan represents an effort to build on existing developments, taking account of the points different jurisdictions have reached and recognising that some outcomes and key directions are dependent on the achievement of others. It acknowledges that different jurisdictions should have the flexibility to prioritise the key directions required to achieve given outcomes, on the basis of their own local needs. It also recognises that some jurisdictions may add their own key directions, again in response to local needs. Monitoring and evaluation will target these broad outcomes.

Promoting mental health and preventing mental health problems and mental illness

The National Mental Health Plan 2003–2008 continues the work begun under the Second National Mental Health Plan (progressed through the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health[3] and the LIFE Framework[18]) in the areas of mental health promotion, and mental illness and suicide prevention.

Promoting mental health

Mental health promotion aims to protect, support and sustain the emotional and social wellbeing of the population, from the earliest years through adult life to old age. It should address people who are currently well, those at risk of developing a mental health problem, and those experiencing mental health problems or mental illness.

A range of factors influences mental health. Public policies in sectors such as health, housing, welfare, education, employment, justice and corrections, art, sport and recreation, and the media impact on mental health. Supportive social, economic, educational, cultural and physical environments provide a basic framework for developing and maintaining mental health, particularly for children and adolescents whose early experiences shape their later mental health. Communities that recognise and accept diversity also contribute to social and emotional wellbeing. Communities in which people feel involved, included and empowered to influence decisions that affect them are supportive of mental health.

Knowledge about risk and protective factors for mental health, symptoms of mental health problems and mental illness, and sources of help and self-help contribute to emotional resilience. Such knowledge is also essential in order to dispel the stigma of mental illness. The media have a major role to play in community education regarding mental health, but there are opportunities for all sectors to contribute to improving the mental health knowledge and skills of individuals, groups and communities. Settings such as schools, workplaces, primary care and community organisations are particularly suitable for such education.

Much of the activity in mental health promotion needs to occur beyond the system of direct mental health service provision, in other sectors that impact on the daily lives of individuals and communities. However, those who work in mental health have an important role to play in engaging these other sectors and alerting them to their capacity to impact positively upon mental health. Mental health services need to embrace mental health promotion in their own settings, by adopting a recovery orientation for consumers. Furthermore, mental health services should consider their wider role in terms of promoting mental health. Attitudes of the mental health workforce can perpetuate the stigma of mental illness. Improved attitudes towards consumers, their families and carers, along with continuous professional development that emphasises the priority of consumer rights and participation, are urgently needed.

Outcome 1: Increase in the extent to which mental health promotion is incorporated into policy and planning, at Commonwealth, State/Territory and local levels

Key direction 1.1: Seek commitment from relevant Australian, State and Territory government departments to incorporate mental health promotion into their policies and activities, where relevant

Outcome 2: Increase in the extent to which mental health and social and emotional wellbeing is promoted within communities

Key direction 2.1: Work with communities to increase their capacity to support active participation by all members and to foster environments that promote mental health.

Outcome 3: Increased levels of mental health literacy in the general community and in particular settings, and decreased levels of stigma experienced by people with mental health problems and mental illness

Key direction 3.1: Build on initiatives aimed at raising community awareness about mental health, mental health problems and mental illness

Key direction 3.2: Develop new and innovative programs and continue to support existing programs aimed at increasing mental health literacy and resilience, delivered in specific settings

Key direction 3.3: Further promotion of accurate portrayal of mental health problems and mental illness in the media

Key direction 3.4: Support anti-discrimination initiatives aimed at identifying and combating the impact of racism on the wellbeing of Aboriginal and Torres Strait Islander populations, and people from culturally and linguistically diverse backgrounds

Outcome 4: Increased extent to which mental health services adopt a recovery orientation

Key direction 4.1: In collaboration with consumers and their families and carers, encourage mental health services to work in ways that promote mental health

Key direction 4.2: Increase the capacity of consumers to take charge of their own care, through self-help resources, culturally appropriate training packages, networks and advocacy agencies

Key direction 4.3: Increase the capacity of mental health services to more appropriately support consumer and carer participation, for example by identifying roles where consumer and carer employment within mental health services is important to a recovery orientation

Key direction 4.4: Work with the employment and training sectors, and with businesses, to support and enhance the employment of consumers and carers

Preventing mental health problems, mental illness and suicide

Endeavouring to prevent mental health problems, mental illness and suicide involves understanding the factors that heighten the risk of these occurring and the factors that are protective against them, identifying the groups and individuals who can potentially benefit from interventions, and developing, disseminating and implementing effective interventions across the lifespan.

Risk factors increase the likelihood that a mental health problem will develop and exacerbate the impact of existing problems. Risk factors can reside within the individual or within the family, social network, community or institutions that surround the individual. Protective factors give people resilience in the face of adversity. They moderate the impact of stress and transient symptoms on emotional and social wellbeing. Like risk factors, protective factors derive from all domains of life.

An understanding of risk and protective factors enables preventive interventions to be targeted. Preventive interventions can be targeted universally at the general population, selectively at population subgroups or individuals whose risk of developing mental health problems or mental illness is significantly higher than average, or as indicated by the needs of high-risk individuals, such as those with early signs and symptoms of mental health problems and mental illness.

Most of the risk and protective factors for mental health problems, mental illness and suicide lie outside the ambit of mental health services, in sectors that impact on the daily lives of individuals and communities. Changes to risk and protective factors generally require long-term sustained efforts across multiple sectors of the community and government; these changes cannot be achieved by the mental health sector alone. Instead, the mental health sector must forge partnerships with other sectors in order to develop successful interventions that favourably shift risk and protective factors.

Having said this, there is much that the mental health sector can achieve within its own ambit. Mental health services need to be aware of the risk and protective factors within their own sphere of influence, particularly for groups such as Aboriginal and Torres Strait Islander people. Mental and general health services must recognise the interdependency of physical and mental health, and be aware of the potential impact of physical conditions on mental health and vice versa. General practitioners may be particularly well placed in this regard, given their role in providing for consumers' interwoven mental and physical health care needs. Mental health services must also be aware of the increased risk to the mental health of the children, families and carers of consumers, and have some responsibility for interventions that reduce risk and increase protective factors for these people.

Outcome 5: Increased capacity of communities to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk

Key direction 5.1: Continue the initiatives put in place through the National Mental Health Promotion, Prevention and Early Intervention Action Plan[3]

Key direction 5.2: Consolidate the evidence base from Australia and overseas on risk and protective factors, conduct high-quality research to address gaps in knowledge, conduct methodologically appropriate evaluations of universal, selective and indicated interventions across the lifespan and for different population groups, and widely disseminate the findings of this work in a nationally coordinated manner

Key direction 5.3: Implement evidence-based universal, selective and indicated interventions in collaboration with other sectors

Key direction 5.4: Support and encourage specialist mental health services, primary care services and general health services to respond to risk and protective factors and to early signs and symptoms in their own settings

Outcome 6: Reduction in suicidal behaviours, reduction in risk factors for suicidal behaviours, and enhancement of protective factors for suicidal behaviours

Key direction 6.1: Recognise and enhance the synergy between national and State/Territory-based strategies aimed at reducing suicide and enhancing mental health

Key direction 6.2: Promote activities aimed at reducing risk factors and enhancing protective factors for suicidal behaviours for the general community and for groups at heightened risk, such as Aboriginal and Torres Strait Islander people

Improving service responsiveness

Since the advent of the National Mental Health Strategy, the complexion of mental health service delivery has changed considerably. The system is no longer based on large stand-alone psychiatric institutions, and now mainly provides care within the mainstream health system and primarily through community-based services, in both the public and private sectors. Although this represents a major achievement in policy and planning terms, the evaluation of the Second National Mental Health Plan,[11] and, in particular, the consultations undertaken by the Mental Health Council of Australia,[17] reported the need to improve services to be more responsive to consumers, their families and carers across all age groups. Restricted access, poor continuity and lack of support for carers were specifically highlighted. This Plan continues to address the ongoing challenge of improving service responsiveness, focusing specifically on issues of access, continuity of care and support for carers.

Access to care

Consumers and their families and carers should be able to access services appropriate to their needs, both within and beyond the specialist mental health sector. Services should be responsive to those with mental health needs in all population groups and across the lifespan. Equitable access depends upon an appropriate level, mix and distribution of services. This poses challenges, especially given the demographic and geographical variations between jurisdictions.

Access issues can arise across the continuum of care, but there are certain points where access is particularly problematic. Public sector access to acute care (e.g., acute inpatient units and crisis assessment teams) is an area of concern, as is access to early intervention services, access to extended, community-based residential care, and access to recovery, rehabilitation and relapse prevention programs. Consumers have expressed a desire for access to a wider range of inpatient replacement services in the private sector. Access to general practitioners – who are often the first point of access for people with mental health problems and perform an important role in providing ongoing physical and mental health monitoring and care – is also problematic, due to reductions in bulk-billing, a maldistribution of the general practitioner workforce, and support for general practitioners to provide mental health care.

Non-government organisations have performed a key role in providing support services for those with mental health problems and mental illness, in advocating for services to be more responsive, and in educating and supporting carers. While the demand on non-government mental health organisations has increased significantly over the past decade, their funding base remains limited.

Beyond mental health services, consumers experience persistent inequities regarding access to some of the support services that are essential to recovery and which impact on their capacity to manage in the community. These services include accommodation, disability, income support, education and training, and employment services.

Certain groups in the community encounter specific access challenges due to cultural, linguistic and geographical barriers, and service gaps. These groups include Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people using forensic services, and people living in rural and remote areas. In addition, those with complex needs are not optimally served. People with comorbid conditions, particularly comorbid substance use disorders, but also intellectual disability and physical illness and disability, often have complex needs that require a coordinated response from multiple service sectors.

Outcome 7: National agreement on the broad levels and mix of services necessary to align current and future supply of and demand for mental health care across the lifespan

Key direction 7.1: Develop State/Territory-level empirical modelling of factors affecting supply and demand, which may include population surveys, service mapping exercises, and consultation with consumers, families, carers and providers

Key direction 7.2: Develop and implement plans to align supply with population need, taking into account available resources and the impact of diversity on models of care

Key direction 7.3: Consult with representatives from across the mental health sector, including, for example, public and private specialist mental health providers and primary care providers, to understand their workforce needs

Outcome 8: Improved access to acute care

Key direction 8.1: Develop a wider spectrum of acute care options in both the public and private sectors, to ensure timely response to people presenting for assessment, and prompt response to people assessed as being in need of acute care

Key direction 8.2: Increase the capacity of inpatient units, crisis assessment teams and emergency departments to provide assessments, triage/referral and acute care, through ongoing staff support and the promotion of evidence-based practice

Key direction 8.3: Improve linkages between acute inpatient units, crisis assessment teams and emergency departments, and between these services and other relevant providers, which may include general practitioners, private psychiatrists, private hospitals, ambulance services and the police

Key direction 8.4: Continue to support deinstitutionalisation activities, as necessary and appropriate

Outcome 9: Improved access to early intervention services

Key direction 9.1: Develop and implement evidence-based early intervention strategies for diverse population groups and a broad range of clinical conditions

Key direction 9.2: Provide incentives for providers in the public, private and non-government sectors to practise early intervention

Key direction 9.3: Develop and implement training programs for consumers, families and carers in understanding signs of illness, onset and relapse and timely access to services

Outcome 10: Improved access to a range of community-based care alternatives

Key direction 10.1: Extend community-based options for the delivery of care, which may include pre-admission and post-discharge support, and residential and community support, where appropriate

Outcome 11: Improved access to general practitioners and other primary care providers

Key direction 11.1: Ongoing support for existing programs in which general practitioners and other primary care clinicians (including, for example, community nurses, psychologists, social workers, occupational therapists, and other allied health providers) provide mental health care to the community

Key direction 11.2: Foster the development of primary care programs in which general practitioners and mental health professionals provide shared mental health care

Key direction 11.3: Strengthen linkages between general practitioners and providers within the specialist mental health sector (both public and private), in order to improve clinical support from and access to private psychiatrists, and shared care protocols

Key direction 11.4: Continue to develop strategies that enhance the role of general practitioners and other primary care providers in delivering mental health care, particularly in rural and remote areas

Outcome 12: Improved access to private psychiatrists

Key direction 12.1: Promote strategies that improve access to private psychiatrists, which may include improving referral pathways, increasing the timeliness of assessments and increasing the availability of out-of-hours services

Key direction 12.2: Expand shared care models between general practitioners, private psychiatrists and public sector providers

Key direction 12.3: Increase the participation of private psychiatrists in consultation-liaison services

Key direction 12.4: Improve access to private psychiatrists for people in rural and remote areas (e.g., through e-health)

Outcome 13: Increased access to recovery and rehabilitation programs

Key direction 13.1: Foster evidence-based recovery and rehabilitation programs within and outside clinical frameworks, and across the public, private and non-government sectors, which may include psychosocial, recreational and vocational programs

Key direction 13.2: Improve referral options for general practitioners and private psychiatrists in terms of recovery and rehabilitation programs offered in the public, private and non-government sectors

Outcome 14: Increased access to appropriate, long-term supported accommodation

Key direction 14.1: Develop and consolidate links with departments of housing

Key direction 14.2: Strengthen the capacity to meet the needs of marginalised groups, such as homeless people with mental health problems and mental illness

Outcome 15: Increased support and recognition of the role of non-government organisations

Key direction 15.1: Develop evidence-based models of service delivery to clarify the role and function of non-government organisations regarding support and advocacy, as well as psychosocial rehabilitation

Key direction 15.2: Continue development of the non-government sector to increase the capacity of non-government organisations to support consumers, families and carers

Outcome 16: Improved access to services for Aboriginal and Torres Strait Islander people

Key direction 16.1: Include Aboriginal and Torres Strait Islander people in mental health policy-making and planning

Key direction 16.2: Deliver mental health care through partnerships between mental health services and Aboriginal and Torres Strait Islander-specific health services, with Aboriginal and Torres Strait Islander people taking a lead role through the Social and Emotional Wellbeing Framework Agreement Partnership Forums

Key direction 16.3: Facilitate access for Aboriginal and Torres Strait Islander people to mental health services, which may include recognising the importance of early intervention in the primary care setting, increasing outreach services, and improving access to psychiatrists

Key direction 16.4: Improve the cultural appropriateness and safety of mental health service options for Aboriginal and Torres Strait Islander people, through enhancing knowledge of risk factors for Aboriginal and Torres Strait Islander people, improving cultural awareness for the mental health workforce, addressing workforce issues for Aboriginal and Torres Strait Islander health and mental health workers, and supporting community initiatives

Key direction 16.5: Improve linkages between mainstream mental health services and general practitioners, and Aboriginal and Torres Strait Islander health services and drug and alcohol services

Key direction 16.6: Support the implementation of the Social and Emotional Wellbeing Framework, once agreed upon

Key direction 16.7: Drawing on the Social and Emotional Wellbeing Framework and this Plan, support the development and implementation of State and Territory Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Plans

Outcome 17: Improved access for other population groups of all age groups with diverse and complex needs

Key direction 17.1: Develop State/Territory Plans to address issues of access for groups who are disadvantaged by geography, demographic factors, cultural and linguistic diversity, or clinical conditions

Key direction 17.2: Provide a broader range of options for mental health care for these groups, by improving linkages between mainstream mental health services and population-specific services, which might include forensic services, transcultural services, youth services, aged care services, or homeless services

Key direction 17.3: Provide better linkages between the mental health and general health sectors in order to improve access to mental health services for people with physical health conditions and to improve access to physical health services for people with mental illness

Outcome 18: Equitable access to housing, employment services, disability services, social services, education and justice

Key direction 18.1: Foster linkages with other key sectors via joint policy and planning initiatives, at Commonwealth, State/Territory and local service delivery levels

Key direction 18.2: Clarify roles and responsibilities of different sectors

Key direction 18.3: Cooperate across sectors to increase the provision of effective and innovative services to people with mental health problems and mental illness

Continuity of care

Continuity of care remains a key challenge. It involves continuity across the course of illness, recognising that consumers will have different needs at different points in time. Continuity of care also encompasses the notion of coordination of services across the lifespan, and in the transitions between child and adolescent services and adult services, and between adult services and aged care services.

Continuity of care involves an integrated specialist mental health system with appropriate inpatient-community and public-private linkages. It also involves linkages between the specialist mental health sector and primary health care, between the mental health sector and the wider health system, and strong relationships with systems outside the health sector that provide support for people with mental health problems and mental illness. More than this, it requires appropriate and timely information transfer, with careful consideration of privacy principles. Continuity of care is not necessarily synonymous with continuous care, and may sometimes be episodic, involving good exit planning and contingency arrangements.

As with access, continuity of care will only be realised with agreement about the appropriate level, mix and distribution of services. Continuity of care requires maintenance of mainstreaming efforts in recognition of the interaction between mental and physical health, the development of care pathways that enable consumers, families and carers to move easily between services, and a recognition that consumers vary in terms of the complexity of their needs, and that their needs may change over time.

Outcome 19: Enhanced care pathways across the spectrum of care

Key direction 19.1: Document and implement nationally agreed, evidence-based care pathways (developed on the basis of empirical studies and consultation with consumers, families, carers and mental health professionals) that reflect the complexity of needs among different consumer groups and in different settings and take into account the different mix of services and service providers in different States and Territories

Key direction 19.2: Develop service eligibility criteria that are based on consumer needs, rather than service structure

Key direction 19.3: Explore the development of standard assessment processes and shared assessment and outcome tools for use within and across service sectors

Key direction 19.4: Improve linkages between the specialist mental health sector and the primary care sector, and between the public mental health sector and the private mental health sector

Key direction 19.5: Increase recognition of the impacts of physical health on mental health and vice versa, and improve the capacity of the mental health sector and the general health sector to deal with this complex interrelationship

Outcome 20: Improved access to services across the lifespan

Key direction 20.1: Ensure the development of child and adolescent mental health services as a key component of the mental health services framework

Key direction 20.2: Ensure older people's mental health services are developed as a key component of the mental health services framework

Key direction 20.3: Foster improved alignment of mental health policy with child, youth, family and older people policies at Commonwealth and State/Territory levels

Key direction 20.4: Ensure that child and adolescent mental health services and mental health services for older people are better linked with the broader mental health and primary care sectors

Key direction 20.5: Increase the options for the provision of evidence-based mental health care across the lifespan, recognising the benefits not only of child, adolescent and aged care specific approaches, but also of system-wide approaches

Outcome 21: Reduced service system gaps and increased integration between private and public mental health services

Key direction 21.1: Continue to consolidate and extend the gains made under the First and Second National Mental Health Plans, building on initiatives such as the Mental Health Integration Projects

Outcome 22: Improved coordination between the mental health sector and other areas of health, such as child and adolescent services, general adult services, aged care services, drug and alcohol services and Aboriginal and Torres Strait Islander health services

Key direction 22.1: Enhance cooperation between the mental health sector and other sectors in terms of service provision, with better articulation of roles and responsibilities

Key direction 22.2: Improve continuity of care between Aboriginal and Torres Strait Islander health services and mental health services through planning and partnership mechanisms at the local level

Support for families and carers

With the move to more community-focused treatment for people with mental illness, the enhanced role of carers must be recognised and supported. The needs of families and carers, particularly where children are carers, should be acknowledged and services put in place to support their efforts and ensure that their own wellbeing is maintained. Initiatives to include families and carers in treatment planning are essential. Mental health services should become more responsive to the needs of carers and increase support options, particularly in providing better access to

Outcome 23: Improved support for families and carers

Key direction 23.1: Develop guidelines for carer plans which, in conjunction with individual consumer care plans, emphasise regular review of the needs of carers

Key direction 23.2: Improve the range of support services available for carers, which may include respite services and services for children of parents with a mental illness

Key direction 23.3: Improve the extent to which information is shared with carers so they are able to participate in care planning

Strengthening quality

Definitions of quality tend to be imprecise, but in general terms the notion of quality emphasises appropriate, evidence-based care that leads to measurable improvement and good results. This Plan aims to better reflect the full range of objectives of the National Mental Health Strategy and progresses the quality agenda using structures implemented through the First and Second Plans to achieve and measure high-quality outcomes. In particular, this Plan continues to support the implementation of the National Standards for Mental Health Services.[14]

Consumer rights and legislation

The rights of people with mental health problems and mental illness should be guaranteed and protected across the life span and at all times throughout the course of illness and recovery in accordance with the Mental Health Statement of Rights and Responsibilities[2] and national and international conventions. Mental health services should be delivered in the least restrictive environment, with an emphasis on privacy, dignity and respect. Consumers should have access to information on their rights, to advocacy services and to effective and appropriate mechanisms for complaint and redress.

Outcome 24: Continue to ensure all States and Territories have legislation and service provision that protects the rights of consumers and the community

Key direction 24.1: Continue review of mental health and related legislation

Key direction 24.2: Ensure the capability exists to permit interstate transfer of individuals detained under mental health legislation

Key direction 24.3: Review the adequacy of existing complaints systems

Consumer and carer participation

Consumer and carer participation and partnership at all levels in policy, planning and treatment is a hallmark of a quality mental health system. Consumers and carers report that there have been increased opportunities for participation in policy and planning, particularly at a national level. However, participation at other policy and planning levels, and participation in service planning and delivery across the spectrum of care from promotion and prevention to recovery, has not yet been achieved. Further work is required to ensure that meaningful participation by all consumers, and their carers and families, is realised.

Outcome 25: Increased levels of full and meaningful consumer, family and carer participation in policy and in service planning, delivery and evaluation at all levels with evidence of improvement in quality

Key direction 25.1: Review and improve current structures for ensuring meaningful consumer, family and carer participation in policy and services planning, development and evaluation at national, State/Territory and local levels, including participation by consumer and carer workers

Key direction 25.2: Include Aboriginal and Torres Strait community, consumer and carer representatives on appropriate committees through the Aboriginal and Torres Strait Islander Framework Agreement Partnership Forums

Key direction 25.3: Review and improve structures (e.g., advocacy support mechanisms) for ensuring consumer, family and carer participation in individual care and recovery plans

Key direction 25.4: Identify improved service quality and consumer outcomes afforded by enhancing consumer, family and carer participation at all levels

Key direction 25.5: Encourage the demonstration of meaningful consumer, family and carer participation at all levels

Key direction 25.6: Provide support and training for consumers, carers and their families to strengthen their capacity to participate at all levels, particularly in quality assurance processes

Safety

Safety is a key component of quality and involves minimising the likelihood of potential harm from mental health care.[19]

Outcome 26: Increased safety of consumers, carers and families, staff and the community and a reduction in adverse incidents

Key direction 26.1: Develop and implement safety protocols that make the activities and environment of mental health services safer for consumers, carers, families, staff and the community

Key direction 26.2: Educate consumers, carers, families and the mental health workforce in the safe and quality use of medicines

Key direction 26.3: Undertake developmental work to determine how quality assurance in mental health can be broadened to link with and incorporate wider health quality and safety policies and agendas

Standards and monitoring

High-quality mental health services will be facilitated through continual review of performance, assessment and accreditation. The mental health quality agenda needs to be broadened from its current emphasis on service inputs and structure to service impacts and outcomes. This can be achieved through the development of a culture of measurement and the establishment of consumer- and clinician-rated measurement systems, national benchmarking of mental health services, and agreement on, and establishment of, appropriate levels and mix of services.

Outcome 27: Increased service quality and numbers of services that meet specified quality criteria in both the public and private specialist mental health sectors

Key direction 27.1: Develop a nationally agreed set of performance indicators that focus on mental health care outputs and outcomes and provide information to managers at all levels of the mental health care system, as well as contributing to an understanding of population needs

Key direction 27.2: Establish continuous quality improvement cycles and public reporting based on the Mental Health Service Standards and the National Practice Standards for the Mental Health Workforce, including comprehensive implementation and ongoing accreditation and review

Key direction 27.3: Benchmark like services against performance indicators

Key direction 27.4: Review national standards to ensure their relevance for key groups with particular needs

Outcome 28: Comprehensive implementation and further development of routine consumer outcome measures in mental health

Key direction 28.1: Continue to support and develop outcome measurement systems, including full implementation of routine outcome measurement systems, in the mental health sector and for use by other mental health providers and related service sectors

Key direction 28.2: Establish a national strategy in collaboration between the Commonwealth, States and Territories for database development, data analysis (which may include normative comparisons and benchmarking exercises), dissemination and training

Key direction 28.3: Support the implementation of routine outcome measurement

Key direction 28.4: Support improvements in the effectiveness and quality of mental health services, through the development of complementary outcome measures and instruments for specialist sectors and particular groups, such as Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities

Outcome 29: Monitoring of the performance of mental health services regarding emotional and social wellbeing issues, through the collection and sharing of information and data

Key direction 29.1: Identify, monitor and disseminate information about effective models of service and partnerships that improve service responsiveness to Aboriginal and Torres Strait Islander people

Key direction 29.2: Improve the usage of Aboriginal and Torres Strait Islander identifiers in health data collections

Funding

The development of strategies that create incentives for high-quality care is crucial.

Outcome 30: Reform of public sector funding models to better reflect need

Key direction 30.1: Continue the development of mental health casemix classifications through the Australian Mental Health Outcomes and Classification Network

Key direction 30.2: Develop funding formulae based on population needs, weighted for Aboriginal and Torres Strait Islander populations, rural and remote locations and other relevant variables

Key direction 30.3: Develop funding formulae taking into account provision of programs which will lessen the adverse impacts of mental health problems and mental illness

Outcome 31: Improved ability of the private sector to meet need through funding models and related reform

Key direction 31.1: Explore ways in which the private health sector can deliver a wider range of services

Key direction 31.2: Explore the potential for private health funds to offer a wider range of service products

Key direction 31.3: Explore models of funding that support involvement of allied health professionals in private mental health service provision

Key direction 31.4: Review impediments and other barriers to innovative service delivery that is appropriate and effective

Workforce

Workforce attitudes, skills, training and education are fundamental to quality mental health care. This Plan focuses on strengthening and supporting the ability of the mental health workforce to provide quality care and to build partnerships with consumers, carers and their families at all stages of service delivery and care. Consideration is also given to the supply, organisation, deployment and retention of the mental health workforce, and their resulting impact on quality.

Outcome 32: Improved attitudes, values, knowledge and skills of the mental health workforce

Key direction 32.1: Implement the National Practice Standards for the Mental Health Workforce to: promote best practice; guide and support clinical supervision mentoring; structure continuing education and curricula development; assist in recruitment and staff retention; and complement other competency standards

Key direction 32.2: Strengthen the role of consumers and carers working in the mental health system through increased training and support

Key direction 32.3: In consultation with consumers and carers, professional discipline groups and service providers, promote the development and delivery of undergraduate, postgraduate and ongoing training in mental health for the specialist mental health workforce (public and private), general practitioners and other primary care providers, and non-government sector workers in order to improve knowledge and skills in assessments, triage/referral, acute care; early intervention, building effective clinical and service linkages, meeting the needs of specific population groups, and providing care across the lifespan

Key direction 32.4: Train mental health workers and primary health care professionals in recognition of the interrelatedness of physical and mental illness

Key direction 32.5: Increase the cultural competency of the mental health workforce

Outcome 33: Improved supply and distribution of the mental health workforce

Key direction 33.1: Develop initiatives to retain clinicians in the specialist public health workforce

Key direction 33.2: Enhance the role of general practitioners and allied health professionals in providing mental health care, particularly in rural and remote areas

Key direction 33.3: Provide incentives for private psychiatrists, general practitioners and allied health professionals to work with public sector mental health services and vice versa

Key direction 33.4: Promote the involvement of professional bodies and education and training institutions in the planning of workforce supply

Key direction 33.5: Increase the proportion of Aboriginal and Torres Strait Islander mental health workers within the mental health workforce, and provide appropriate support and career structures

Key direction 33.6: Strengthen initiatives to enhance the recruitment, retention, status, skills and numbers of the mental health nursing workforce

Outcome 34: Improved workforce environment

Key direction 34.1: Improve occupational health and safety for the mental health workforce

Key direction 34.2: Improve the communication infrastructure of the mental health workforce

Key direction 34.3: Improve support for general practitioners and other primary mental health providers, especially in rural and remote areas

Fostering research, innovation and sustainability

Much has been achieved throughout the First and Second National Mental Health Plans in reforming the Australian mental health system. A range of innovative initiatives, including clinical trials, pilot projects, research and development programs have informed this process, providing a strong foundation for innovation in the National Mental Health Plan (2003–2008).

This Plan is committed to the future development of a strategic mental health research agenda to underpin mental health policy and practice. This will optimise the research investment that has been made throughout the life of the National Mental Health Strategy and take a strong, forward-looking approach to research development and sustainability. The National Mental Health Plan 2003–2008 embraces the challenge to promote research into mental health and mental illness across the lifespan, develop and trial new treatments and models of care and technology, and evaluate the effectiveness, long-term sustainability and applicability of this work in the mental health system.

Setting the research agenda

The burden of disease attributable to mental illness is growing in Australia, as in all countries, and the demand for services and the complexity of illnesses is increasing. The extent to which much of the burden is unable to be averted is becoming clearer. The research achievements made to date have been significant, but there is a pressing need to meet this growing demand through increased research knowledge and understanding of the aetiology of mental health problems and mental illness and better treatments and cures.

No country has the capacity to address all its research and development needs. Prioritisation of new and existing research initiatives will be crucial to ensuring optimum investment of the research dollar. During the period of the Second National Mental Health Plan the Australian Government commissioned an analysis of the mental health research priorities of a wide range of mental health stakeholders.[20] The findings of this work will inform the prioritisation process.

Partnerships are necessary in order to promote research that strategically informs policy-makers, planners, decision-makers who allocate funding and services, managers and service providers. A national framework for coordinated, innovative research and development will be established. The framework will be strongly informed by consumer and carer perspectives, and underpinned by the objectives of the National Mental Health Plan 2003–2008. It will incorporate and consolidate existing research initiatives to ensure their outcomes are achieved. The research will be holistic, and recovery- and outcome-

orientated, and will identify clinical and service level interventions that have the greatest potential to increase population mental health and reduce suffering across the lifespan.

The development of a strong research culture and critical research mass within the mental health sector is crucial. So too are research partnerships between sectors, institutions and disciplines.

Enhanced research capacity will be encouraged and supported through linkages and funding partnerships with other sectors, and between investigators, policy-makers and funders in the public and private sectors.

Fostering innovation

Promoting mental health and preventing mental health problems and mental illness

Furthering our knowledge of the promotion of mental health and the prevention of mental illness is an important element of the research agenda. There has been limited research into the determinants of mental health and wellbeing across the lifespan. Research into causal pathways and risk and protective factors for mental health will be encouraged. The implementation of effective and efficacious strategies to promote mental health and prevent mental health problems will be fostered. Early intervention initiatives that can be generalised to and sustained within health and mainstream mental health services will also be prioritised.

Improving service responsiveness

As knowledge of the aetiology of illness becomes more sophisticated, it will be crucial to rigorously explore 'what works for whom and in what settings' and to translate this into mainstream mental health practice. Research will continue to develop more innovative and cost-effective treatments and service models for people with mental health problems and mental illness, including under-researched groups. Suicide will be an area of ongoing focus, as will the development of psychosocial rehabilitation systems and models that facilitate recovery.

The period of the First and Second National Mental Health Plans has seen changes in the complexity of and demand for services, and the structure and mix of mental health services. Research can help provide ways that consumer, family and carer needs are more successfully met within this evolving environment. Initiatives that develop new and improved models of service delivery will be supported. These might include comprehensive continuums of care within and outside the mental health sector, the development and implementation of effective intersectoral care models, and innovative approaches to the establishment of pathways to care. Research initiatives will also focus on the development of care packages required by different groups with mental health problems and on mental illness as a basis for future service mix and level and assessment of optimal levels of care. The use of new technologies, including e-health and telephone innovations in care, will be explored.[21]

Strengthening quality

Continued research to develop consumer- and carer-administered mental health measures is important. Research should include the development and implementation of quality and outcome measures, including consumer- and carer-rated outcome measures, instruments to measure access and pathways to care, indicators of functionality, distress and meaningful consumer and carer participation. There will also be a focus on the development of outcome measurement systems relevant to Aboriginal and Torres Strait Islander people and to specialty areas, particularly child and adolescent services.

Human resources are critical to effective mental health programs. Research which focuses on workforce supply, organisation and environment is critical. Research into the training needs of different groups within the mental health workforce, and the long-term impact and effectiveness of these strategies, is also important.

Innovative approaches to quality improvement based on the National Mental Health Service Standards and the National Practice Standards for the Mental Health Workforce will be progressed throughout the period of the National Mental Health Plan (2003–2008). Developmental work will also be undertaken to determine how quality assurance in mental health can incorporate the wider quality and safety agenda in health and beyond. Disability associated with mental health problems and mental illness has implications not only for the individual and their family but also for society as a whole. There are costs associated with not treating mental health problems and mental illness, and effective treatments that reduce or eliminate disability have considerable economic return. In an environment of limited resources and increasing demand, it is important to justify resource usage in terms of consumer outcomes and returns on investment. Mental health research must answer economic as well as clinical questions.

Research in this area is in its infancy in Australia and will be promoted through the period of the National Mental Health Plan (2003–2008). Areas of focus will include quantifying the economic benefits of reducing the burden of care and the benefits of disability reduction within and outside the workforce. Potential areas for further research that will support economic analyses include epidemiological longitudinal and large population studies that focus on the prevalence and burden of disease, and casemix projects that identify consumer attributes that predict resource use in different settings.

Ensuring sustainability

Australia has embraced the reform agenda with enthusiasm and important pilots and trials have been undertaken in a number of areas. There is concern, however, that pilot projects and developmental research initiatives do not attract ongoing, sustainable funding despite demonstrated effectiveness. This Plan emphasises the need to optimise the investment in pilot projects by ensuring that innovation found to be effective and appropriate is effectively disseminated and adequately resourced to enable ongoing implementation and translation into mainstream, evidence-based best practice.

evaluation

5

The First and Second National Mental Health Plans both emphasised the importance of measurement and accountability. Both Plans were evaluated, with each evaluation containing a number of components that assessed their appropriateness and effectiveness. In both cases, these components included a mix of quantitative data, taken primarily from the information in the relevant National Mental Health Report, and qualitative data derived from consultations with key informants and commentary from international experts.

This Plan stresses the need to continue public reporting of nationally aggregated data, and maintains a commitment to independent evaluation. Steps should be put in place at the outset of this Plan to ensure that its evaluation is an integral part of its implementation. Evaluation efforts should begin when the Plan commences. Early on, it will be important to translate the broad outcomes of the Plan into a series of nationally consistent indicators, against which success, or lack of success, can be measured. Developing these indicators will allow a determination of what data need to be collected. Evaluation efforts should be broad in scope, and collect baseline information against which to assess the impacts and outcomes of reforms across all sectors. It will be important to determine which indicators can be measured with information that is currently collected, and which ones will require additional information to be sought. Redevelopment of reporting frameworks will need to reflect changed and agreed service directions. Qualitative information will continue to be vital in the evaluation. The views of consumers, families and carers must be solicited, as must the views of the broader community. Ideally, key informant interviews would occur at different stages of the Plan, and not just at its conclusion.

Just as the overall evaluation of the Plan is crucial, so too is the evaluation of specific initiatives undertaken within it. In particular, pilot projects that are conducted with funding under the Plan should be subjected to rigorous scrutiny, so that it is possible to determine what works, what does not work, and what should be replicated or further developed.

conclusion

6

The National Mental Health Plan 2003–2008 provides a framework for consolidating the achievements of and building on the First and Second National Mental Health Plans. It emphasises the centrality of consumers, families and carers in reform. This Plan focuses on achieving gains through a population health framework, and sets important priorities for the next five years of the National Mental Health Strategy.

In taking forward this Plan, it should be the aim of all stakeholders to improve the mental health and wellbeing of the Australian community, and to improve the treatment, care and quality of life of people with mental health problems and mental illness across the lifespan. The next five years provide an important opportunity to build on the gains made over the past decade.

glossary of terms and definitions

7

Acute care: Acute care 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 key characteristic of acute services is that the treatment effort is focused on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short-term treatment. Acute services may be:

- Focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms
- Targeted at the general population, or specialist in nature, targeted at specific clinical populations. The latter group includes psychogeriatric, child and adolescent, and forensic psychiatry services

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.

Benchmarking: Benchmarking is concerned with the systematic process of searching for and implementing a standard of best practice within an individual service or similar groups of services. Benchmarking activities focus on service excellence, customer/client needs, and concerns about changing organisational culture. (Bullivant, JRN. Benchmarking for continuous improvement in the public sector. UK: Longman, 1994.)

Care pathways: Formally articulated mapping of services provided within and across sectors and with agreed streamlined entry/exit procedures that support continuity of care by ensuring that consumers of services are able to negotiate the system in a seamless and timely manner.

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

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

Casemix: A classification system that combines episodes of care into clinically meaningful groups, such that episodes within a given group require the same level of resources.

Clinical indicator: A measure of clinical management and outcomes of care; a method of monitoring care and services which attempts to identify problem areas and evaluate trends, in order to direct attention to issues requiring further review.

Colocated service: Psychiatric inpatient services established physically and organisationally as part of a general hospital. There are two variations on this theme:

- The psychiatric unit is built and managed as a unit within a general hospital, or
- The psychiatric service operates in a separate building but is located on, or immediately adjoining, the general hospital campus. Beds within the psychiatric service are classified as 'colocated' providing all of the following criteria apply: (a) a single organisational or management structure covers the general hospital and the psychiatric facility; (b) a single employer covers the staff of the general hospital and the psychiatric service; (c) the location of the general hospital and the psychiatric service can be regarded as part of a single, overall hospital campus; and (d) the patients of the psychiatric service are regarded as patients of the single integrated health service

Community capacity building: Developing investment in mental health on multiple levels in government and non-government sectors, and utilising the knowledge and expertise of consumers, carers and others in the general population.

Complex conditions: Conditions in which a person experiences mental illness as well as other multiple and complex social, emotional and/or physical health problems. Complex conditions include mental illness with problematic substance abuse, histories of abuse, intellectual disability, and challenging, at risk, suicidal and criminal behaviours. People with complex conditions often have needs that require a co-ordinated response from multiple service sectors.

Consultation-liaison services: Formal support and clinical guidance provided by specialist mental health care to other providers, including general practitioners.

Consumer: A person who is currently utilising, or has previously utilised, a mental health service.

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

Cost-effectiveness: The most effective use of limited resources. Cost-effectiveness analysis summarises the health benefits and resources used by a health program. (Over, M. Economics for Health Sector Analysis – Concepts and Cases. Washington, D.C: The World Bank, 1992.)

Crisis assessment teams: Mental health teams which provide 24-hour mobile support and intervention for people who are being considered for psychiatric hospital admission. Crisis assessment teams also provide treatment and support for people whose acute mental illness can be managed in the community. (Adapted from Auditor General. Mental Health Services for People in Crisis. Victoria, 2002.)

Disease burden: The impact of a mental illness on the psychological, social and economic wellbeing of consumers, carers and their families caused by premature mortality, and disability.

Early intervention: Timely interventions which target people displaying the early signs and symptoms of a mental health problem or a mental disorder. Early intervention also encompasses the early identification of patients suffering from a first episode of disorder.

Epidemiology: The study of the distribution and determinants of mental health and illness as applied to a whole community.

Extended, community-based residential care: Medium- to long-term inpatient and residential treatment and rehabilitation for individuals who have unremitting and severe symptoms of mental illness.

Forensic services: Services provided to:

- Offenders or alleged offenders referred by police, courts, legal practitioners or independent statutory bodies for psychiatric assessment and/or treatment
- Alleged offenders detained, or on conditional release, as being unfit to plead or not guilty by reason of mental impairment
- Offenders or alleged offenders with mental illness ordered by courts or independent statutory bodies to be detained as an inpatient in a secure forensic facility
- Prisoners with mental illness requiring secure inpatient hospital treatment
- Selected high-risk offenders with a mental illness referred by releasing authorities
- Prisoners with mental illness requiring specialist mental health assessment and/or treatment in prison
- People with mental illness in mainstream mental health services who are a significant danger to their carers or the community and who require the involvement of a specialist forensic mental health service (the diagnostic groups of people who determine this group will be determined by the jurisdiction)

Framework Agreements: Framework Agreements commit the parties to a joint process of regional planning to meet Aboriginal and Torres Strait Islander health needs within that jurisdiction, and to guide future resource allocation.

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

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

Intersectoral linkages: Collaboration between mental health policies/programs/services and other relevant policies/programs/services at Australian, State/Territory and local government levels, as well as in the private and non-government sectors, designed to ensure the overall needs of people with mental illness are addressed effectively.

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

Mental health: A state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential.[21] It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with

their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities.[2] Mental health is not simply the absence of mental illness. Its measurement is complex and there is no widely accepted measurement approach to date. The strong historical association between the terms 'mental health' and 'mental illness' has led some to prefer the term 'emotional and social wellbeing', which also accords with holistic concepts of mental health held by Aboriginal peoples and Torres Strait Islanders and some other cultural groups,[10] or alternatively, the term 'mental health and wellbeing'.

Mental health literacy: The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors for and causes of mental health problems and mental illness; knowledge of self-treatment and of professional help available; and attitudes that promote recognition and appropriate help-seeking. (Jorm, A. et al. "Mental Health Literacy: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment". Medical Journal of Australia. 1997:166,182.)

Mental health problems: A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.

Mental health sector: Includes the specialist mental health sector (both public and private) and elements of the primary care sector providing mental health care.

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, Fifth Edition (DSM-IVR)[1] or the International Classification of Diseases, Tenth Edition (ICD-10).[4] These classification systems apply to a wide range of mental disorders (for the DSM-IV) and mental and physical disorders (for the ICD-10). Not all the DSM-IV mental disorders are within the ambit of the National Mental Health Plan 2003–2008. In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and there is a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their comorbidity with mental illness.

Morbidity: The incidence of disease within a population.

Mortality: Death attributable to mental illness.

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

Non-government organisations: Private, not-for-profit, community-managed organisations that provide community support services for people affected by mental illness. Non-government organisations may promote self-help and provide support and advocacy services for consumers and carers or have a psychosocial rehabilitation role.

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

Outreach services: Community-based mobile support, rehabilitation and treatment services, primarily provided on a visiting basis.

Performance indicators: Measures of change in the health status of populations and in service delivery and clinical practice, collected in order to monitor and improve clinical, social, vocational and economic outcomes.

Population health approach: An understanding that the influences on mental health are complex and occur in the events and settings of everyday life. A population health approach encourages a holistic approach to improving mental health and wellbeing and develops evidence-based interventions that meet the identified needs of population groups and span the spectrum from prevention to recovery and relapse prevention across the lifespan.

Private sector mental health services: Specialised health services that are specifically designed for people with a mental health problem or mental disorder seeking treatment in the private sector. In Australia, private sector mental health services include the range of mental health care and services provided by psychiatrists in private practice, and those inpatient and day-only services provided by private hospitals, for which private health insurance funds pay benefits. Private sector services may also include services provided in general hospital settings and services provided by general practitioners and by other allied health professionals.

Primary care sector: The primary care sector includes general practitioners, and many other primary care providers such as emergency departments and community health centres, as well as others who are integrally involved in the detection, diagnosis and treatment of mental illness, and/or have much to offer in terms of promoting mental health.

Productivity: The amount of output per unit of inputs used to produce it. It may be measured by the number of hours engaged in work or other activities carried out by an individual which contributes to some good/product or service being produced.

Psychogeriatric services: These services principally target people aged 65 years and over, or younger people with age-related psycho-geriatric disorders. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient, community and ambulatory services on aged persons. This category does not include general psychiatry services that may treat older people as part of their usual service delivery.

Psychosocial rehabilitation: Services with a primary focus on interventions to reduce functional impairments that limit the independence of people whose independence and physical/ psychological functioning has been negatively impacted upon as a result of a mental illness. Psychosocial rehabilitation focuses on disability and the promotion of personal recovery, giving people the opportunity to work, live and enjoy a social life in the community. It is also characterised by an expectation of substantial improvement over the short to mid-term. This term is sometimes used interchangeably with the term 'rehabilitation'.

Quality of life: This term embraces a spectrum of uses and meanings. Within this document 'quality of life' is a multidimensional concept that includes subjectively and objectively ascertained levels of physical, social and emotional functioning. (Adapted from Katschnig H, Freeman H, Sartorius N. Quality of Life in Mental Disorders. England: John Wiley & Sons,1998.)

Recovery: A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose as the person grows beyond the effects of psychiatric disability. (Adapted from Anthony, W.A. Recovery from mental illness: the guiding vision of the mental health service system in the 1990's, Psychiatric Rehabilitation Journal,16(4):159.)

Referral pathways: Referral systems and protocols that ensure linkages between services to support continuity of care and ensure that consumers of services are able to negotiate the system in a seamless and timely manner.

Rehabilitation: Intervention to reduce functional impairments that limit the independence of consumers. Rehabilitation services are focused on disability and the promotion of personal recovery. Consumers who access rehabilitation services usually have a relatively stable pattern of clinical symptoms and there is an emphasis on relapse prevention. This term is sometimes used interchangeably with the term 'psychosocial rehabilitation'.

Relapse prevention: Reducing recurrence of illness and strengthening functioning capacity.

Service mix: The combination of services used to meet the spectrum of needs of a consumer.

Shared care: Care provided collaboratively by general practitioners and specialist mental health care providers or by public sector mental health services and private psychiatrists.

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

Specialist mental health sector: Comprises both public and private mental health services and providers, including some specialist non-government organisations. The primary function of these services is to provide treatment, rehabilitation or community support targeted towards people affected by mental illness. Such activities are delivered by providers, services or facilities that are readily identifiable as both specialised and serving a mental health function.

Standards: Clinical practice standards are defined and agreed clinical procedures and practices for the optimal treatment and care of people with mental illness. Service standards define what is required for a quality mental health service.

Transcultural services: Transcultural services promote access to mental health services for people from culturally and linguistically diverse populations. Transcultural services work with consumers, carers, health professionals and the community to promote positive attitudes to mental health and to ensure that the needs of people from culturally and linguistically diverse populations (including access, equity and cultural safety and appropriateness) are addressed at policy, planning and service delivery levels.

Vocational rehabilitation: Services with a primary focus on interventions to assist people who have experienced or continue to experience a mental illness to enter or re-enter the workforce and to sustain employment. Vocational rehabilitation focuses on prevocational preparation, vocational skills training, placement, support and advocacy. People who use these services usually have a relatively stable pattern of clinical symptoms.

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national mental health strategy

A joint Australian, State and Territory Governments Initiative

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.

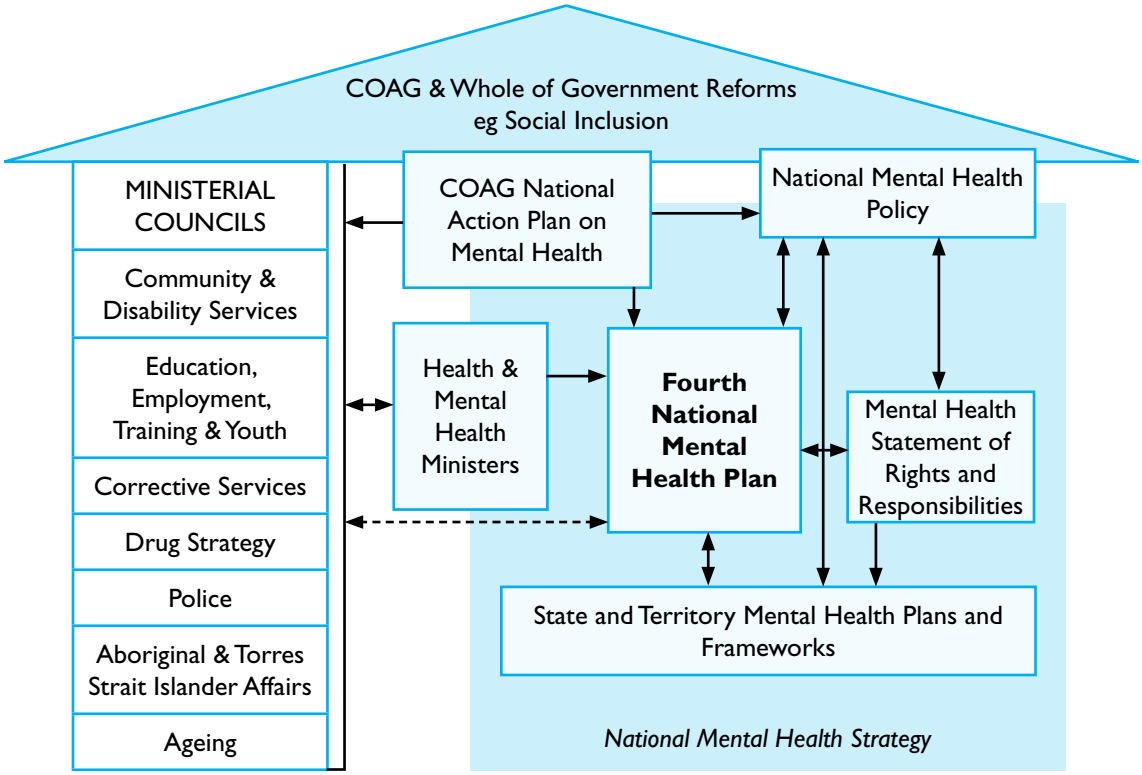
A whole of government approach

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

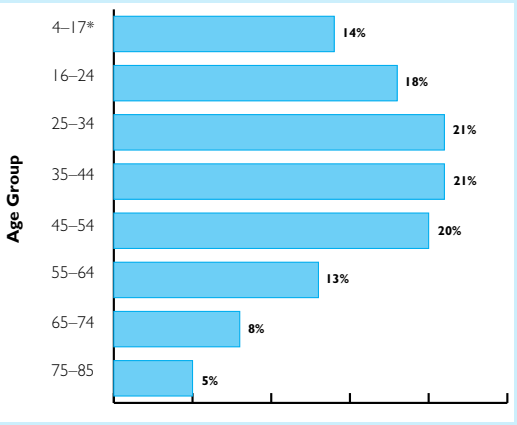
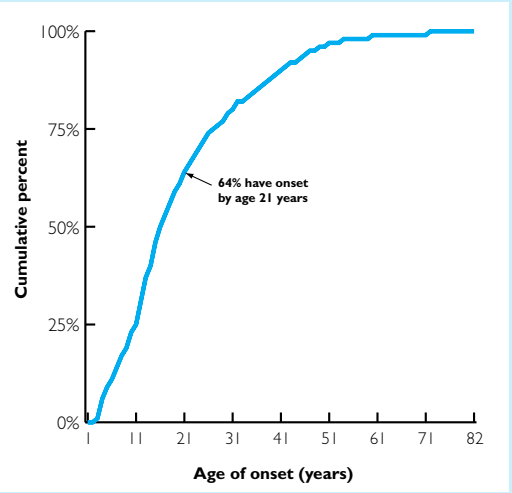


Figure 3: Age of onset for the most common mental illnesses (anxiety and affective disorders)



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.

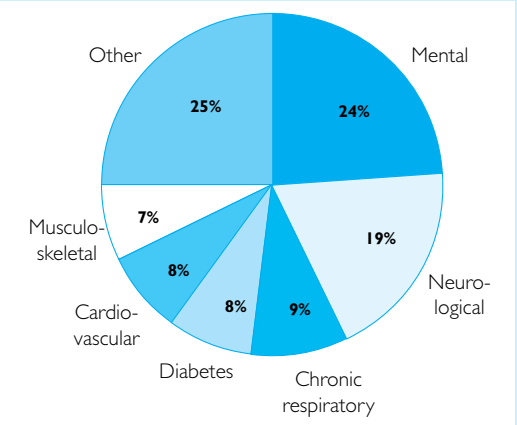
People with mental illness are also over represented in the homeless and prison populations. Australian data suggests that up to 75% of homeless adults have a mental illness and, of these, about a third (approximately 29,000 people) are affected by severe disorders. Additionally, Australian studies have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

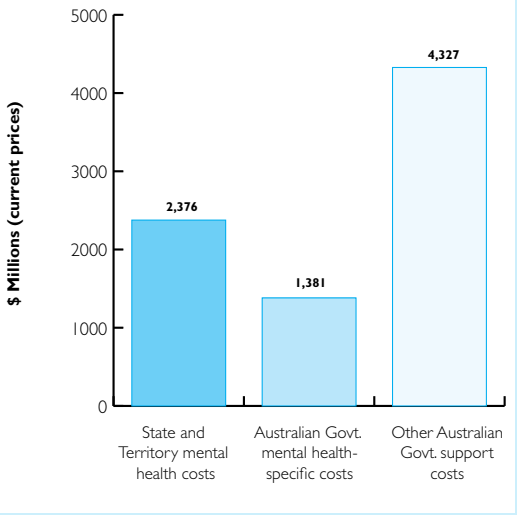
In addition to outlays by government, mental illness impacts on the broader economy by reducing workforce participation and impairing the productivity of those who are in employment. Estimates of the annual costs of the productivity losses attributable to mental illness range from $10 to $15 billion.

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

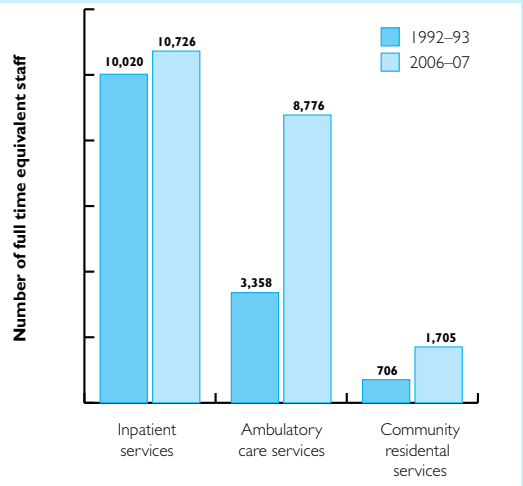
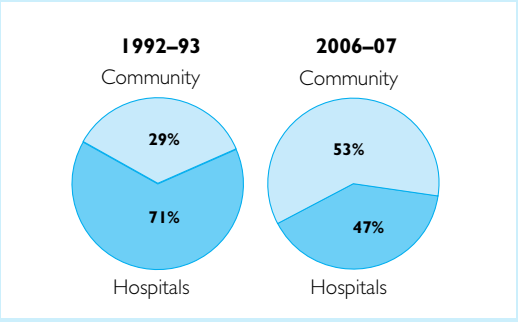


Figure 7: Community based services as percentage of total state and territory spending on mental health services, 1992–93 and 2006–07



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).

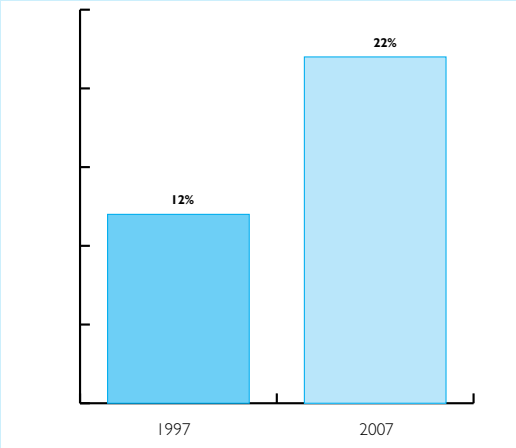
Community mental health literacy has also improved during the life of the *National Mental Health Strategy*, indicating that the substantial investment in mental health promotion initiatives—particularly those driven by *beyondblue*—are bearing fruit. Research undertaken by the University of Melbourne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

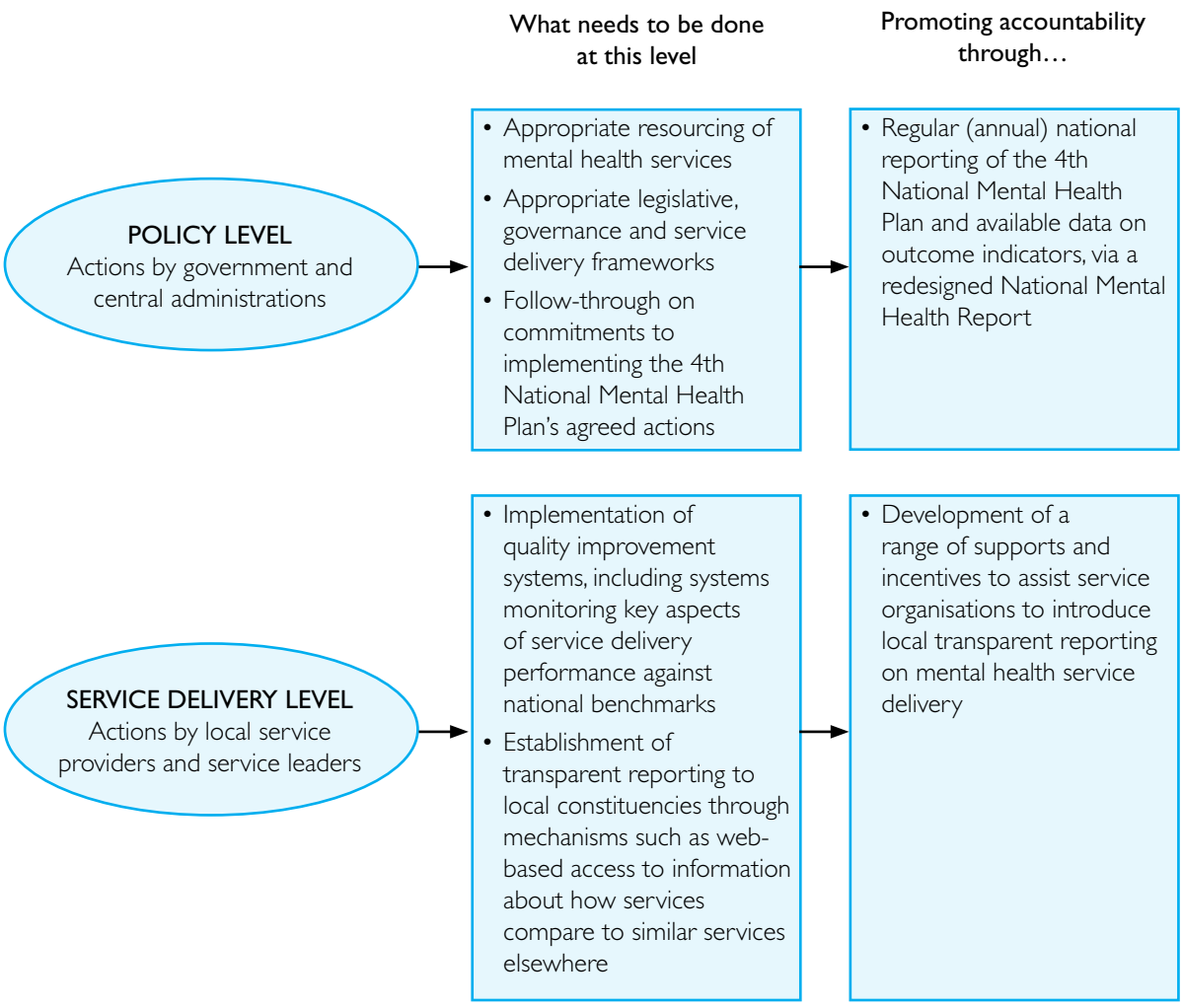
Australia's mental health sector has been a world leader in reporting on indicators of mental health reform, and has a longer and stronger history of doing so than many other sectors. The process began with the original *National Mental Health Plan* in 1992, when health ministers imposed on themselves 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 employment1 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.

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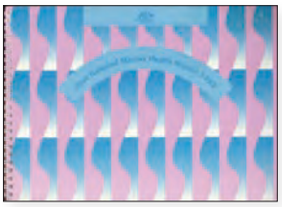
National Mental Health Report 1993



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National Mental Health Report 1994

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Coverage: Progress in 1993-94

National Mental Health Report 1995

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Coverage: Progress to 1994-95

National Mental Health Report 1996

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Coverage: Progress to 1995-96

National Mental Health Report 1997

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National Mental Health Report 2002

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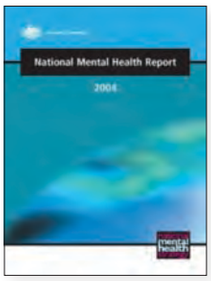
National Mental Health Report 2004



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National Mental Health Report 2007

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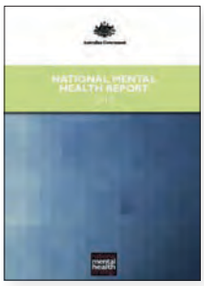
Coverage: Progress to 2004-05

National Mental Health Report 2010



Released: December 2010
Coverage: Progress to 2007-08

National Mental Health Report 2013

Released: October 2013
Coverage: Progress to 2010-11

About the cover

Cover image

NEG, *Landscape of the Mind, 2005*, watercolour on paper, 32 x 24 cm
The Cunningham Dax Collection. www.daxcentre.org

Artist Profile

NEG has had an experience of mental illness since the age of nine. Following participation in the Prahran Mission's 2nd Story Program, she took a place as an artist in their Stables Studio. NEG has undertaken a Writing and Editing course at RMIT and various art therapy sessions. She has also worked as a secondary school teacher and bookshop assistant.

Artist Statement

"A friend once told me you never want to fight your demons, they always win. You can escape them tho' and ***that's what art does:*** you're so focussed on what you're doing: get that line just right, that shading there, and so on, that the demons don't even get a look in, unless you're drawing them, and like vampires they really don't like that, (They're 'sprung' as it were) so they just give up out of boredom and wander off until the next time they can take you by surprise." NEG, 2008, *The Borderline Picture Book*.

About the Cunningham Dax Collection

The Cunningham Dax Collection, amassed over a 70 year period, consists of over 15,000 artworks including works on paper, photography, paintings, sculptural work, journals, digital media and video created by people with an experience of mental illness and/or psychological trauma. The Cunningham Dax Collection is part of the Dax Centre. The Dax Centre promotes mental health and wellbeing by fostering a greater understanding of the mind, mental illness and trauma through art and creativity.

For more information on the Cunningham Dax Collection, The Dax Centre and to view the online gallery of past exhibitions, visit: www.daxcentre.org

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Foreword

Mental health reform has been a longstanding priority for all governments, commencing with the endorsement of the National Mental Health Strategy by Australian Health Ministers in 1992. Through various changes in government at the federal, state and territory levels, the Strategy has continued as a bipartisan reform agenda and the *National Mental Health Report* series has been maintained as the prime vehicle for monitoring reform progress. Continuation of the report was mandated in the *Fourth National Mental Health Plan* and its scope broadened to incorporate reporting on progress against the outcome indicators and actions agreed in the Plan. *The Fourth Plan* also required the report to be endorsed by all Health Ministers.

The current report is the twelfth in the series. It summarises the system level changes that have taken place in mental health between 1993 and 2011. As such, the report provides a view of trends and performance at the national and state and territory levels over the period spanning the first, second and third National Mental Health Plans and the first two years of the *Fourth National Mental Health Plan*. The time series and breadth of coverage of the report is unparalleled internationally.

It is clear from the information presented in this report that much has changed over the course of the National Mental Health Strategy. All governments have increased their reform efforts in recent times with significant investments in clinical and community support services. A key finding of the report is that government spending on mental health has outpaced overall health spending growth in recent years, with the result that mental health as a proportion of health expenditure in 2010-11 was the highest (7.7 per cent) recorded since the *National Mental Health Report* series commenced in 1993.

Readers of previous National Mental Health Reports will know that the report only tells part of the story. While the focus of the report on resources and high level indicators is essential, it does not tell us about what it is like to experience services from the perspective of those that they serve. For this we need different reporting arrangements that give greater transparency to the performance of mental health services from the perspective of people with a lived experience of mental illness, their families and carers. The recent addition of the annual *National Report Card on Mental Health and Suicide Prevention*, prepared by the National Mental Health Commission, serves this function and adds an important complement to the *National Mental Health Report*.

Despite the achievements made over the course of the National Mental Health Strategy, consumers, carers and other stakeholders rightly emphasise that much remains to be done to build a modern, responsive mental health system in Australia. It is important to note in this context that all governments renewed their commitment to further mental health reform with the endorsement and release by the Council of Australian Governments (COAG) in December 2012 of the *Roadmap for National Mental Health Reform 2012-2022*. The Roadmap outlines the directions that will be taken by governments over the next ten years and sets out new governance and accountability arrangements designed to directly engage stakeholders and ensure that governments are held to account. These new arrangements include the establishment of a COAG Working Group on Mental Health Reform that is required to develop, by mid-2014, a successor to the *Fourth National Mental Health Plan* that will set out how the Roadmap will be implemented.

Alongside the release of the Roadmap and pending development of a new National Mental Health Plan, states and territories have developed their own mental health plans that reflect the goals and principles of the national approach, but have been tailored to meet local requirements. Jurisdictions' own plans remain the key documents for setting out the specific details of how they will work towards achieving the objectives agreed under the National Mental Health Strategy.

On behalf of Australia's Health Ministers, I am pleased to endorse this twelfth *National Mental Health Report*, prepared by the Australian Government Department of Health and Ageing. These reports entail considerable work by many people including consumers, carers, service providers and the mental health units of various state and territory health administrations. I wish to extend my thanks to all who have contributed to the report.

The Hon Michelle O'Byrne MP
Chair
Standing Council on Health

July 2013

Acknowledgements

This report has been produced by the Australian Government Department of Health and Ageing. Drafting of the report was undertaken by a consortium led by the University of Melbourne, a consultancy arrangement managed by the Department of Health and Ageing. The report relies on data that could not have been presented without the cooperation of many people and organisations throughout Australia. In particular, the Department of Health and Ageing would like to acknowledge the assistance and cooperation of:

- State and territory governments for providing data through the various mental health National Minimum Data Sets, and other data submitted to the Department of Health and Ageing for the purposes of this report;
- The Department of Veterans' Affairs and Department of Families, Housing, Community Services and Indigenous Affairs for providing information on mental health initiatives and services;
- The Australian Bureau of Statistics for providing data from the annual Private Hospitals Establishment Collection, and updated data in relation to suicide statistics;
- The Private Mental Health Alliance for providing data in relation to mental health services delivered by the private hospital sector;
- The Pharmaceutical Benefits Division and Medicare Benefits Division of the Department of Health and Ageing for providing data in relation to mental health expenditure and services delivered through their respective programs;
- The Mental Health Information Strategy Standing Committee and its National Mental Health Report Editorial Advisory Group for providing expert advice on the drafting of the report;
- The Australian Institute of Health and Welfare for its work in managing the mental health National Minimum Data Sets and for its detailed quality review of data used in this report;
- Strategic Data Pty Ltd, for providing the technical services to enable data processing and web based validation of the mental health National Minimum Data Set, and for data management associated with the production of this report;
- Buckingham and Associates Pty Ltd, for assisting the Department of Health and Ageing with data analysis and advice on drafting the report.

Finally, the Department expresses its appreciation to the University of Melbourne consortium for its skilled work in drafting this report, and Richard O'Gorman for graphic design.

Whilst responsibility for conclusions drawn in this report is held by the Department of Health and Ageing, the contribution and assistance of all persons and organisations that contributed to its production are gratefully acknowledged.

Key messages

System-level indicators of mental health reform in Australia, 1993 to 2011

National spending on mental health

- The original commitment made by all governments to protect mental health resources under the National Mental Health Strategy has been met. Total government expenditure on mental health increased by 178% in real terms between 1992-93 and 2010-11. In 2010-11, Australia spent $4.2 billion more of public funds on mental health services than it did at the commencement of the Strategy in 1992-93.

- Until recently, growth in mental health spending mirrored overall health expenditure trends for most of the 18 year period since the Strategy began. In the most recent year (2010-11), mental health increased its position in terms of relative spending within the broader health sector.

- Australian Government spending has increased by 245% compared to an increase of 151% by state and territory governments. This increased the Australian Government share of total national spending on mental health from 28% in 1992-93 to 35% in 2010-11. Most of the increase in Australian Government spending in the first ten years of the Strategy was driven by increased outlays on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme, but more recently other activities have taken over as the main drivers of increased mental health spending.

- The considerable variation in funding between the states and territories that existed at the beginning of the Strategy is still evident 18 years later, mid-way through the *Fourth National Mental Health Plan*. The gap between the highest spending and the lowest spending jurisdiction increased over the 1992-93 to 2010-11 period. The disparity between the states and territories points to wide variation in the level of mental health services available to their populations.

- Despite claims to the contrary, there are no reliable international benchmarks by which to judge Australia's relative investment in mental health. These await international collaboration on costing standards to ensure 'like with like' comparisons.

National workforce trends

- The direct care workforce employed in state and territory mental health services increased by 72%, from 14,084 full-time equivalent (FTE) in 1992-93 to 24,292 FTE in 2010-11

- On a per capita basis, this equates to an increase from 80 FTE per 100,000 in the former period to 108 FTE per 100,000 in 2010-11, or an

increase of 35%. New South Wales reported the most growth (52%), followed by Tasmania (47%) and Queensland (43%).

- Nationally, the absolute increase in the direct care workforce size of 72% was lower than the increase in recurrent expenditure on state and territory inpatient and community-based services (119%). Factors such as rising labour costs and increases in overhead and infrastructure costs may contribute to this discrepancy.

- At a conservative estimate, 3,119 full-time equivalent mental health professionals provided services through Australian Government funded primary mental health care initiatives in 2010-11. The majority of these (1,928 or 62%) were psychologists. The next largest professional group was psychiatrists (817 or 26%).

- In total, 1,517 full-time equivalent mental health professionals were employed in private hospitals in 2010-11. The workforce mix mainly comprised nurses (1,165, 77%) and allied health professionals (310, 20%). Medical practitioner services provided to consumers treated in private hospitals are delivered primarily through the Medicare Benefits Schedule rather than direct employment arrangements.

Trends in state and territory mental health services

- Between 1992-93 and 2010-11, annual state and territory government spending on services provided in general hospitals and the community grew by $2.6 billion, or 283%. This was accompanied by a decrease in spending on stand-alone psychiatric hospitals of $289 million, or 35%. About two thirds of the $2.6 billion was invested in community-based services (ambulatory care services, services provided by non-government organisations or NGOs, and residential services). The remaining third was spent on increased investment in psychiatric units located in general hospitals.

- Funding to ambulatory care services increased between 1992-93 and 2010-11 by 291% (from $421 million to $1.6 billion). Over the same period, the full-time equivalent direct care workforce in these services also increased, but not by the same magnitude (215%).

- The non-government community support sector's share of the mental health budget increased from 2.1% to 9.3%, with $372 million allocated to NGOs in 2010-11. Psychosocial support services account for about one third of this funding, and staffed residential mental health services accounted for about one fifth.

- Community residential support services expanded between 1992-93 and 2010-11. The number of 24 hour staffed general adult beds doubled (from 410 to 846). The number of 24 hour staffed older persons' beds was also higher in 2010-11 (682) than it was in 1992-93 (414) although it reached a peak in 1998-99 (805) and has been declining since then. The number of non-24 hour staffed beds in general adult residential services and the number of supported public housing places also increased with time.

- The number and mix of inpatient beds has changed during the course of the National Mental Health Strategy. There were significant decreases in beds in stand-alone psychiatric hospitals in the early years of the Strategy, particularly non-acute beds and general adult and older persons' beds. These decreases have been followed by more gradual declines in recent years. The decreases have been accompanied by commensurate increases in psychiatric beds in general hospitals, particularly acute beds. The average bed day costs in inpatient settings have increased (by 77% in stand-alone hospitals and by 51% in general hospitals).

Trends in private sector mental health services

- There was significant growth in mental health care activity in private hospitals between 1992-93 and 2010-11. Bed numbers in specialist psychiatric units in private hospitals increased by 40%, the number of patient days increased by 106%, and the number of full-time equivalent staff increased by 87%. Expenditure by private hospital psychiatric units grew by 142% between 1992-93 and 2010-11.

- Medicare Benefits Schedule (MBS) expenditure on mental health services increased significantly with the introduction of the Better Access program. Better Access provided a rebate on the MBS for selected services provided by general practitioners, psychiatrists, psychologists, social workers and occupational therapists. In 2006-07, MBS expenditure on mental health services had reached a low of $474 million. In 2007-08, the first full year of Better Access, there was a sharp increase to $583 million, and by 2010-11 the overall MBS mental health specific expenditure figure rose to $852 million, accounting for 35% of overall Australian Government mental health spending.

- In 1992-93, services provided by psychiatrists and general practitioners accounted for all of the MBS expenditure on mental health services. By 2010-11, MBS-subsidised services provided by medical practitioners were complemented by services delivered by clinical psychologists, registered psychologists and other allied health professionals who accounted for 41% of MBS mental health specific expenditure.

- In 2011-12, 1.6 million people received mental health services subsidised by the Medicare system, some from several providers. In total, 7.9 million mental health services were provided in that year.

Consumer and carer participation in mental health care

- In 2010-11, about half of Australia's state and territory mental health services had either appointed a person to represent the interests of mental health consumers on their organisational management committees or had a specific Mental Health Consumer/Carer Advisory Group established to advise on all aspects of service delivery. However, one quarter had no structural arrangements in place for consumer and carer participation.

- Significant proportions of state and territory mental health services also had some other arrangements in place for consumer and carer participation, although the extent to which organisations had established particular initiatives varied. Mechanisms for carer participation have been less developed than those for consumer participation, but the gap is closing.

- In 2010-11, there were 4.6 consumer and carer workers employed for every 1,000 full-time equivalent staff in the mental health workforce. This figure has risen by 33% since 2002-03, when it was 3.5 per 1,000.

- In recent times, there have been a number of consumer and carer developments that have had an increased emphasis on social inclusion and recovery. For example, the recently established National Mental Health Commission has produced its first *Report Card*, identifying and reporting on several areas that are important to consumers' ability to lead a contributing life. Moves are also underway to establish a new national mental health consumer organisation, auspiced by the Mental Health Council of Australia, that will ensure that a strong and consolidated consumer voice can contribute to more responsive and accountable mental health reform.

Monitoring progress and outcomes under the *Fourth National Mental Health Plan*

Priority area 1: Social inclusion and recovery

Indicator 1a: Participation rates by people with mental illness of working age in employment: General population

- In 2011-12, 62% of working age Australians with a mental illness were employed, compared to 80% of those without a mental illness.

- Employment participation rates for this group ranged from 52% in Tasmania to 73% in the Australian Capital Territory.

- Nationally, employment rates for this group decreased slightly from 64% in 2007-08 to 62% in 2011-12.

Indicator 2a: Participation rates by young people aged 16-30 with mental illness in education and employment: General population

- In 2011-12, 79% of Australians aged 16–30 years with a mental illness were employed and/or enrolled in study towards a formal secondary or tertiary qualification, compared to 90% of their same age peers.
- Employment and education participation rates for this group for most states and territories were within 10% of the national average.
- Nationally, employment and education participation rates for this group remained stable between 2007-08 and 2011-12.

Indicator 3: Rates of stigmatising attitudes within the community

- Social distance is a term used to indicate the willingness of people to interact with people experiencing mental illness. In 2011, on average, Australians rated themselves as relatively more 'willing' than 'unwilling' to interact socially with people with a mental illness. Stigmatising attitudes varied across the different types of mental illness, with the average desire for social distance being highest for chronic schizophrenia, followed by early schizophrenia, depression and depression with suicidal thoughts.
- Comparing the 2011 results with equivalent data from 2003-04, Australians' desire for social distance from people with depression with suicidal thoughts had decreased. However, their desire for social distance from people with depression without suicidal thoughts, early schizophrenia and chronic schizophrenia remained relatively unchanged.
- There is evidence that the efforts of organisations like *beyondblue* may have contributed to this improvement, at least in the case of depression.

Indicator 4: Percentage of mental health consumers living in stable housing

- Nationally, the percentage of adult consumers of state and territory mental health services (aged 15-64) with no significant problems with their living conditions has been stable from 2007-08 to 2010-11 (sitting at around 78%). Consumers in the Australian Capital Territory were the least likely to report problems and those in the Northern Territory were the most likely to do so.
- The percentage of older adult consumers (aged 65+) with no significant problems with their living conditions has shown a slight improvement over time, rising from 79% in 2007-08 to 83% in 2010-11. Older consumers in New South Wales were the least likely to report problems, and those in Tasmania were the most likely to do so.
- Safe, secure and affordable accommodation is critical to recovery for people with living with a mental illness.

Priority area 2: Prevention and early intervention

Indicator 6: Proportion of primary and secondary schools with mental health literacy component included in curriculum

- Australia has invested significant resources in programs that promote mental health literacy in schools – notably MindMatters in secondary schools and Kidsmatter in primary schools.
- In 2011, 45% of schools had implemented a mental health framework, 60% were offering mental health programs, and 69% were providing mental health literacy resources.

Indicator 7: Rates of contact with primary mental health care by children and young people

- There was a three-fold increase in the number of children and young people receiving Medicare-funded primary mental health care services from 2006-07 (79,139) to 2011-12 (337,177). This represents an increase from 1.1% of children and young people receiving these services to 4.6% of children and young people doing so.
- The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%).
- This improvement is largely due to the introduction of the Better Access initiative in 2006.

Indicator 8: Rates of use of licit and illicit drugs that contribute to mental illness in young people

- Data from the National Drug Strategy Household Survey show that use of both licit and illicit drugs has decreased over time.
- In 2001, 47% of 14-29 year olds engaged in risky drinking in the previous year. This had reduced to 42% by 2010, the lowest figure recorded to date.
- In 1998, 36% of 14-29 year olds used cannabis. By 2010, this figure had halved (19%), although the latter figure represented a rise from 2007.
- Ten per cent of 14-29 year olds used amphetamines in 1998 compared with 4% in 2010. As with alcohol, these are the lowest figures recorded to date.

Indicator 9: Rates of suicide in the community

- In 2011, there were 2,273 suicides in Australia, 76% of which were by males.
- Nationally, the average annual suicide rate for the period 2007-11 was 10.6 per 100,000 (16.3 per 100,000 for males; 4.9 per 100,000 for females). The Northern Territory stood out as having particularly high rates.
- The average suicide rate has remained stable since 2003-07. The rate is considerably lower than it was before Australia began its concerted efforts to address suicide through strategic national action.

Indicator 11: Rates of understanding of mental health problems and mental illness in the community

- In 2011, nearly three quarters (74%) of Australian adults could recognise depression. This figure was even higher (86%) for depression accompanied by suicidal thoughts.
- Rates of recognition of early and chronic schizophrenia and post-traumatic stress disorder were lower, with only about one third of the population being able to recognise these disorders. Rates of recognition of social phobia were the worst at 9%.
- Rates of recognition of depression have improved since 1995, whereas rates of recognition of schizophrenia peaked in 2003-04 and have declined slightly since. Recognition of post-traumatic stress disorder and social phobia were only assessed in 2011, so no comparison data are available.

Indicator 12: Prevalence of mental illness

- In 1997, 18% of adults experienced a common mental illness (anxiety disorders, affective disorders and substance use disorders) in the past 12 months. In 2007, the figure was slightly higher at 20% but this may be explained by methodological differences in the way in which these prevalence figures were gathered.
- In both 1997 and 2007, young adults experienced higher rates of mental illness than older adults.
- In 1998, 14% of children and adolescents were affected by a clinically significant mental health problem. More current data will be collected in 2013.

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

Indicator 13: Percentage of population receiving mental health care

- The percentage of the population seen by state and territory community mental health services from 2006-07 to 2010-11 remained relatively stable at 1.5%.
- The percentage of the population receiving mental health specific Medicare-funded services rose from 3.1% in 2006-07 to 6.9% in 2010-11. This increase was largely due to the introduction and uptake of services provided through the Better Access initiative.
- Targets for population coverage by mental health services are yet to be agreed but are expected to be advanced as part of the continuing development of the *Roadmap for Mental Health Reform*[1] agreed by the Council of Australian Governments (COAG) in December 2012.

Indicator 14: Readmission to hospital within 28 days of discharge

- In 2010-11, the percentage of admissions to state and territory acute psychiatric inpatient units that were followed by a readmission within 28 days was 15% nationally. This figure has been stable since 2005-06.
- Two states had readmission rates lower than 10% in 2010-11: the Australian Capital Territory (5%) and South Australia (9%). South Australia's figures should be interpreted with caution because they may represent an undercount.
- There has been little movement over time in almost all states and territories, except in the Australian Capital Territory where the rate has more than halved since 2005-06.

Indicator 15: Rates of pre-admission community care

- In 2010-11, 47% of admissions to state and territory acute inpatient psychiatric units were preceded by community care in the seven days before the admission. This figure represents a small improvement over recent years.
- There is considerable cross-jurisdictional variability. The Australian Capital Territory is the only jurisdiction to have achieved rates above 70%, with 76% of its acute inpatient admissions in 2010-11 being preceded by community care in the seven days prior to admission.
- The 2010-11 figures for the other states and territories range from 27% in the Northern Territory to 63% in Western Australia.

Indicator 16: Rates of post-discharge community care

- In 2010-11, 54% of Australian admissions to state and territory acute psychiatric inpatient units were followed by community care (in the seven days after discharge). This percentage has been improving incrementally since 2005-06.

- There is substantial variation across jurisdictions, with 2010-11 one week post-discharge follow up rates ranging from a low of 19% (in the Northern Territory) to a high of 79% (in the Australian Capital Territory).

Indicator 19: Prevalence of mental illness among homeless populations

- Routinely collected data from the former Supported Accommodation Assistance Program (SAAP) suggests that, in 2010-11, 11% of SAAP clients sought accommodation because of mental health problems, 9% did so because of substance use problems, and 7% did so because of comorbid mental health and substance use problems.

- These figures are likely to underestimate the true prevalence of mental illness among homeless populations because they focus on clients whose referral to SAAP was associated with these problems. They do not take into account clients who may have underlying conditions that are not directly responsible for the referral.

- From July 2011, the Special Homelessness Services (SHS) collection will enable more accurate estimates of mental illness among homeless populations to be calculated.

Indicator 20a: Prevalence of mental illness among people who are remanded or newly sentenced to adult correctional facilities

- In 2010, 31% of new entrants to adult prisons reported having been told by a health professional that they had a mental illness, 16% reported that they were currently taking mental health related medication, and 14% reported very high levels of psychological distress.

- These figures indicate that new prisoners have poorer mental health than the general population.

- Ongoing collaborative efforts between the health and justice sectors are required to reduce the prevalence of mental illness among prisoners.

Priority area 4: Quality improvement and innovation

Indicator 21: Proportion of total mental health workforce accounted for by consumer and carer workers

- Nationally, in 2010-11, 4.6 per 1,000 (or 0.5%) of the total full-time equivalent (FTE) mental health workforce was accounted for by consumer and carer workers. This represents an increase of 33% since the 2002-03 level of 3.5 FTE per 1,000 (0.3%). This growth is due to an almost fourfold increase in the number of FTE carer workers per 1,000, compared to a slight decrease in FTE consumer workers per 1,000.

- There is substantial variation across jurisdictions, with the highest proportions in South Australia (6.3 per 1,000 in 2010-11, or 0.6%) and Victoria (6.1 per 1,000, 0.6%), and the lowest rates in the Australian Capital Territory and the Northern Territory (0.0 per 1,000, or 0.0%).

Indicator 22: Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards

- In 2010-11, 84% of specialised mental health services in Australia had undertaken external accreditation and been judged to meet all standards set out in the National Standards for Mental Health Services (Level 1). A further 8% met some but not all standards (Level 2), 4% had made some progress towards external review (Level 3) and 4% did not meet criteria for Levels 1-3 (Level 4).

- In two jurisdictions (the Australian Capital Territory and the Northern Territory) 100% of services met the standards set for Level 1. Three others (Queensland, Victoria and South Australia) came close to this, with at least 96% of their services achieving Level 1. In other states the proportion of services achieving Level 1 was lower. In New South Wales (79% at Level 1) and Tasmania (48% at Level 1), the balance of services had undertaken external review and reached threshold for Level 2, whereas in Western Australia (49% at Level 1), the balance had not completed external review and were graded as Levels 3 or 4.

- Ongoing effort is required to ensure more uniform levels of accreditation across jurisdictions.

Indicator 23: Mental health outcomes for people who receive treatment from state and territory services and the private hospital system

- Around three quarters of consumers admitted to state and territory public sector mental health inpatient services improve significantly, just under one quarter show no change, and a small percentage deteriorate. This pattern also holds true in private psychiatric hospital units.

- In state and territory community services, the picture depends on the nature of the episode of care. Fifty per cent of those who receive relatively short term care and are then discharged improve significantly, 42% show no change, and 8% deteriorate. Twenty six per cent of those who receive longer term, ongoing care show significant improvement, 58% show no change, and 16% deteriorate.

- This picture is complex and requires careful interpretation in light of the goals of care within each setting and for each type of episode and the limitations of the measurement process. Further work needs to be done to determine what outcomes are consistent with a service system offering 'best practice' care across the board.

Profiles of state and territory reform progress

- State and territory data are provided on a range of indicators of resourcing levels, outputs and outcomes.

- The comparisons emerging from the data highlight differences in service levels and mix, outputs and outcomes, as well as identifying common ground between the various mental health service systems in Australia.

- In interpreting relative progress, it is important to recognise the different histories, circumstances and priorities of each jurisdiction, and the requirement for mental health service planning to be based on local population needs.

Part 1: Introduction and background

1.1 Purpose of the report

At the time of releasing this report, Australia is at the beginning of a third decade of targeted reform of mental health services that is referred to as the National Mental Health Strategy. Commencing in April 1992 with the endorsement by Health Ministers of a *National Mental Health Policy*,[2] the National Mental Health Strategy committed governments to undertake action within their respective jurisdictions, as well as to collaborate on policy and service development issues requiring a national focus. This was the first attempt in Australia to set a common course of action by governments in the development of public mental health services which had been the exclusive responsibility of the eight state and territory governments since Federation.

Much has changed since the original agreement of 1992, with the Strategy progressing through a series of five year national mental health plans, and more recently, a number of whole-of-government national plans and initiatives endorsed through Australia's peak intergovernmental coordinating body, the Council of Australian Governments (COAG). The national policy environment for mental health reform in Australia is now far more complex than was the case when the original agreement to a *National Mental Health Policy* was signed in 1992.

The *National Mental Health Report* has been a constant throughout this process. In agreeing to the National Mental Health Strategy, Health Ministers recognised that an important aspect of the reform process was to ensure that progress is monitored and publicly reported. The *National Mental Health Report* was prescribed as the main vehicle for this to be achieved.

Its original stated purpose was to:

- present relevant information about the resources that underpin mental health service delivery (human and financial), their funding sources and how those resources are being applied to achieve the national reform aspirations;
- monitor changes that have taken place in the provision of mental health care;
- act as an information resource on the state of mental health services in Australia, for use by a range of interested parties; and
- improve community understanding of the reform of Australia's mental health services.

The *Fourth National Mental Health Plan*,[3] covering the current period to 2014, placed greater emphasis on monitoring of outcomes than its predecessors and committed to a restructured *National Mental Health Report*. The current report is consistent with this new focus. It includes the most current information on a series of indicators associated with particular outcomes, and reports on the progress of the actions committed to by governments in each of the five priority areas outlined in the *Fourth Plan*. At the same time, it continues to provide an analysis of the key measures that were central to all previous *National Mental Health Reports* (for example, per capita expenditure, workforce levels, hospital/community mix).

This redesigned *National Mental Health Report*, the twelfth in the series, draws on a range of sources to present an analysis of reform trends, and has the imprimatur of Health Ministers who have bound their respective administrations to collecting and reporting on relevant data in a timely fashion. The reference year for the majority of the data presented in the report is 2010-11.

1.2 The magnitude of the problem: Indicators of mental illness in Australia

In order to examine the achievements of the National Mental Health Strategy, it is necessary to gauge the number of people affected by mental illness in the Australian population, and to understand how mental illness affects their lives.

When the National Mental Health Strategy began, no information was available about the extent and impact of mental illness in Australia, so, in the late 1990s, a program of population surveying was commenced. Known collectively as the National Survey of Mental Health and Wellbeing, it comprised three cross-sectional surveys. The first took place in 1997 and investigated the prevalence and impact of common mental disorders (depression, anxiety and substance use disorders) in adults.[4] The second survey, also conducted in 1997 and targeted at adults, focused on the less common mental illnesses (in particular, psychotic disorders).[5] Because neither of the first two surveys could shed light on young people's mental health, the third study was commissioned in 1998 to capture information about the mental health of children and adolescents.[6] The two surveys of adults were repeated in 2007 and 2010, respectively.[7-9] A new survey of children and adolescents has been commissioned and will be conducted in 2013. More detail about the scope of these studies is provided in Table 1
National Survey of Mental Health and Wellbeing: Epidemiological studies commissioned to measure the extent and impact of mental illness in Australia. The text below the table draws on data from the most recent surveys only.

Table 1
National Survey of Mental Health and Wellbeing Epidemiological studies commissioned to measure the extent and impact of mental illness in Australia

Survey	Year	Target group and focus	Sample size	Recruitment method	Data collection method	Prevalence estimates
Survey of adult population	1997	Adults (aged 18+), common mental disorders (depression, anxiety and substance use)	10,641	Recruited through households	Structured diagnostic interviews	One year prevalence (community): 17.7%
	2007	Adults (aged 16-85), common mental disorders (particularly depression, anxiety and substance use disorders)	8,841	Recruited through households	Structured diagnostic interviews	One year prevalence (community): 20.0% Lifetime prevalence (community): 45.0%
Survey of people living with psychotic illness	1997	Adults (aged 18-64), psychotic disorders	980	Recruited through specialist mental health services, GPs and private psychiatrists	Census, interviews, information from service providers	One month prevalence (treated): 0.4-0.7%
	2010	Adults (aged 18-64), psychotic disorders	1,825	Recruited through specialist mental health services and non-government organisations	Census, interviews, information from GPs and other service providers	One month prevalence (treated): 0.3%; One year prevalence (treated): 0.5%
Survey of children and adolescents	1998	Children and adolescents (aged 4-17), common mental disorders	4,509	Recruited through households	Interviews	Point prevalence (community): 14.1%
	Survey in the field May to December 2013	Children and adolescents (aged 4-17), common mental disorders	6,300	Recruited through households	Structured diagnostic interviews	Results due for publication late 2014

The 2007 survey of the adult population found that one in five (20%) – 3.2 million individuals – experienced one of the common mental disorders in the preceding year. Fourteen per cent experienced anxiety disorders, 6% mood disorders, and 5% substance use disorders. One quarter experienced two or more of these conditions in the year of interest. Prevalence was highest among those aged 16-24 (26%) and declined with age, and two thirds of those with depression and/or anxiety disorders had experienced their first episode before the age of 21. This highlights the need for an emphasis on early intervention services that target younger people.

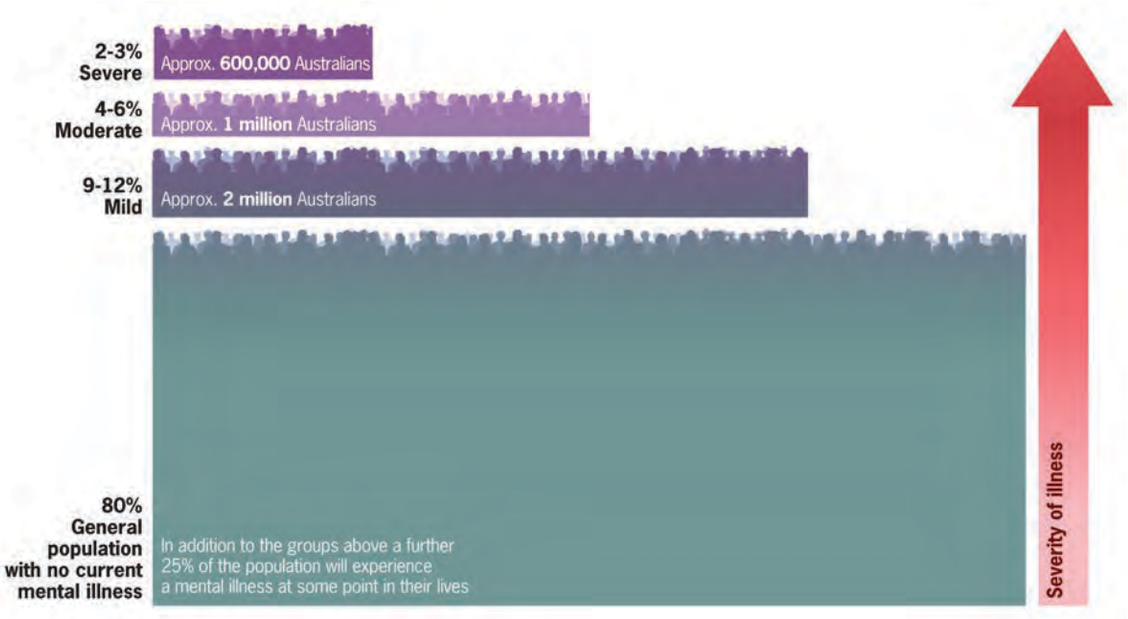
Turning to lower prevalence disorders, the 2010 Survey of People Living with Psychotic Illness found that 0.5% of the adult population had been treated for a psychotic disorder in the previous year. This equates to 64,000 people, almost half of whom had schizophrenia. Two thirds of these people experienced their initial episode before they turned 25, and many of them had experienced disabling, unremitting symptoms since the onset of their illness.[7] Psychotic illnesses are the focus of many state and territory mental health services and account for the majority of resources devoted to specialist mental health care in Australia.

The above adult surveys showed that many people with mental illness experience symptoms quite early in their lives. The 1998 child and adolescent survey further emphasised the importance of the early years, showing that 14% of those aged 4-17 were affected by a clinically significant mental health problem. This amounted to about 500,000 individuals, including 93,000 with anxiety or depression, 200,000 with aggressive behaviours, and 93,000 with attention deficit disorders. As noted above, these figures will be updated by the 2013 survey data.

Prevalence estimates only provide part of the picture and need to be complemented by an understanding of the extent to which mental illness contributes to overall ill health. Figures from the 2003 World Health Organization's Global Burden of Disease (GBD) study provide some insights here. The GBD study measured the burden of all diseases using a common metric that is based on years of life lost due to premature mortality and years of life lived in less than full health (morbidity). Most of the burden of mental disorders is associated with morbidity, not mortality. Mental disorders accounted for 24% of the total burden of non-fatal disease and injury in Australia in 2003.[10] The recently released figures from the 2010 GBD study present a similar picture.[11]

Mental illness impacts on people's lives at different levels of severity. Various modelling exercises have been conducted that combine data from the Australian prevalence studies with data from other sources, including the GBD study, in order to inform service system planning (see Figure 1).[12] These analyses suggest that an estimated 2-3% of Australians – around 600,000 people – have severe disorders, as judged by diagnosis, intensity and duration of symptoms, and degree of disability. This group is not confined to those with psychotic disorders who in fact represent only about one third of those with severe mental illness; it also includes people with severe and disabling forms of depression and anxiety. Another 4-6% of the population (approximately 1 million people) have moderate disorders, and a further 9-12% (approximately 2 million people) have mild disorders.

Figure 1
12 month prevalence estimates of mental illness in the population by severity level, based on diagnosis, disability and chronicity



Taken together, the combined estimates of prevalence, disability and severity provide guidance for planning services, allocating resources and evaluating the overall effectiveness of the National Mental Health Strategy. They show that mental illness is a common problem in the Australian community. They also suggest, however, that individuals experience mental illness in different ways. Some people have severe and debilitating disorders, whereas others have mild or moderate conditions.

The corollary of this is that there is not a one size fits all solution to mental health care. Some people have extensive and ongoing needs for services whereas others may only need care occasionally or for a brief period, or may not need care at all. The 2007 National Survey of Mental Health and Wellbeing of adults showed that only 35% of those who met criteria for a mental disorder made use of services for mental health problems, but that this varied by level of severity (64% of those with severe disorders received services, 39% of those with moderate disorders did so, and 17% of those with mild disorders did so).[8 13] However, 86% of those who did not receive mental health care indicated that they had no need for any of the kinds of services that are typically offered (for example, information, medication, talking therapy, social intervention and skills training).[14] Ensuring that appropriate, high quality services are available to those who need them, when they need them, has been a consistent goal of the National Mental Health Strategy since its inception.

The National Mental Health Strategy aims to reduce both the prevalence and severity of mental illness. This is embodied in the Strategy's population health approach, which recognises that the determinants of mental health status comprise a range of psychosocial and environmental factors (including, for example, income, employment, education and access to community resources), and encompasses the entire spectrum of interventions from mental health promotion and mental illness prevention through to recovery. A reduction in the prevalence of mental illness may be brought about by preventive efforts to stop an illness occurring in the first place, or by increasing access to effective treatments to reduce the duration of illness for those who already have symptoms. Reducing the severity of mental illness requires a range of services designed to alleviate the disablement that may be associated with a person's social, personal and vocational functioning.

1.3 Setting the scene: The national mental health reform context

Overview of the National Mental Health Strategy

The National Mental Health Strategy has provided the overarching policy framework that has guided an extensive process of mental health reform in Australia for the last 20 years. Commencing with the endorsement of the *National Mental Health Policy* in 1992, the concept of the National Mental Health Strategy has grown to encompass the range of national policy and planning documents relating to mental health reform that have been agreed by all governments, either through their respective Health Ministers, or at the level of First Ministers through the Council of Australian Governments (COAG). These include four five year *National Mental Health Plans* covering the period 1993 to 2014, a revised *National Mental Health Policy* released in 2008,[15] the COAG *National Action Plan on Mental Health* endorsed in 2006[16] and, more recently, an agreement by COAG in December 2012 to the *Roadmap for National Mental Health Reform 2012-2022*.[1] As a national agreement endorsed by all heads of governments, the *Roadmap* represents the most current statement of intergovernmental commitment to mental health reform as an ongoing national priority, and outlines the directions that reform will take over the next 10 years.

The direction of reform has changed considerably over the 20 years that the National Mental Health Strategy has been in place, reflecting both the achievement of previous objectives and the incorporation of new priorities, driven by emerging knowledge and changing community expectations. A brief, chronological history of the policy directions of the Strategy is provided below.

The *First National Mental Health Plan* (1993-1998) represented the first attempt to coordinate mental health care reform in Australia. It focused primarily on state and territory mental health services and advocated for major structural reform, with a particular emphasis on decreasing the reliance on stand-alone psychiatric hospitals, expanding community based care alternatives, and 'mainstreaming' the delivery of acute inpatient care into general hospitals.

An evaluation of the *First National Mental Health Plan* was conducted in 1997.[17] This was generally positive, but observed that there were some areas that could be strengthened. As a result, when the *Second National Mental Health Plan* (1998-2003)[18] was released in 1998 it continued the work of the *First Plan* towards structural reform, but expanded into additional areas such as mental health promotion, mental illness prevention and destigmatisation. In terms of mental illnesses, the remit of the *Second Plan* was broader than that of the *First Plan*; it moved beyond the severe and disabling disorders that are typically treated in state and territory-funded services, and also considered more prevalent conditions like depression and anxiety. It also fostered important partnerships – between the public and private sectors, between specialist services and primary care providers, and, more broadly, between the health sector and sectors outside health that have an influence on people's lives.

The *Second National Mental Health Plan* underwent a mid-term review in 2001.[19] It was evaluated more formally in 2003,[20] and the *Third National Mental Health Plan (2003-2008)*[21] was released later that year. Again, the findings of the review and evaluation of the *Second Plan* helped to shape the directions of the *Third Plan*. The *Third Plan* set out to consolidate the achievements of the previous two 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* emphasised the importance of cross-sectoral partnerships in supporting mental health and wellbeing, and the need to respond to mental illness through a whole-of-government approach. These themes were elevated as priorities in 2006 when COAG

agreed to the *National Action Plan on Mental Health*. The *National Action Plan* was developed by governments to give further impetus to mental health reform and sharpen the focus on areas that were perceived by stakeholders to have not progressed sufficiently under the first three *National Mental Health Plans*. It represented the first time that heads of governments had focused on the issue of mental health and agreed to a national plan of action to reform mental health services. It took the delivery of services for people with mental illness into areas beyond the boundaries of traditional health care. Key human service programs operating outside the health system with major responsibilities under the COAG *National Action Plan* include housing, employment, education and correctional services. The *National Action Plan* also emphasised the role of the non-government sector in the delivery of a wide range of community support services.

In 2008, the National Mental Health Strategy was extended through a new *National Mental Health Policy*, endorsed by Health Ministers. The new *Policy* carried forward the central tenets of the previous *Policy*, but updated various elements of it to bring it into closer alignment with the whole-of-government approach articulated in the COAG *National Action Plan*. The new *Policy* provided 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.

2008 also saw a summative evaluation of the *Third National Mental Health Plan*,[22] the findings from which influenced the *Fourth National Mental Health Plan* which was released in the following year. The *Fourth Plan* specified priorities for collaborative government action, identifying 34 reform actions to be undertaken across five priority areas, namely:

- social inclusion and recovery;
- prevention and early intervention;
- service access, coordination and continuity of care;
- quality improvement and innovation; and
- accountability.

In 2010, Health Ministers endorsed the Implementation Strategy for the *Fourth National Mental Health Plan* that detailed specific implementation strategies against each of the 34 actions in the *Fourth Plan*, and the first report on implementation progress was released in 2011. More recently, the Australian Health Ministers' Advisory Council endorsed a more focused approach to implementation, with a view to integrating mental health reform efforts outlined in the 2011-12 Federal Budget and broader reforms that are being progressed through the COAG *National Action Plan*. The result of this decision was that the approach to implementation of the *Fourth Plan* became more streamlined and strategic in focus. Emphasis was given to 22 of the actions that were identified as capable of being progressed independently of the wider national reforms, and this was later increased to 23.

In January 2012, the Federal Government established a new agency – the National Mental Health Commission – to provide a new approach to guiding and monitoring mental health reform in Australia. The Commission's core function is to monitor and evaluate the mental health system as a whole, and do this by working closely with consumers, carers, stakeholders and all jurisdictions. The Commission is located in the Prime Minister's portfolio, recognising the importance to mental health reform of cross sectoral, whole-of-government leadership. Similar state-level Commissions have also been established by New South Wales and Queensland. The Western Australian Mental Health Commission, the first in Australia, was established with a broader range of functions including the responsibility for public investment in mental health.

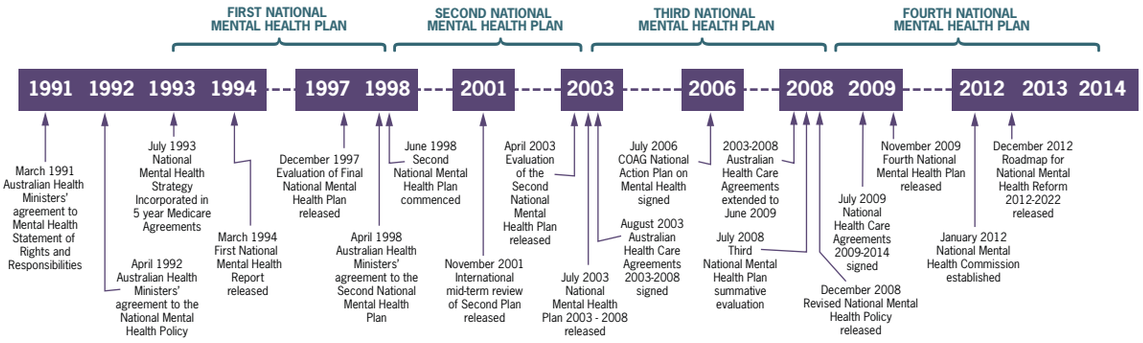
Most recently, in December 2012, COAG agreed to the *Roadmap for National Mental Health Reform* that outlines the directions that will be taken by governments over the next 10 years. The *Roadmap* set out new governance and accountability arrangements designed to directly engage stakeholders and ensure that governments are held to account. These new arrangements include the establishment of a COAG Working Group on Mental Health Reform that is required to develop, for COAG's consideration by mid-2014, a successor to the

Fourth National Mental Health Plan that will set out how the *Roadmap* will be implemented.

Alongside the above national activities, states and territories have developed their own mental health plans that have reflected the goals and principles of the national approach, but have been tailored to meet local requirements. Jurisdictions' own plans remain the key documents for setting out the specific details of how they will work towards achieving the objectives agreed under the National Mental Health Strategy.

A summary of key milestones in the life of the National Mental Health Strategy is provided in Figure 2.

Figure 2
Milestones in the life of the National Mental Health Strategy



Framework for national action

From its inception, the National Mental Health Strategy has been premised on an understanding of the complementary roles of the Australian Government and state and territory governments.

The states and territories have traditionally been responsible for the funding and provision of the public sector mental health services that provide specialist care for people with severe mental illness. These include services delivered in inpatient settings and services delivered by community-based teams. As the main source of both funding for specialised mental health services, the states/territories have occupied a central position in Australia's mental health system.

For its part, the Australian Government is responsible for providing leadership to guide national action, and monitoring the reform process. It also funds a range of services for people with mental illness via the Medicare Benefits Schedule, the Pharmaceutical Benefits Schedule and programs administered by the Department of Health and Ageing (DoHA), the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the Department of Veterans' Affairs (DVA). Its role expanded substantially as a result of the COAG *National Action Plan on Mental Health* in 2006, and more recently through a broad range of new and expanded programs announced in the 2011 Federal Budget. These included the expansion of mental health services subsidised by Medicare, and a range of mental health specific community support programs managed through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA).
The Australian Government also funds a range of mainstream programs and services which provide essential support for people with mental illness. These include income support, social and community support, disability services, workforce participation programs, and housing assistance.

1.4 Reporting on mental health services in Australia

Few national policy areas in Australia are subject to an equivalent level of reporting and accountability as required under the National Mental Health Strategy. The *National Mental Health Report* is complemented by four other major reports on mental health services and mental health reform, described below:

- *Mental Health Services in Australia* is published by the Australian Institute of Health and Welfare and presents detailed information on the activity and resourcing of mental health services, primarily drawing on the National Minimum Data Sets for Mental Health.[23]

- Annual *Progress Reports on the COAG National Action Plan on Mental Health* are prepared under the auspices of the Australian Health Ministers Standing Council on Health (SCoH) and focus on the agreed actions and indicators in the COAG *National Action Plan*. The final report on the *National Action Plan* is due for release in 2013.[24-27]

- The mental health chapter of the *Report on Government Services (RoGS)* is published by the Productivity Commission on behalf of the COAG Steering Committee on Government Service Provision.[28] It provides summary information on resourcing and delivery of mental health services, drawing on data presented in *Mental Health Services in Australia* and the *National Mental Health Report,* and data provided by the Australian Bureau of Statistics.

- The annual *National Report Card on Mental Health and Suicide Prevention* is prepared by the National Mental Health Commission.[29] This new report aims to give a whole-of-government view of mental health reform in Australia, giving greater transparency to the performance of the systems that support people with a lived experience of mental health issues, their families, carers and other support people. The Commission released its first *Report Card* in November 2012.

All of these publications are published annually or biennially, and, with the exception of the COAG *National Action Plan on Mental Health Annual Progress Reports*, all are expected to continue into the foreseeable future.

Most recently, an additional report on mental health reform has been endorsed by COAG as a component of its *Roadmap for National Mental Health Reform 2012-2022*. The National Mental Health Commission will prepare three yearly reports to COAG to document progress towards achieving the *Roadmap* vision, with monitoring of progress focused on long term change at the national level, reflecting the ten year span of the *Roadmap*.

1.5 Structure of the current report

This report is presented in four parts, followed by a set of appendices:

- Part 1 outlines the purpose of the report and sets the scene by providing an overview of the National Mental Health Strategy.
- Part 2 presents system-level indicators of mental health resourcing and service delivery in Australia. It is organised around five groups of indicators (national spending on mental health, national workforce trends, trends in state and territory mental health services, trends in private sector mental health services, and consumer and carer participation in mental health care).
- Part 3 is dedicated to monitoring the actions of the *Fourth National Mental Health Plan*. It is organised around the *Plan's* five priority areas, and describes progress in implementation of key action areas and presents data for relevant indicators.
- Part 4 presents jurisdiction-level indicators, and includes resourcing indicators on the provision of mental health services and selected indicators reported at a national level in Part 2.
- The appendices identify the sources of data used in the report and provide explanatory notes on selected indicators.

1.6 Conventions used in the current report

Several conventions are used to improve the readability of this report.

- Financial years are generally presented in a standard format (for example, 2010-11 refers to the year from 1 July 2010 to 30 June 2011). Occasionally, financial years are abbreviated by referring to the last calendar year of the pair (for example, 2010-11 is abbreviated to 2011 and the period 1992-93 to 2010-11 is abbreviated to 1993-2011).
- Unless otherwise stated, all expenditure and revenue are expressed in 2010-11 constant prices.
- Unless otherwise stated, all population data are expressed as crude (non-age standardised) rates.
- In general, figures are rounded to whole numbers and decimal points are only used in the text, figures and tables when an individual number in the series is less than 10. The effect of this rounding is that totals do not always equal 100%.
- Government bodies, initiatives and reports are referred to by their full name the first time they are mentioned in a given section but are often abbreviated on subsequent mentions (for example, the Council of Australian Goverments is sometimes referred to as 'COAG', the 'National Mental Health Strategy' is sometimes referred to as 'the Strategy' and the *Fourth National Mental Health Plan* is sometimes referred to as the *Fourth Plan*).

Part 2: System-level indicators of mental health reform in Australia, 1993 to 2011

2.1 Introduction

Since its original publication, the *National Mental Health Report* has focused on building a long term picture of mental health reform in Australia. It has done this by presenting summary information on system-level indicators of reform that track changes in the mix of services along with the financial and human resources that underpin those services. Part 2 continues that tradition by adding the most recently available data in five key areas, namely:

- National spending on mental health;
- National workforce trends;
- Trends in public sector mental health services;
- Trends in private sector mental health services; and
- Consumer and carer participation in mental health care.

Data sources and explanatory notes for data presented in Part 2 are provided in Appendix 1.

2.2 National spending on mental health

KEY MESSAGES:

- The original commitment made by all governments to protect mental health resources under the National Mental Health Strategy has been met. Total government expenditure on mental health increased by 178% in real terms between 1992-93 and 2010-11. In 2010-11, Australia spent $4.2 billion more of public funds on mental health services than it did at the commencement of the Strategy in 1992-93.
- Until recently, growth in mental health spending mirrored overall health expenditure trends for most of the 18 year period since the Strategy began. In the most recent year (2010-11), mental health increased its position in terms of relative spending within the broader health sector.
- Australian Government spending has increased by 245% compared to an increase of 151% by state and territory governments. This increased the Australian Government share of total national spending on mental health from 28% in 1992-93 to 35% in 2010-11. Most of the increase in Australian Government spending in the first ten years of the Strategy was driven by increased outlays on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme, but more recently other activities have taken over as the main drivers of increased mental health spending.

- The considerable variation in funding between the states and territories that existed at the beginning of the Strategy is still evident 18 years later, mid-way through the *Fourth National Mental Health Plan*. The gap between the highest spending and the lowest spending jurisdiction increased over the 1992-93 to 2010-11 period. The disparity between the states and territories points to wide variation in the level of mental health services available to their populations.

- Despite claims to the contrary, there are no reliable international benchmarks by which to judge Australia's relative investment in mental health. These await international collaboration on costing standards to ensure 'like with like' comparisons.

Public reporting on the level of spending on mental health services has been a central function of previous *National Mental Health Reports*. Under the *First National Mental Health Plan*, all governments agreed to maintain a level of expenditure on specialised mental health services at least equivalent to the level at the beginning of the National Mental Health Strategy, and to review annually whether this was occurring.

Regular monitoring of the relative contributions of the main funding authorities responsible for mental health services also serves as a check against the possibility that the reform process may simply lead to shifts of financial responsibility from one funder to another, rather than overall growth in services. This was a concern expressed by advocacy groups at the outset of the Strategy.

This section of the report provides an overview of 2010-11 spending on mental health services within the context of information about spending patterns since the Strategy began.

Total spending on mental health services, 2010-11

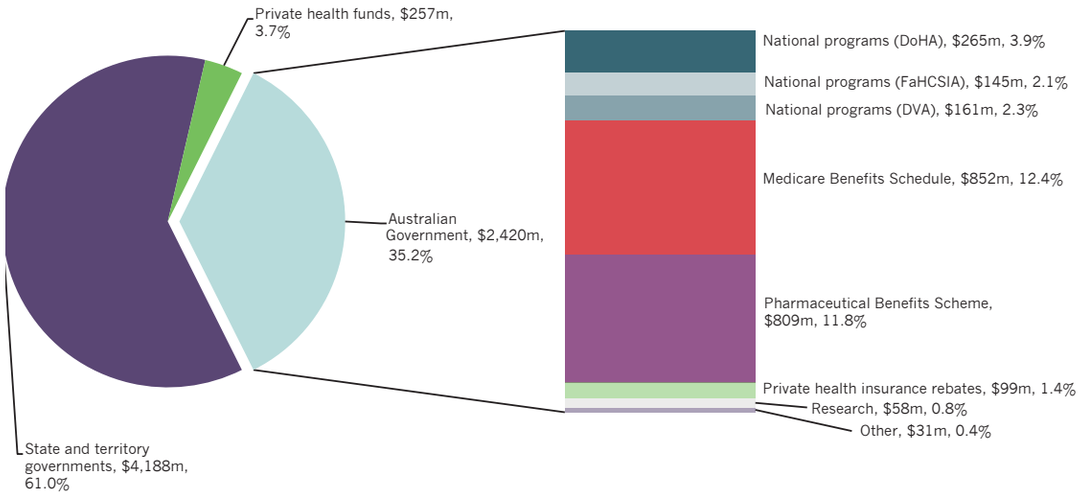
Total spending on mental health services by the major funders in Australia in 2010-11 was $6.9 billion. This represents an increase of 6.7% in real terms from 2009-10. Spending on mental health services and related activity represented 7.7% of total government health spending in 2010-11, compared with 7.3% at the beginning of the National Mental Health Strategy.[A] This is the highest level of mental health spending as a share of overall health expenditure recorded since the *National Mental Health Report* series commenced in 1993.

The major funders are the Australian Government, state and territory governments and private health insurers. Their relative contributions are summarised in Figure 3. Collectively, state and territory governments continue to play the largest role in specialised mental health service delivery, as they are primarily responsible, either directly or indirectly, for the delivery and management of most services. They have been the main focus of previous *National Mental Health Reports*, and remain a major feature of the current report.

The Australian Government is the largest single funder and was responsible for more than one third (35%) of total spending in 2010-11. It provides funding for a range of services and programs but does not deliver these services directly.

[A] Based on Department of Health and Ageing analysis of health expenditure data prepared by the Australian Institute of Health and Welfare and extracted from the national database used for the publication *Health Expenditure Australia 2010-11* (Health and Welfare Expenditure Series No. 47, Cat. No. HWE 46). Canberra: Australian Institute of Health and Welfare, 2012. The calculation of the proportion of total health expenditure directed to mental health includes only government and private health insurance revenue sources.

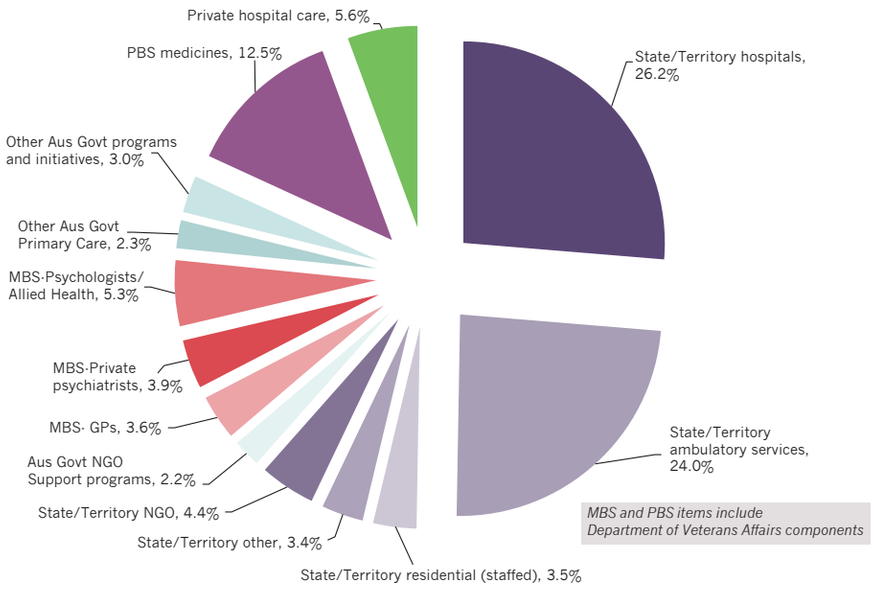
Figure 3
Distribution of recurrent spending on mental health, 2010-11 ($millions)



How Australia's 2010-11 spending was invested

Figure 4 shows how Australia's $6.9 billion investment in mental health in 2010-11 was spent. Hospital services administered by state and territory governments accounted for the largest share of total national spending (26%). This was followed by state and territory ambulatory care services (24%) and psychiatric medicines subsidised through the Australian Government Pharmaceutical Benefits Scheme (13%).

Figure 4
National spending on mental health, 2010-11



Total 2010 –11 spending on mental health programs and services: $6.9 billion

National spending trends

Annual recurrent expenditure on mental health services by the major funding authorities increased by 171% from 1992-93 (the year before the National Mental Health Strategy began) to 2010-11 (the mid-point year of the *Fourth National Mental Health Plan*). Figure 5 shows that growth occurred to varying extents in all three major funding streams:

- Combined state and territory spending increased by 151% or $2.5 billion;
- Australian Government expenditure increased by 245% or $1.7 billion; and
- Spending by private health funds increased by 59% or $95 million.

In per capita terms, national spending on mental health increased from $144 in 1992-93 to $309 in 2010-11.

To put this in context, it is worth considering how the combined expenditure on mental health by the Australian Government and state and territory governments compares with their overall expenditure on health. Looking at government spending only, recurrent expenditure on mental health increased by 178% between 1992-93 and 2010-11, averaging 6% growth per year. This figure is difficult to compare with overall expenditure on health because it includes some expenditure from outside health departments, most notably by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) in the more recent years. Removing funding administered by FaHCSIA from the equation, recurrent expenditure on mental health increased by 172% from 1992-93 to 2010-11, whereas recurrent expenditure on health increased by 157% (see Figure 6).
In the first decade of the National Mental Health Strategy, the two figures tracked closer together, but commencing in the mid-2000s, mental health has incrementally increased its position in terms of relative spending within the overall health sector. The increased growth of mental health relative to general health is most pronounced in 2010-11.

Figure 5
National expenditure on mental health by source of funds, 1992-93 to 2010-11 ($millions)

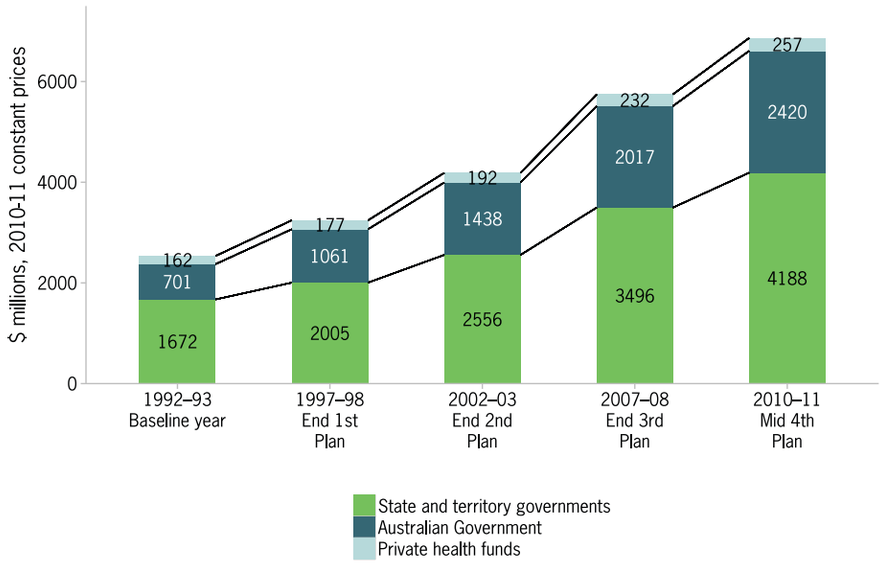
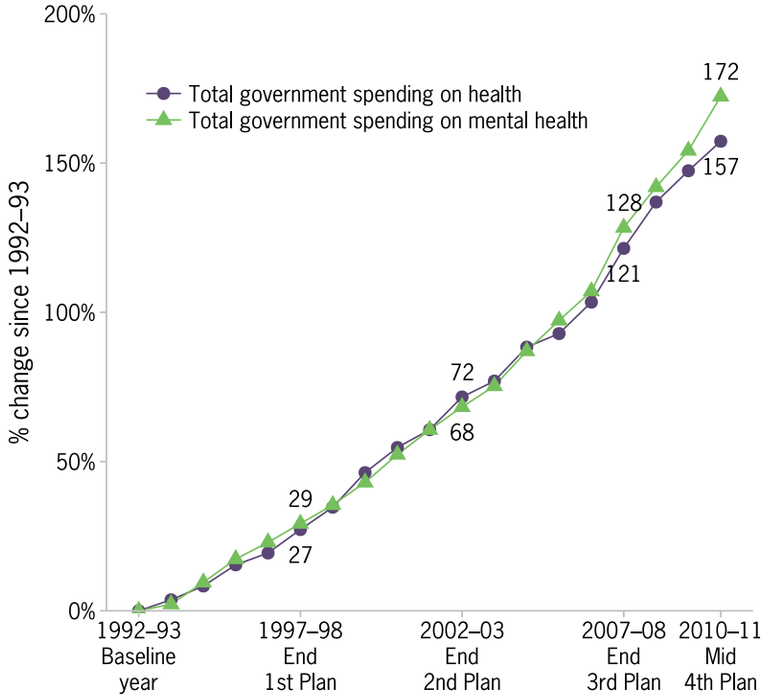


Figure 6
Cumulative growth in government spending on health and mental health, 1992-93 to 2010-11



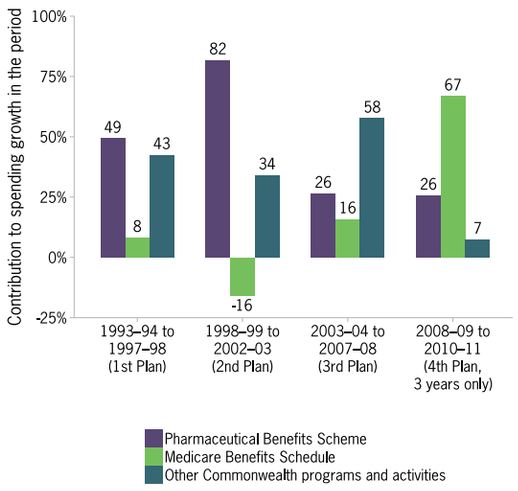
Further context would ideally be provided by comparisons to other countries from around the world. Unfortunately, there are no reliable benchmarks available to assess whether the 'right' level of funding is allocated for a given population's mental health needs. Significant differences exist between countries in how mental health is defined, how expenditure is reported, what is included as 'health expenditure', and what costing methodologies are employed, making comparisons of available data unreliable and potentially misleading. Substantial collaboration between countries will be required for any future international comparisons of mental health spending to be valid.

Australian Government expenditure

The Australian Government's spending on mental health increased from $701 million in 1992-93 (28% of national mental health spending) to $2.4 billion in 2010-11 (35% of national spending). This increased share was due to a combination of growth in new activities and programs and increases in existing services. Figure 7 shows that in the early years of the National Mental Health Strategy, the main driver of growth was expenditure on psychiatric medicines subsidised through the Pharmaceutical Benefits Scheme (PBS). Increased spending on subsidised pharmaceuticals accounted for 49% of the growth in Australian Government expenditure under the *First National Mental Health Plan* and 82% under the *Second National Mental Health Plan*. The impact of psychiatric medicines on Australian Government mental health spending reduced markedly under the *Third* and *Fourth National Mental Health Plans*, dropping to 26% in both of these periods. This was due to a combination of factors, including the fact that several commonly prescribed antidepressants came off patent during this time, allowing new generic products into the Australian

market. The costs of these products fell below the PBS subsidy threshold, or required significantly less Australian Government subsidisation than the patented products. Additionally new programs funded under the COAG *National Action Plan* began to be rolled out between 2006 and 2008, including the introduction of new Medicare-funded 'talking therapies' provided by psychologists and other allied health professionals. Each of these factors moderated the previous role of the PBS as the main driver of Australian Government mental health spending.

Figure 7
Drivers of growth in expenditure on mental health by the Australian Government under the National Mental Health Plans, 1992-93 to 2010-11



State and territory government expenditure

The commitment by state and territory governments to some form of budget protection was part of the original *National Mental Health Policy* and has since been reinforced at various points through the Strategy. The commitment was intended to serve three purposes. Firstly, the Australian Government required a guarantee that the benefits of additional funds provided under the National Mental Health Strategy would not be negated by a reduction in state and territory funding for mental health. Secondly, there was recognition that existing service levels in Australia were struggling to meet even the highest priority needs and could not be further reduced without serious consequences. Thirdly, the commitment safeguarded against erosion of resources that was believed to be occurring with the downsizing of state- and territory-managed psychiatric hospitals and the incorporation of mental health services into mainstream health care.

The original *National Mental Health Report*, released in 1994, established the baseline for measuring change in state and territory mental health resources and documented the gross recurrent expenditure by each jurisdiction in 1992-93. The current report compares ongoing expenditure against this baseline, using the same approach that has been taken in the intervening reports. This approach describes what was spent by a particular state or territory, as opposed to what was spent within it, by deducting specific Australian Government payments from the total spending reported by each state and territory. This reduces the impact of growth in state and territory expenditure caused by mental health specific grants made by the Australian Government under the former Health Care Agreements and more current mental health specific Commonwealth-State funding agreements and payments provided by the Department of Veterans' Affairs for the mental health care of veterans by state and territory services. The intent of this approach is to focus on health funding that is under the discretionary control of state and territory governments – that is, funding that may or may not be spent on mental health.

Table 2 shows the summary picture of expenditure by state and territory governments, comparing baseline spending in 1992-93 with spending at the close of the first three *National Mental Health Plans* and the mid-point of the *Fourth National Mental Health Plan*.

All state and territory governments have met their commitment to maintaining mental health spending over the period 1992-93 to 2010-11. Spending growth increased by 145% overall, averaging 8% per year. With the exception of Victoria, all jurisdictions more than doubled their expenditure during the period.

Table 2
Recurrent expenditure on mental health services by state and territory governments, 1992-93 to 2010-11 ($millions)[a]

	1992-93 (Baseline year)	1997-98 (End 1st Plan)	2002-03 (End 2nd Plan)	2007-08 (End 3rd Plan)	2010-11 (Mid 4th Plan)	Change since 1992-93	Average annual growth
NSW	$564	$653	$867	$1,085	$1,303	131%	7%
Vic	$496	$534	$673	$857	$974	96%	5%
Qld	$253	$361	$454	$681	$830	228%	13%
WA	$164	$244	$305	$434	$523	219%	12%
SA	$150	$184	$205	$295	$327	118%	7%
Tas	$47	$54	$59	$98	$116	149%	8%
ACT	$23	$28	$45	$63	$72	208%	12%
NT	$14	$20	$22	$36	$43	211%	12%
Total	$1,710	$2,168	$2,630	$3,550	$4,188	145%	8%

(a) Excludes Australian Government dedicated mental health funding to states and territories but includes revenue from other sources (including patient fees and reimbursement by third party compensation insurers) and non-specific Australian Government funding provided under the Australian Health Care Agreement base grants/National Healthcare Agreement specific purpose payments.

Per capita spending by state and territory governments

Different population sizes and rates of growth need to be taken into account when reviewing trends in resourcing of mental health services. Higher population growth in some jurisdictions places greater demands upon the resources available for mental health care. Adjusting for this growth is necessary given that this report covers an 18 year period during which significant population shifts occurred.

When population growth is taken into account, growth in mental health spending becomes more conservative than the 145% suggested in Table 2.

Figure 8 shows that per capita adjusted growth over the 18 years was 94%, or an annual average of 5%. Figure 9 shows that the relative positions of the states and territories have shifted over time with, for example, Victoria investing the highest amount per capita in 1992-93 and the lowest amount in 2010-11. Additional detail on jurisdictions' growth is provided in Part 4.

Figure 8
Average per capita expenditure by state and territory governments, 1992-93 to 2010-11 ($)

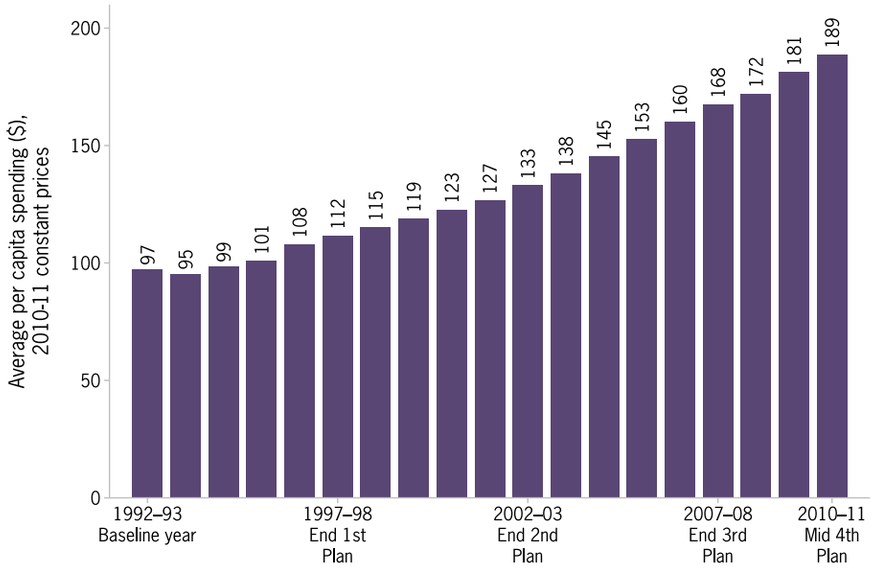
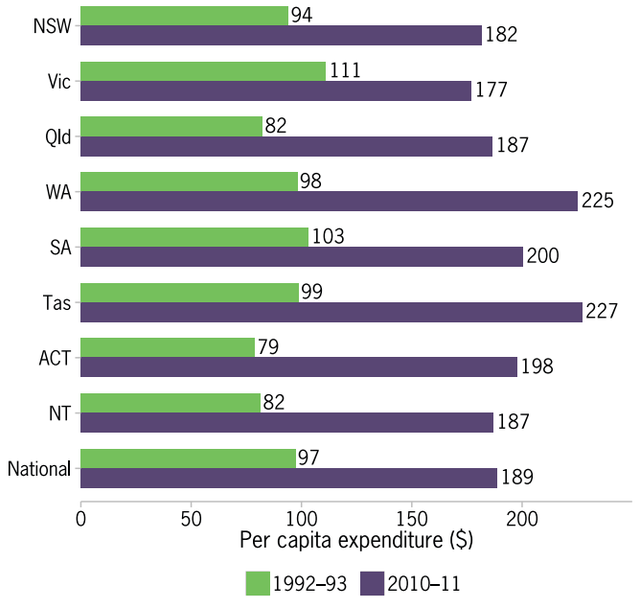


Figure 9
Per capita expenditure by state and territory governments, 1992-93 and 2010-11 ($)



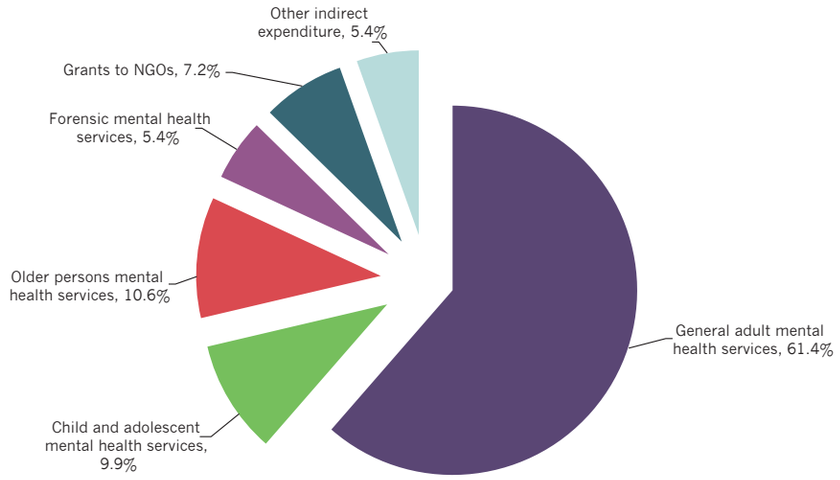
State and territory investment in programs for age specific populations

The above perspective provides an overall picture of the relative investments by each of the states and territories in providing mental health services, but does not shed light on how particular population groups are served. Data from the 2010-11 National Minimum Data Set – Mental Health Establishments collection provide the basis for such an analysis, although they do not permit the exclusion of mental health specific grants made by the Australian Government in the same way as the data reported in the overall state and territory analyses described above.

Distribution of funds in each state and territory is organised into general adult, older persons, child and adolescent and forensic programs and services. Figure 10 summarises how state and territory funding was distributed across these program areas in 2010-11. It shows that just under two thirds of expenditure was directed to general adult services, which primarily serve those aged 18-64 years. The remainder was distributed across the other population groups, in grants to NGOs and in other indirect expenditure.

Substantial differences exist between jurisdictions in both the extent to which mental health services are differentiated according to age specific programs and the level at which these programs are funded. Figure 11 shows the per capita level of funding provided for general adult mental health services by each state and territory, and Figure 12 and Figure 13 provide the same information for child and adolescent services and older persons' services respectively.

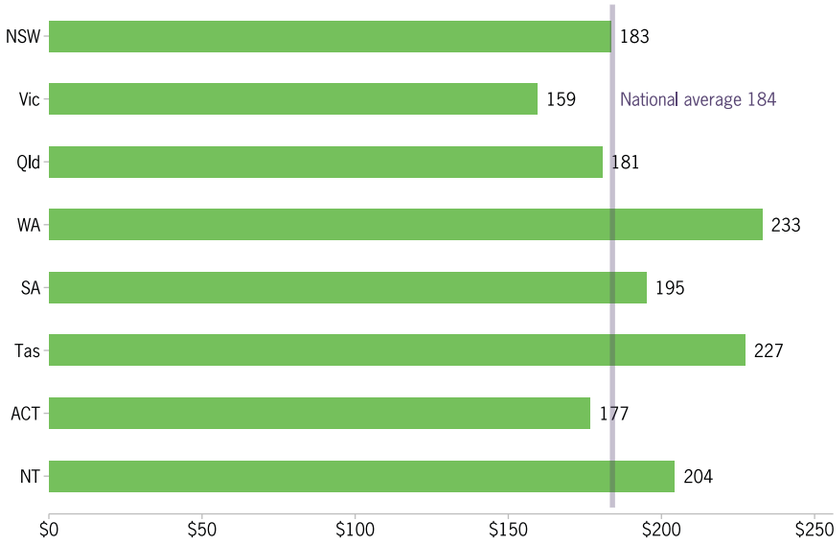
Figure 10
National summary of state and territory government mental health expenditure by program type, 2010-11[a,b]



Total state and territory services expenditure: $4.2 billion

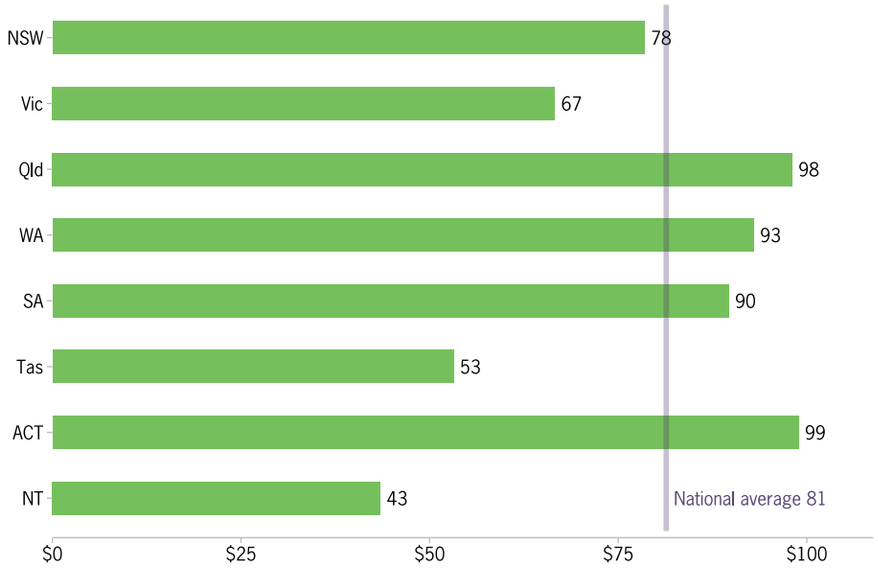
(a) Youth mental health services (0.2% of total state and territory mental health expenditure) have been included in child and adolescent mental health services; (b) NGO expenditure excludes residential services managed by the NGO sector. This expenditure is targeted mainly at the adult population.

Figure 11
Per capita expenditure by states and territories on general adult mental health services ($), 2010-11[a,b,c]



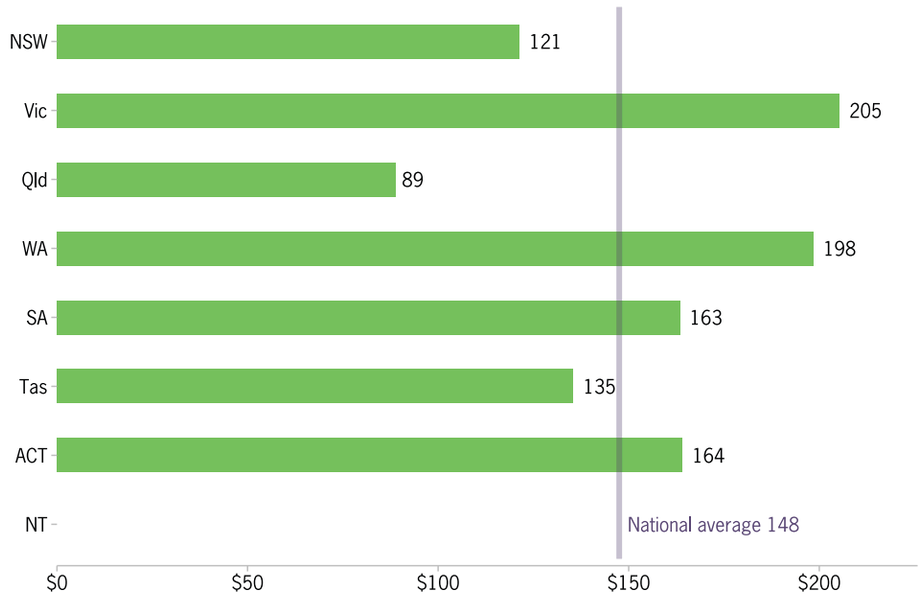
(a) Estimated expenditure for each age specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Dataset, not the age of consumers treated; (b) Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry; (c) Per capita rates calculated using age specific population denominators.

Figure 12
Per capita expenditure by states and territories on child and adolescent mental health services ($), 2010-11[a,b,c]



(a) Estimated expenditure for each age specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Dataset, not the age of consumers treated; (b) Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry; (c) Per capita rates calculated using age specific population denominators.

Figure 13
Per capita expenditure by states and territories on older persons' mental health services ($), 2010-11[a,b,c]



(a) Estimated expenditure for each age specific population is based on the classification of services reported to the Mental Health Establishments National Minimum Dataset, not the age of consumers treated; (b) Analysis excludes NGO grants (other than NGO managed staffed residential services) and expenditure on services classified as Forensic Psychiatry; (c) Per capita rates calculated using age specific population denominators.

Together, these figures show that the relative positions of the 'well resourced' and 'poorly resourced' jurisdictions differ depending on which age related program is considered. For example, although Queensland is one of the lower per capita spending jurisdictions, its expenditure on child and adolescent mental health services in 2010-11 was 21% above the national average. Tasmania, on the other hand, is the second top spending jurisdiction overall, but spends 35% less than the national average on child and adolescent mental health services.

The analysis highlights that, while mental health services are not provided uniformly across Australia, the greatest variation is in the availability of specialist child and adolescent and older persons' services, with a nearly two and a half fold difference between the highest and lowest spending jurisdictions.

It should also be noted that general adult mental health services provide care not only for the adult population but also for children and adolescents and older persons. Indeed, where such services do not exist or are less well developed (such as in the Northern Territory), general adult services substitute. The net impact is that in some jurisdictions, estimates of the total expenditure on adults are overstated because a proportion of the resources is necessarily used to provide services to younger or older people.

Differences between the jurisdictions may reflect different population needs, different ways of organising services, or a combination of both. At this stage, there is no national agreement on how mental health budgets should be split across age specific programs.

Caveats about mental health spending trends

The data presented in this report on mental health spending trends need to be interpreted in the context of two reminders about the limitations of an exclusive focus on health spending.

The first concerns the fact that spending patterns do not tell us about what is actually delivered in terms of the volume and quality of services and the outcomes they achieve. In the context of the National Mental Health Strategy, understanding how resources are allocated is necessary but not sufficient to judge whether policy directions are achieving the intended benefits for the community. Simply put, more dollars do not necessarily produce more or better services. The indicators reported in Part 3 go some way towards addressing this issue, offering a basis for monitoring 'value for money' in current mental health investment.

The second limitation concerns the relationship between resources and needs. Measuring growth over the past 18 years informs us about changes since the commencement of the Strategy. It does not tell us whether the original 1992-93 funding levels were adequate to meet community need, or whether the growth that has taken place has been sufficient to meet new demands that have emerged since the Strategy began. The 2007 National Survey of Mental Health and Wellbeing highlighted continuing and substantial levels of unmet need for mental health services.

The implication is that current funding levels may not be enough to meet priority needs of the Australian population. These concerns underpinned many of the new initiatives announced under the 2006 COAG *National Action Plan on Mental Health,* and, more recently, the 2010 and 2011 Federal Budget measures that allocated $2.2 billion over five years for a broad range of mental health initiatives. The *Fourth National Mental Health Plan* includes a commitment by all governments to develop a National Mental Health Service Planning Framework that establishes targets for the optimal mix and level of the full range of mental health services that will provide a framework to guide future investment.

2.3 National workforce trends

KEY MESSAGES:

- The direct care workforce employed in state and territory mental health services increased by 72%, from 14,084 full-time equivalent (FTE) in 1992-93 to 24,292 FTE in 2010-11.
- On a per capita basis, this equates to an increase from 80 FTE per 100,000 in the former period to 108 FTE per 100,000 in 2010-11, or an increase of 35%. New South Wales reported the most growth (52%), followed by Tasmania (47%) and Queensland (43%).
- Nationally, the absolute increase in the direct care workforce size of 72% was lower than the increase in recurrent expenditure on state and territory inpatient and community-based services (119%). Factors such as rising labour costs and increases in overhead and infrastructure costs may contribute to this discrepancy.
- At a conservative estimate, 3,119 full-time equivalent mental health professionals provided services through Australian Government funded primary mental health care initiatives in 2010-11. The majority of these (1,928 or 62%) were psychologists. The next largest professional group was psychiatrists (817 or 26%).
- In total, 1,517 full-time equivalent mental health professionals were employed in private hospitals in 2010-11. The workforce mix mainly comprised nurses (1,165, 77%) and allied health professionals (310, 20%). Medical practitioner services provided to consumers treated in private hospitals are delivered primarily through the Medicare Benefits Schedule rather than direct employment arrangements.

The wide-ranging changes that have occurred in the financing and structure of Australia's mental health sector over the period from 1992-93 to 2010-11 are reflected in shifts in the profile of the workforce. These changes are summarised below.

Size and composition of the workforce in state and territory mental health services

Between 1992-93 and 2010-11, the direct care workforce[B] in state and territory mental health services increased by 72% (see Figure 14). This is equivalent to 10,208 full-time staff.

Figure 15 summarises this trend at a national level, showing that the number of full-time equivalent direct care staff rose from 80.1 per 100,000 in 1992-93 to 108.1 per 100,000 in 2010-11. Although all jurisdictions increased the overall size of their respective workforces during this period, New South Wales reported the most growth (52%), followed by Tasmania (47%) and Queensland (43%). More detail on individual jurisdictions' growth can be found in Part 4.

[B] 'Direct care staff' include those within the health professional categories of 'medical', 'nursing', 'allied health' and 'other personal care'.

Figure 14
Number of direct care staff (FTE) employed in state and territory mental health service delivery, 1992-93 to 2010-11

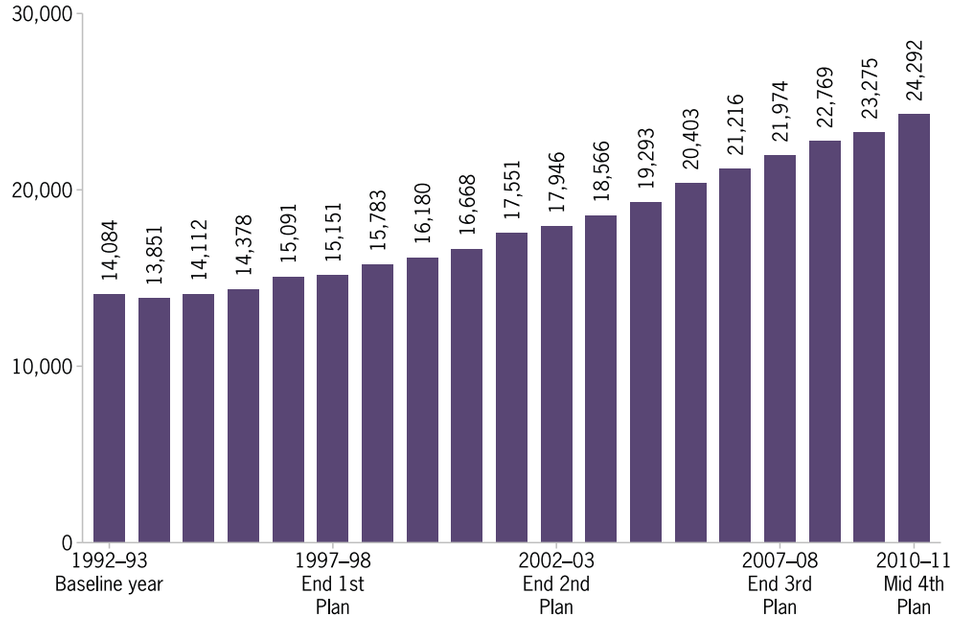
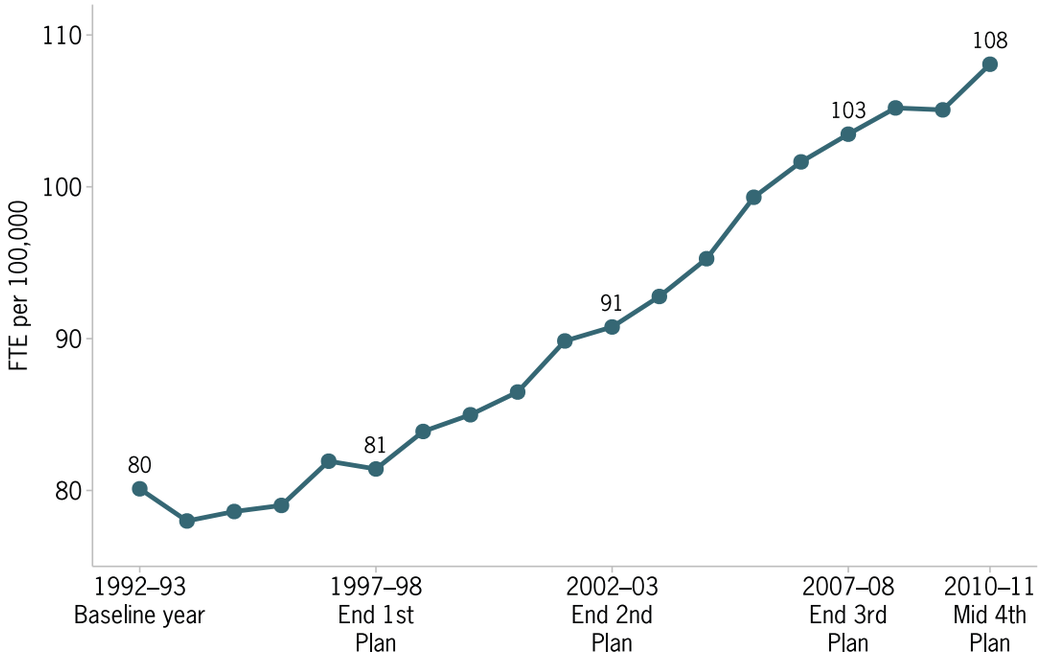


Figure 15
Number of direct care staff (FTE) employed in state and territory mental health service delivery per 100,000, 1992-93 to 2010-11



The growth in the direct care workforce in state and territory mental health services equates to a 35% increase when population size is taken into account.

Table 3 summarises the composition of the mental health professional workforce since 1994-95, the year for which a breakdown by provider types first became available. It shows that all provider groups have expanded under the Strategy, but there has been a shift in the professional staffing mix. The numbers of allied health professionals grew the most (120%), followed by medical practitioners (106%) and then nurses (54%). In 2010-11, nurses accounted for 64% of the mental health professional workforce, allied health professionals for 24% and medical practitioners for 12%. This represents a drop of 7% for nurses as a percentage of the total state and territory workforce and an increase of 5% for allied health professionals, reflecting a move to develop multi-disciplinary community services.

Nationally, increases in spending by states and territories on inpatient and community-based services were greater than the workforce growth in these settings. Figure 16 shows that by 2010-11, when the direct care workforce had grown 72% compared with the baseline year, recurrent expenditure had increased by 119%.

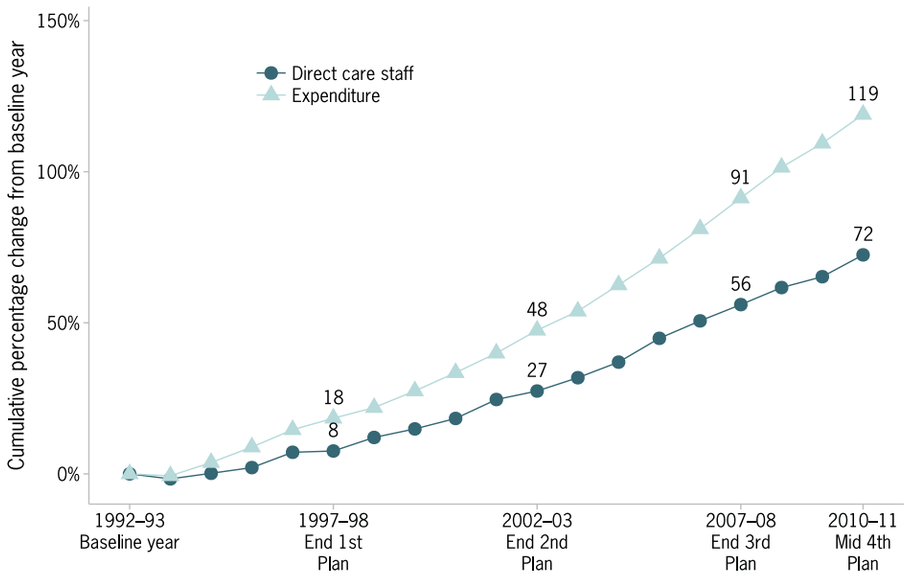
There are various reasons why higher spending may not translate into proportionally equivalent numbers of staff, and these may have a differential impact in different jurisdictions. These include, for example, rising labour costs and increases in overhead and infrastructure (including training and support) costs.

Table 3
Change in the health professional workforce (FTE) in state and territory mental health services, 1994-95 to 2010-11[a]

		1994-95 (Mid 1st Plan)	1997-98 (End 1st Plan)	2002-03 (End 2nd Plan)	2007-08 (End 3rd Plan)	2010-11 (Mid 4th Plan)
Medical	Consultant psychiatrists	560	657	753	1,094	1,355
	Psychiatry registrars and trainees	568	659	882	1,102	1,259
	Other medical officers	273	303	284	329	271
	Total medical	1,401	1,619	1,920	2,525	2,885
Nursing	Registered nurses	8,318	8,504	9,649	11,405	12,592
	Enrolled nurses	1,262	1,323	1,663	2,166	2,196
	Total nursing	9,580	9,827	11,312	13,571	14,788
Allied health	Psychologists	696	1,024	1,417	1,741	1,810
	Social workers	759	975	1,233	1,563	1,867
	Occupational therapists	525	548	697	859	1,038
	Other allied health professionals	546	624	779	864	845
	Total allied health	2,527	3,171	4,125	5,027	5,560
Total		13,508	14,617	17,357	21,122	23,232

(a) Totals differ slightly from those in Figure 14 because they do not include other personal care staff and do include a small number of staff employed at the organisational level.

Figure 16
Growth in service expenditure compared with growth in direct care staff (FTE), 1992-93 to 2010-11



Size and composition of the Australian Government funded primary mental health care and private hospital workforce

There is a significant workforce of mental health professionals delivering services in primary mental health care settings and in private hospitals. This workforce has grown over time as a result of a range of factors, most notably the introduction of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative ('Better Access', described in more detail at 2.5, below). Better Access introduced a series of new item numbers on the Medicare Benefits Schedule which provided a rebate for mental health care services delivered by eligible providers, expanding the MBS-funded services provided by general practitioners and psychiatrists and introducing services provided by psychologists and other allied health professionals. Other programs have also contributed to an expansion of this workforce, including the Access to Allied Psychological Services (ATAPS) program introduced in 2002 which enables general practitioners to refer consumers to allied health professionals, through Medicare Locals. Additionally, the Mental Health Nurse Incentive Program (MHNIP) was introduced in 2006 and provides a non-MBS incentive payment to community based general practices, private psychiatrist services, Divisions of General Practice, Medicare Locals and Aboriginal and Torres Strait Islander Primary Health Care Services who engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders.

It is not possible to quantify the exact magnitude of workforce growth associated with these initiatives, because comprehensive figures on workforce numbers in the early years are not available. However, estimates for 2010-11 exist and are shown in Table 4. It should be noted that these estimates are conservative because they only include selected programs (Better Access, ATAPS and MHNIP) and providers. They exclude initiatives such as *headspace* and certain providers (notably general practitioners who are key providers of primary mental health care) for which reliable mental health specific workforce estimates are not yet available. Table 4 shows that 3,119 full-time equivalent mental health professionals provided

services through Australian Government funded primary mental health care initiatives in 2010-11. The majority of these (1,928 or 62%) were psychologists. The next largest professional group was psychiatrists (817 or 26%).

Table 4 also shows the size of the workforce of mental health professionals working in private hospitals in 2010-11. Again, these figures are an underestimate because they do not include psychiatrists and other medical practitioners with admitting rights who are funded on a fee for service basis through the Medicare Benefits Schedule. In total, 1,517 full-time equivalent mental health professionals were employed in private hospitals in 2010-11. Of these, 1,165 (77%) of these were nurses and 310 (20%) were allied health professionals.

Overall, 4,635 full-time equivalent mental health professionals provided services through Australian Government funded primary mental health care initiatives and in private hospitals in 2010-11. This is around one fifth of the size of the workforce employed in state and territory mental health services (23,232), reported in Table 3.

Table 4
Health professional direct care workforce (FTE) in Australian Government funded primary mental health care[a,b] and private hospitals[c], 2010-11

MBS and other Australian Government funded primary mental health care	Psychiatrists	817
	Mental health nurses	240
	Psychologists	1,928
	Other allied health professionals	134
	Total	3,119
Private hospitals	Medical professionals	42
	Nurses	1,165
	Allied health professionals	310
	Total	1,517
Total		4,635

(a) Excludes general practitioners because their numbers cannot be accurately estimated; (b) Excludes providers funded through the Department of Veterans Affairs, or providers offering services through *headspace*, the National Youth Mental Health Foundation; (c) Excludes psychiatrists and other medical practitioners with admitting rights who work in private hospitals on a fee for service basis through the Medicare Benefits Schedule.

2.4 Trends in state and territory mental health services

KEY MESSAGES:

- Between 1992-93 and 2010-11, annual state and territory government spending on services provided in general hospitals and the community grew by $2.6 billion, or 283%. This was accompanied by a decrease in spending on stand-alone psychiatric hospitals of $289 million, or 35%. About two thirds of the $2.6 billion was invested in community-based services (ambulatory care services, services provided by non-government organisations or NGOs, and residential services). The remaining third was spent on increased investment in psychiatric units located in general hospitals.

- Funding to ambulatory care services increased between 1992-93 and 2010-11 by 291% (from $421 million to $1.6 billion). Over the same period, the full-time equivalent direct care workforce in these services also increased, but not by the same magnitude (215%).

- The non-government community support sector's share of the mental health budget increased from 2.1% to 9.3%, with $372 million allocated to NGOs in 2010-11. Psychosocial support services account for about one third of this funding, and staffed residential mental health services accounted for about one fifth.

- Community residential support services expanded between 1992-93 and 2010-11. The number of 24 hour staffed general adult beds doubled (from 410 to 846). The number of 24 hour staffed older persons' beds was also higher in 2010-11 (682) than it was in 1992-93 (414) although it reached a peak in 1998-99 (805) and has been declining since then. The number of non-24 hour staffed beds in general adult residential services and the number of supported public housing places also increased with time.

- The number and mix of inpatient beds has changed during the course of the National Mental Health Strategy. There were significant decreases in beds in stand-alone psychiatric hospitals in the early years of the Strategy, particularly non-acute beds and general adult and older persons' beds. These decreases have been followed by more gradual declines in recent years. The decreases have been accompanied by commensurate increases in psychiatric beds in general hospitals, particularly acute beds. The average bed day costs in inpatient settings have increased (by 77% in stand-alone hospitals and by 51% in general hospitals).

Monitoring the progress of states and territories in the restructuring of their mental health services has been a central component of all *National Mental Health Reports*. Each of the four *National Mental Health Plans* has advocated fundamental change in the balance of services, focused on overhauling the institutional-centred systems of care that prevailed at the beginning of the 1990s.

The first *National Mental Health Report* documented the 'baseline' situation in 1992-93

and pointed to the scale of the task ahead. At the commencement of the Strategy:

- 73% of specialist psychiatric beds were located in stand-alone institutions;
- only 29% of mental health resources were directed towards community-based care;
- stand-alone hospitals consumed half of the total mental health spending by states and territories;
- less than 2% of resources were allocated to non-government programs aimed at supporting people in the community.

Agreement on a national approach to mental health reform committed state and territory governments to expand their community-based services and devolve management from separate 'head office' administrations to the mainstream health system. In those jurisdictions where decentralisation had occurred prior to 1992-93, the *First National Mental Health Plan* promoted the integration of inpatient and community services into cohesive mental health programs. The *Second, Third* and *Fourth National Mental Health Plans* continued this direction, but expanded the focus of reform to additional activities to complement development of the specialist mental health system.

Previous *National Mental Health Reports* have provided evidence of significant change in the direction advocated by the Strategy, although this change has been variable across jurisdictions. National trends in the first five years were largely dominated by extensive structural changes in Victoria. The restructuring of services in other jurisdictions became more prominent in the early part of the *Second National Mental Health Plan*.

This section of the report updates information published in previous *National Mental Health Reports* and presents a summary of progress to 2010-11.

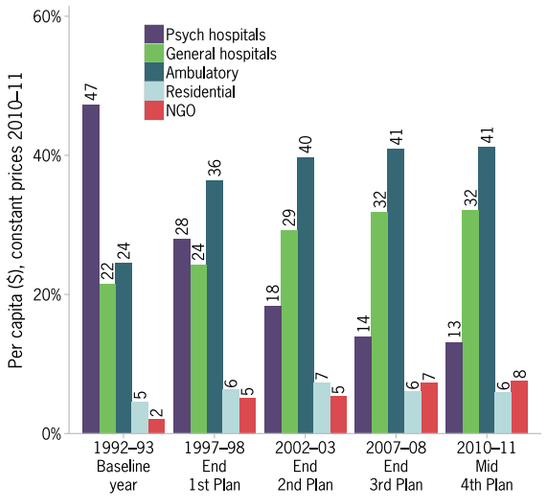
Investment in service mix reform

Information collected through the annual National Minimum Data Set – Mental Health Establishments collection (and its predecessor, the National Survey of Mental Health Services) provides the basis for assessing changes in the structure of the mental health service systems administered by state and territory governments.

Figure 17 shows the relative proportions of the total state and territory mental health budgets that were spent on various types of services between 1992-93 and 2010-11. Annual spending on stand-alone psychiatric hospitals decreased by 35% ($289 million), taking their share of total spending on services from 47% to 13%. Annual spending on services provided in general hospitals and in the community grew by 283%, equivalent to $2.6 billion in real terms.

The impact has been to reduce Australia's reliance on institutional care and strengthen community alternatives that address the inadequacies of service systems that were the focus of the original *National Mental Health Policy*.

Figure 17
Distribution of total state and territory expenditure on mental health services, 1992-93 to 2010-11[a]



(a) NGO managed residential services are included in the 'Residential' category.

Expansion of community-based services

About two thirds of the $2.6 billion growth in annual spending on services to replace stand-alone hospitals has been invested in expansion of community-based services – most notably ambulatory care services (48%), but also services provided by NGOs (11%) and residential services (6%). The remainder is accounted for by increased investment in psychiatric units located in general hospitals (36%). Each of these developments is described in more detail below.

Ambulatory care

Ambulatory care services comprise outpatient clinics (hospital and clinic-based), mobile assessment and treatment teams, day programs and other services dedicated to the assessment, treatment, rehabilitation and care of people affected by mental illness or psychiatric disability who live in the community.

Figure 18 shows that there has been significant growth in the resources directed to ambulatory mental health care services during the course of the National Mental Health Strategy. Between 1992-93 and 2010-11, there was a 291% increase in expenditure on ambulatory services (from $421 million to $1.6 billion). Over the same period, the full-time equivalent direct care workforce employed in ambulatory settings increased by 215% (from 3,358 to 10,592). In per capita terms, this is an increase from 19.1 per 100,000 population to 47.1 per 100,000 population (see Figure 19).

All jurisdictions have more than doubled their ambulatory care workforce over the course of the Strategy. Two (Western Australia and Queensland) stand out with increases of 307% and 440%, respectively. More detail on jurisdictions' performance can be found in Part 4.

Figure 18 also shows that growth in expenditure has outstripped growth in the direct care workforce, even when inflation is taken into account. The implication is that more dollars have not proportionally translated into increased staffing levels in state and territory ambulatory services. Nationally, the purchasing power of the mental health dollar in 2010-11 was 24% less than in 1992-93 when measured by the number of staff employed in ambulatory care. This may be due to a number of factors, including employment of clinical staff with higher qualifications (and salaries), a greater overall increase in costs in mental health relative to overall health care, or higher administrative overhead costs associated with the process of managing an increasingly complex service system. As noted later in this report, similar cost increases have occurred in inpatient services.

Figure 18
Changes in resourcing of ambulatory care services, 1992-93 to 2010-11

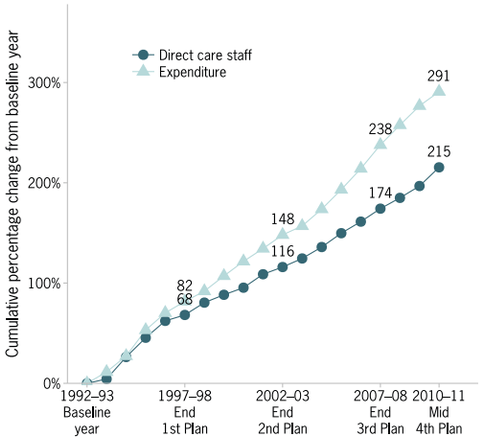
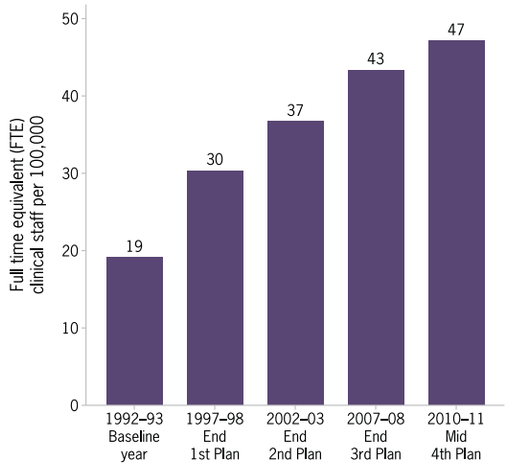


Figure 19
Full-time equivalent (FTE) direct care staff per 100,000 population employed in ambulatory mental health care services, 1992-93 to 2010-11



These indicators provide a simplified view of the collective progress of the states and territories. However, they do not tell us about the workforce levels required to meet priority community needs, nor about the amount of care actually provided. The National Mental Health Service Planning Framework, mentioned above, will establish targets for the optimal mix and level of the full range of mental health services, including ambulatory services.

The non-government community support sector

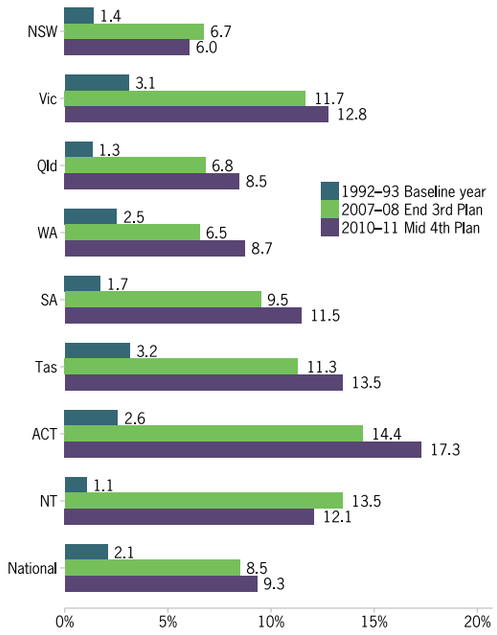
The non-government community support sector includes services provided by not-for-profit NGOs, funded by governments to provide support for people with a psychiatric disability arising from a mental illness. The NGO sector provides a wide range of services including accommodation, outreach to support people living in their own homes, residential rehabilitation units, recreational programs, self-help and mutual support groups, carer respite services and system-wide advocacy.

From the outset, the National Mental Health Strategy advocated the expansion of the role of NGOs in providing support services to consumers and carers whose lives are affected by mental illness. Expansion of the sector was promoted as a means to strengthen community support and develop service approaches that complement the clinical services provided by inpatient services and community teams. More recently, the COAG *National Action Plan on Mental Health* renewed the call to elevate the priority of the NGO sector, and stimulated a major expansion of funding by most jurisdictions.

Figure 20 shows that the overall proportion of mental health budgets allocated to NGOs before the National Mental Health Strategy began was only 2.1%. This share grew during the course of the *First* and *Second National Mental Health Plans,* such that by the end of the *Third Plan* (2007-08), 8.5% of state and territory mental health budgets was directed to the sector. Mid-way through the *Fourth Plan*, the figure now sits at 9.3%. Total state and territory funding allocated to NGOs in 2010-11 amounted to $372 million, distributed to a broad range of organisations from some very small entities employing only a few workers to complex, multi-million dollar organisations.[c]

Figure 20 also shows that despite the significant growth in recent years, differences between jurisdictions remain prominent. By 2010-11, the 'NGO share' was strongest in the Australian Capital Territory (17.3%) and lowest in New South Wales (6.0%).

Figure 20
Percentage of total mental health services expenditure allocated to non-government organisations, 1992-93 to 2010-11



[c] Prior to 1999-00, all services provided by non-government organisations were reported only in terms of total funds allocated by state and territory governments. Commencing in 1999-00, staffed community residential units managed by the sector began to report separately and were grouped with 'government managed' residential services in previous *National Mental Health Reports*. For the purposes of the analysis in this section, funding to NGO-managed staffed residential services (approximately $66 million in 2010-11) has been combined with non-residential NGO programs to ensure better consistency in monitoring the 18 year spending trends. The 2010-11 estimate of 9.3% of expenditure allocated to NGOs described in this section differs from the 7.6% shown in Figure 17 because, in the latter, NGO-managed residential programs are grouped with other residential services.

Previous *National Mental Health Reports* have observed that the role played by NGOs varies across the jurisdictions, reflecting differences in the extent to which states and territories fund the organisations that take on the functions that substitute for those traditionally provided by the government sector, or to develop complementary services. In this environment, a diverse array of services has been developed by the NGO sector to meet varied needs. Figure 21 shows the national profile of NGO services funded by states and territories in 2010-11. Psychosocial support services account for about one third of the funding, and staffed residential mental health services account for about one fifth.

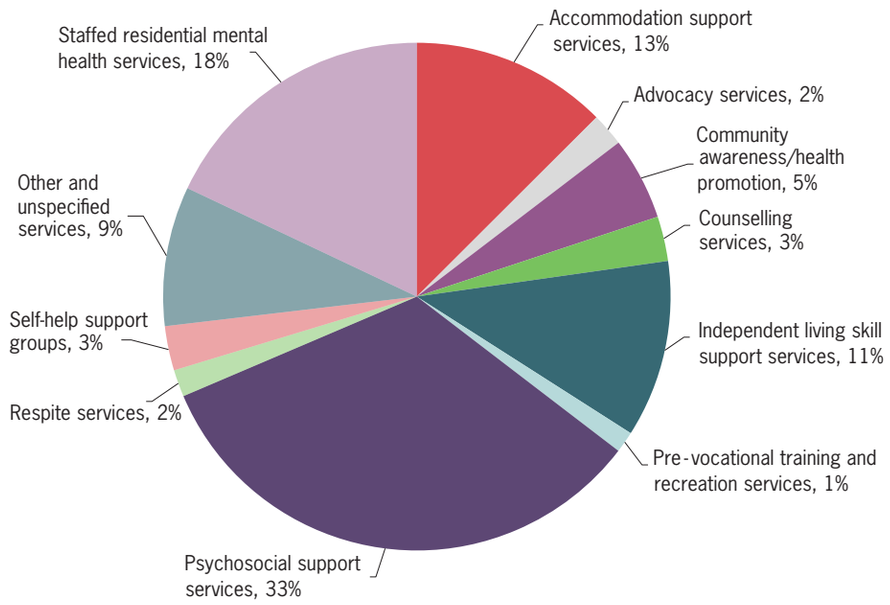
Community residential services

From its inception, the National Mental Health Strategy recognised the central place of accommodation in promoting quality of life and recovery for people living with a mental illness. A wide spectrum of accommodation services is needed, including tenured housing, supervised community residential units, crisis and respite places and flexible support systems that provide assistance to people living in independent settings.

Deficiencies in accommodation options to replace the former role of large stand-alone institutions have been linked to the failure of mental health reform initiatives overseas and were the focus of criticism in Australia by the Human Rights and Equal Opportunities Commission in the period immediately preceding the Strategy. Similar opinions have been voiced by consumer advocacy groups over the course of the Strategy.

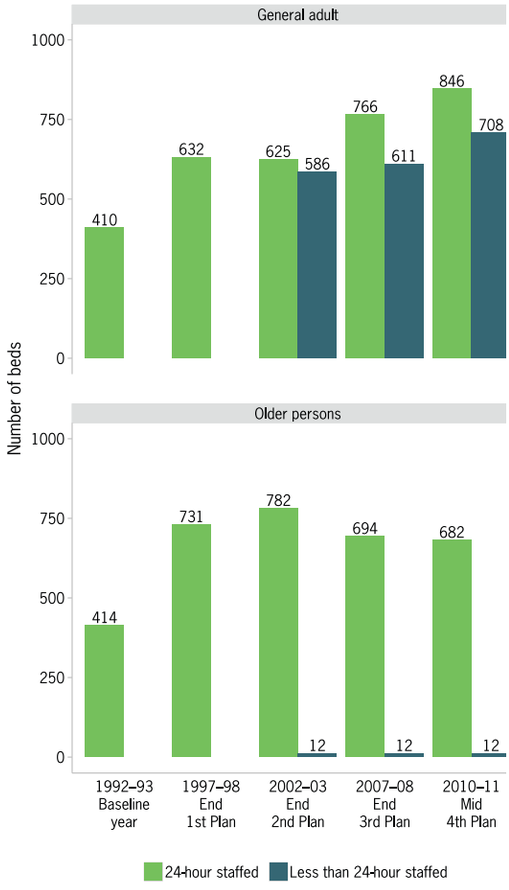
The approach taken by previous *National Mental Health Reports* to monitoring community accommodation under the Strategy has focused mainly on the extent to which each state and territory has developed specialised community residential services, staffed by trained mental health workers, that provide alternative care to that previously available in longer term psychiatric institutions. This report also presents information on 24 hour staffed beds in these specialised services, but augments it with data on services with beds staffed on a less than 24 hour basis. Figure 22 shows that in 2010-11, the number of 24 hour staffed general adult beds was more than double that in 1992-93 (846 compared with 410). The number of 24 hour staffed older persons' beds was also

Figure 21
Types of services funded by state and territory grants to non-government organisations, 2010-11



higher in 2010-11 (682) than it was in 1992-93 (414), although it reached a peak in 1998-99 (805) and has been declining since then. Data on non-24 hour staffed beds have not been available for the full period, but have increased since 2002-03 (from 586 to 708) in general adult residential services and remained the same (12) in older persons' residential services.

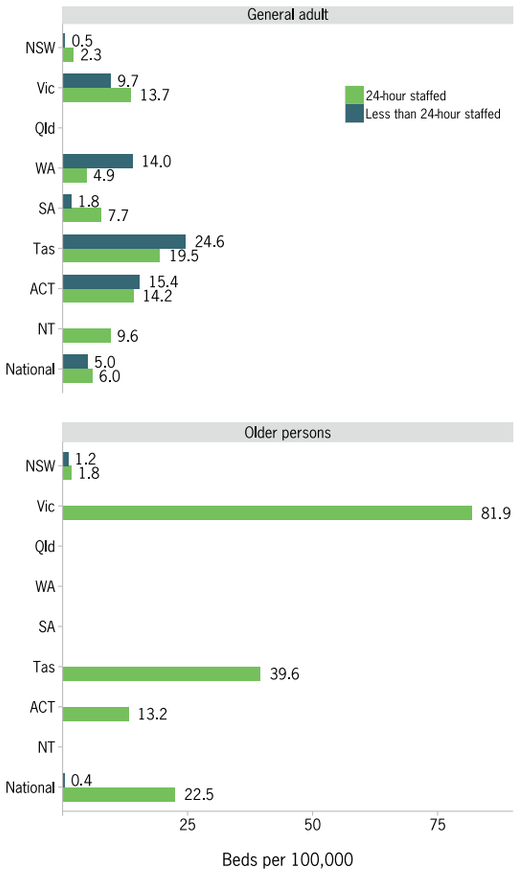
Figure 22
Total beds in general adult and older persons' residential services, 1992-93 to 2010-11[a]



(a) No graphic is provided for child and adolescent beds because they are very few in number (13).

Development of staffed community residential services has been patchy, with much variation between jurisdictions. Until well into the mid-2000s, Victoria led the way. More recently, however, jurisdictions with very limited early development have begun investing in staffed residential services for adult consumers to fill a widely acknowledged service gap.

Figure 23
Number of beds per 100,000 in general adult and older persons' residential services by jurisdiction, 2010-11[a]



(a) No graphic is provided for child and adolescent beds because they are very few in number (13).

Figure 23 compares the jurisdictions on adult and older persons' residential services available in 2010-11. For general services, three jurisdictions – Tasmania, the Australian Capital Territory and Victoria – were the leading providers, standing well above their peers. For older persons' residential services there was greater variability but the same three jurisdictions were marked by their service provision levels relative to other jurisdictions. Victoria in particular is unusual when compared to other jurisdictions in terms of its investment in specific residential services for older consumers. Nine out of ten residential beds for older persons available in Australia in 2010-11 were provided by Victoria.[D]

[D] Caution is required when interpreting residential services data for Queensland. A substantial number of general adult beds in Queensland that meet the definition of beds in staffed residential services were reported by Queensland as non-acute inpatient beds. Queensland has foreshadowed that it will review reporting of these beds in future years.

At a national level, the growth since 1992-93 in 24 hour staffed residential services (717 beds) is equivalent to only about one quarter of the reduction in longer stay (non-acute) beds in psychiatric hospitals (2,719 beds). The additional 730 beds staffed on less than a 24 hour basis became available during the period and provide partial compensation, but it is not possible to chart how these have developed over the full 18 year period. They have almost exclusively been developed for adults rather than older persons, and provide varying levels of on site supervision, ranging from six to 18 hours per day.

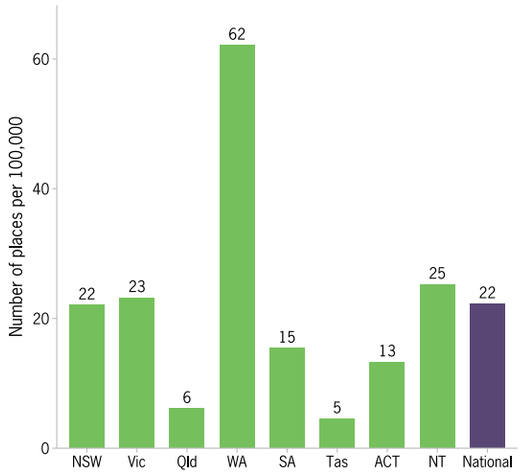
The number of supported public housing places is also relevant here. These places are designed to assist people to live as independently as possible through the provision of ongoing clinical and disability support, including outreach services in their homes. These are seen by consumer advocates as essential components of a recovery oriented system, and provide independent living support to some people who, in 1992-93, might have been in receipt of long stay institutional care. Several jurisdictions are developing individual care and support packages tied to public housing in preference to investing in staffed residential units, arguing that this sort of care is preferred by many consumers. The New South Wales Housing and Support initiative, for example, provides for support packages ranging from low to intensive support, the latter of which have similar costs to individual care provided in staffed residential services.

Figure 24 summarises the data on the availability of supported public housing places over time. It shows that 4,997 such places were available in 2010-11, 87% more than in 2002-03. This equates to 22.2 places per 100,000 in the latter period, an increase of 64% over the 13.5 places per 100,000 that were available in 2002-03.

Figure 25 shows that although all states and territories provided supported public housing places in 2010-11 and contribute to the above national averages, there was considerable cross-jurisdiction variation. Western Australia was the clear leader, with 62.1 places per 100,000. Queensland and Tasmania provided far fewer than the national average, at 6.1 and 4.5 per 100,000, respectively.

Figure 24
Growth in supported public housing places (absolute and per 100,000), 2002-03 to 2010-11

Figure 25
Number of supported public housing places per 100,000 by state and territory, 2010-11



There is no national consensus on planning benchmarks for the provision of community residential services or supported housing places. However, there is agreement that such services are an integral part of the full range of community services required to replace the historical functions of the stand-alone psychiatric hospitals. Developments during the *Third* and *Fourth National Mental Health Plans* indicate that jurisdictions are undertaking the service development needed to fill gaps that existed when the National Mental Health Strategy began. As noted earlier, the National Mental Health Service Planning Framework will establish targets for residential and supported housing places that will guide future service development.

Changes in inpatient services

The profile of inpatient services has changed significantly during the course of the National Mental Health Strategy. As noted in Part 1, the *First National Mental Health Plan* emphasised decreasing the number of psychiatric beds in favour of community-based options, reducing the reliance on stand-alone psychiatric hospitals, and 'mainstreaming' the delivery of acute inpatient care into general hospitals. Progress against these indicators has been extensively discussed in previous *National Mental Health Reports* and is presented in a more abbreviated fashion here because the majority of the change occurred during the early part of the Strategy.

In the year before the *First National Mental Health Plan* was launched (1992-93), the number of psychiatric beds available in Australia was 7,991 (46 per 100,000). By the end of the *First Plan* (1997-98) this had dropped to 6,265 (34 per 100,000), and by the end of the *Second Plan* (2002-03) it had reduced further to 6,073 (31 per 100,000). After this, the bed numbers increased slightly in absolute terms but plateaued on a per capita basis. In 2010-11, mid-way through the Fourth Plan, there were 6,755 psychiatric beds (30 per 100,000).

Reduction in stand-alone psychiatric hospitals

To put these reductions in context, Australia, like many other countries around the world, had already instituted a significant process of deinstitutionalisation in the decades before the National Mental Health Strategy began. In the mid-1960s, when the isolation and detention of people with mental illness in long stay institutions dominated the treatment culture, bed numbers had peaked at around 30,000.

A significant proportion of the reduction in beds is accounted for by ongoing closures of stand-alone psychiatric hospitals. Between 1992-93 and 2002-03, the number of beds in stand-alone hospitals decreased by 59%, from 5,802 (33 per 100,000) to 2,360 (12 per 100,000). By 2010-11, there had been a further 5% decrease (to 2,083, or nine per 100,000).

During this period there was a commensurate increase in psychiatric beds located in general hospitals. In 1992-93, Australia had 2,189 such beds (13 per 100,000). By 2002-03, this had increased by 70% to 3,713 (19 per 100,000), and by 2010-11 it had increased by an additional 44% to 4,672 (21 per 100,000).

Changes in the inpatient program mix

The decrease in hospital bed numbers has been accompanied by changes in the mix of inpatient services. Reductions during the National Mental Health Strategy have been selectively targeted at the service type mostly delivered by psychiatric hospitals – that is, hospital wards that provide medium to longer term care. Figure 26 charts the changes in the provision of acute and non-acute beds from 1992-93 to 2010-11. On a per capita basis, the availability of acute beds has remained level (at around 20 per 100,000), whereas the availability of non-acute beds has dropped (from 25 per 100,000 to 10 per 100,000). There is general consensus that 20 acute beds per 100,000 constitutes a reasonable level of service delivery,

whereas there is less agreement about the provision of non-acute beds and much greater variability across jurisdictions. In part this relates to the varying levels of community residential services that provide longer term care in different states and territories (see above).

Figure 27 provides data on beds available for each of the four target populations served by public sector inpatient units. The denominator has been calculated separately for each group from 2010-11 back to 1993-94 (the first year of the National Mental Health Strategy), rather than 1992-93 (the baseline year used elsewhere). Figure 27 shows that most of the reductions in bed numbers have taken place within adult and older persons' mental health services, with the former reducing by 29% and the latter by 57%. Beds provided in child and adolescent and forensic mental health services increased in per capita terms by 15% and 25%, respectively, both from a low baseline.

Changes in the resourcing of inpatient units

A concern expressed at the outset of the National Mental Health Strategy was that the transfer of inpatient services to general hospitals would lead to increased bed day costs and absorb much of the savings potentially available to expand community care.

Analysis of data collected over the period from 1992-93 to 2010-11 confirms that the reconfiguration of inpatient services has been associated with significant movement in unit costs. Figure 28 shows the average bed day costs for stand-alone psychiatric hospitals and for psychiatric beds in general hospitals. Over the 18 year period, the average bed day costs in the former increased by 77% in constant price terms, and in the latter by 51%. The average cost per patient day in stand-alone hospitals was 23% below that in general hospitals in the baseline year, but by the beginning of the *Second National Mental Health Plan* was almost equal to it. These costs tracked alongside each other until towards the end of the *Third National Mental Health Plan* and then diverged again. In 2010-11, the average bed day cost in stand-alone hospitals was 9% lower than that in general hospitals.

Figure 26
Acute and non-acute psychiatric inpatient beds per 100,000, 1992-93 to 2010-11

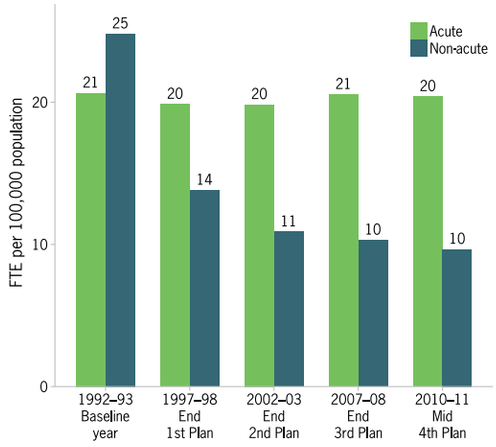


Figure 27
Total psychiatric inpatient beds per 100,000 by target population, 1993-94 to 2010-11

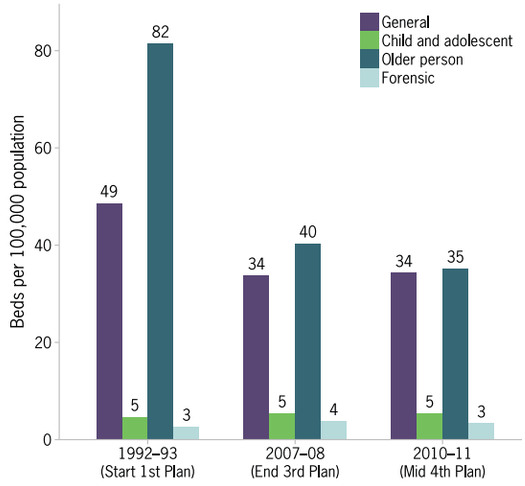
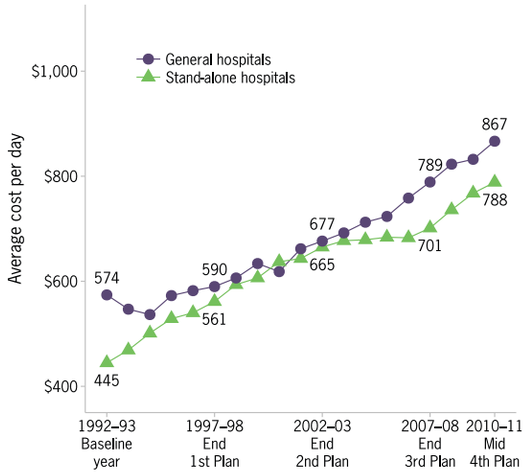


Figure 28
Average costs per day in psychiatric inpatient units, 1992-93 to 2010-11



Economic and clinical factors are responsible for the increase in the costs of hospital care, although the relative contribution of each is not known. Economic factors are implicated in the data shown in Figure 29 which charts resource shifts within Australia's psychiatric inpatient services over the period from 1992-93 to 2010-11. It shows that, at the national level, reduced bed numbers have not translated into reduced overall spending. While the number of beds and the number of bed days have reduced by 15% and 13%, respectively, spending on hospital services has increased by 52%. Direct care staffing levels in inpatient units have increased by 19%, about one third of the rate of growth in overall expenditure on inpatient services. The implication is that inpatient services are substantially more costly than they were at the beginning of the National Mental Health Strategy. When measured in terms of days in hospital, 2010-11 funding would buy 47% less by way of services than the same level of funding 18 years earlier.

Clinical factors contributing to increased costs include the changing role of stand-alone psychiatric hospitals. These services have developed specialised roles as they have reduced in size, treating consumers with more complex conditions that require increased staff:consumer ratios. Specific efforts have also been made to bring overall staffing within these hospitals to an acceptable level, commensurate with that provided in general hospital psychiatric units. Data reported by states and territories over the course of the Strategy provide some support for this view, and suggest that average direct care staffing levels within psychiatric inpatient units have increased by 38% (see Figure 30).

Figure 29
Changes in the number of psychiatric inpatient beds, patient days, expenditure and direct care full-time equivalent staff relative to 1992-93

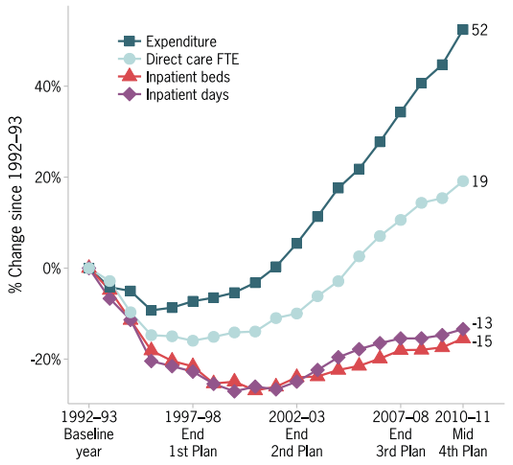
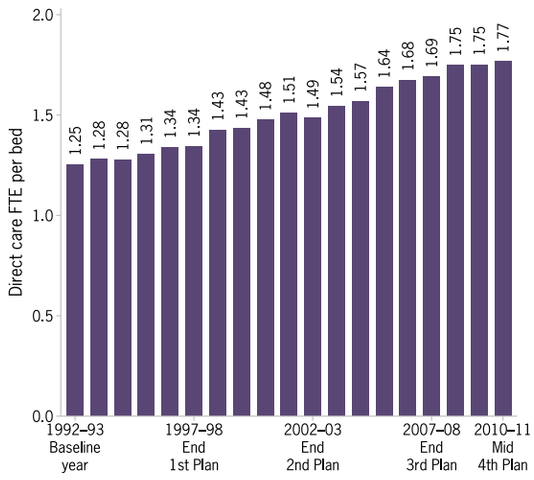


Figure 30
Average number of direct care staff (FTE) per bed, psychiatric inpatient units, 1992-93 to 2010-11



Comparative service levels in 24 hour staffed residential community services and in inpatient services

It is important to consider inpatient and community residential services data in tandem in order to gain a fuller understanding of how Australia has progressed in terms of levels of service availability. Table 5 provides a detailed view of the inpatient and residential service mix available for specific target populations in each jurisdiction in 2010-11. When inpatient and community residential beds are combined, the average number of beds is 40 per 100,000. Two jurisdictions provide well above this per capita average – Tasmania at 58 per 100,000 and Victoria at 49 per 100,000. These states are among the lower providing states when public sector inpatient beds are considered in isolation, but their relatively high provision of beds in community residential settings – particularly those with 24 hour staffing – increases their overall per capita provision to above the other jurisdictions.

Another way of thinking about this is the relative proportions of all psychiatric beds that are located in the different settings. Nationally, 75% of all public sector beds are available in inpatient units, and 17% and 8% in 24 hour staffed and non-24 hour staffed community residential units, respectively. There is considerable variation across jurisdictions, however, with Queensland and New South Wales being particularly heavily reliant on their inpatient units, and Tasmania, the Australian Capital Territory and Victoria providing less than 50% of their beds in these settings.

Table 5
Inpatient and community residential beds per 100,000 population, 2010-11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Nat. Avg.
GENERAL ADULT									
Acute inpatient	28.9	20.6	21.6	24.5	24.5	25.9	20.3	21.3	24.3
Non-acute inpatient	13.3	3.0	17.4	8.9	5.9	8.6	0.0	0.0	10.0
24 hour staffed residential	2.3	13.7	0.0	4.9	7.7	19.5	14.2	9.6	6.0
Non-24 hour staffed residential	0.5	9.7	0.0	14.0	1.8	24.6	15.4	0.0	5.0
Total general adult	45.0	46.9	39.0	52.2	39.9	78.7	49.9	31.0	45.3
CHILD AND ADOLESCENT									
Acute inpatient	4.5	5.4	4.9	3.7	3.4	0.0	0.0	0.0	4.4
Non-acute inpatient	1.9	0.0	1.4	1.1	0.0	0.0	0.0	0.0	1.0
24 hour staffed residential	0.5	0.0	0.0	0.0	0.0	0.0	6.3	0.0	0.3
Non-24 hour staffed residential	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Total child and adolescent	7.5	5.4	6.3	4.8	3.4	0.0	6.3	0.0	5.9
OLDER PERSONS									
Acute inpatient	17.6	28.1	9.0	40.7	26.8	0.0	39.6	0.0	21.3
Non-acute inpatient	18.6	0.0	25.2	7.1	26.4	0.0	0.0	0.0	13.9
24 hour staffed residential	1.8	81.9	0.0	0.0	0.0	39.6	13.2	0.0	22.5
Non-24 hour staffed residential	1.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4
Total older persons	39.2	110.0	34.2	47.8	53.2	39.6	52.8	0.0	58.1
FORENSIC									
Acute inpatient	2.5	2.2	0.0	1.7	0.6	4.9	0.0	0.0	1.7
Non-acute inpatient	2.3	1.3	1.8	0.4	2.4	0.0	0.0	0.0	1.6
Total forensic	4.8	3.5	1.8	2.1	3.0	4.9	0.0	0.0	3.4
ALL BEDS									
All inpatient	36.4	22.6	31.2	30.2	30.2	25.0	18.0	14.5	30.1
All 24 hour staffed residential	1.8	19.8	0.0	3.2	4.8	18.3	12.4	6.5	6.9
All non-24 hour staffed residential	0.6	6.1	0.0	9.1	1.1	15.1	10.5	0.0	3.2
TOTAL	38.8	48.5	31.2	42.4	36.1	58.3	40.9	21.0	40.2

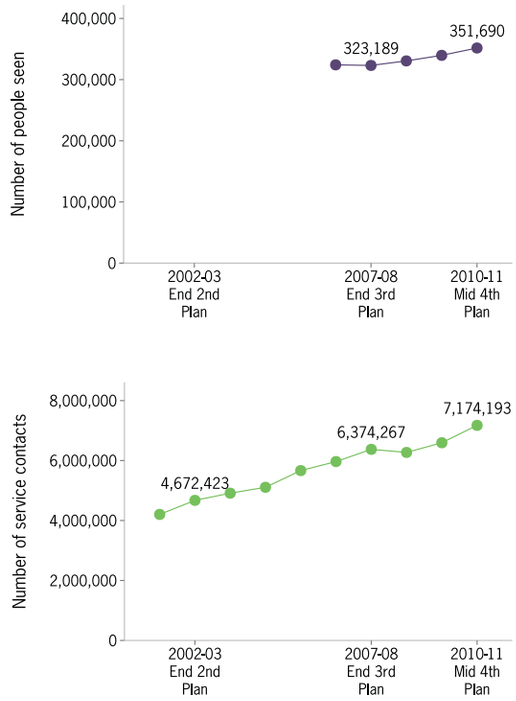
Trends in service delivery

Reliable national data on the number of people seen by state and territory community mental health care are available from 2006-07 to 2010-11. These raw numbers are provided in Figure 31 and show that the number of people seen increased from 324,160 in 2006-07 to 351,690 in 2010-11. In the latter year, about 40% of persons seen were new clients (i.e., clients who had not been seen by the service in the preceding five years). [28]

Figure 31 also provides data on the number of service contacts provided and the number of people seen in community mental health care from 2001-02 to 2010-11. The number of service contacts rose from 4.2 million in 2001-02 to 7.2 million in 2010-11.

The frequency of services provided to people seen by state and territory community mental health services has remained fairly stable when measured by the number of days on which a service is provided (referred to as a 'treatment day'). Figure 32 shows that on average, consumers of state and territory mental health services are seen on 6.0 to 6.5 days each three month period while under care, equating roughly to once per fortnight. On average, registered consumers are seen on 14 days over a 12 month period, although there is substantial variation and many consumers receive community mental health care over substantially briefer periods than a full year. Ten per cent of consumers are seen by state and territory mental health services on more than 30 days over the year.

Figure 31
Number of service contacts[a] provided, 2001-02 to 2010-11, and number of people seen by state and territory community mental health services, 2006-07 to 2010-11



(a) Includes unregistered contacts. Not all jurisdictions report unregistered contacts and reporting practices may have changed over time.

In the inpatient setting, the total number of patient days decreased on an annual basis from 2.5 million in the year before the National Mental Health Strategy began (1992-93) to a low of just over 1.8 million in 1999-00. Since then, the number has risen again and in 2010-11 it was 2.1 million. Figure 33 provides a detailed picture of the change in patient days over time.

Taken together, it can be seen that these trends in service delivery are consistent with the changes in investment in service mix, particularly in terms of the expansion of community-based services described above. The increased numbers of people seen and services provided in community mental health care settings reflect the significant growth in resources directed to these services during the life of the National Mental Health Strategy.

Figure 32
Average number of treatment days per three month period of community mental health care, 2005-06 to 2010-11

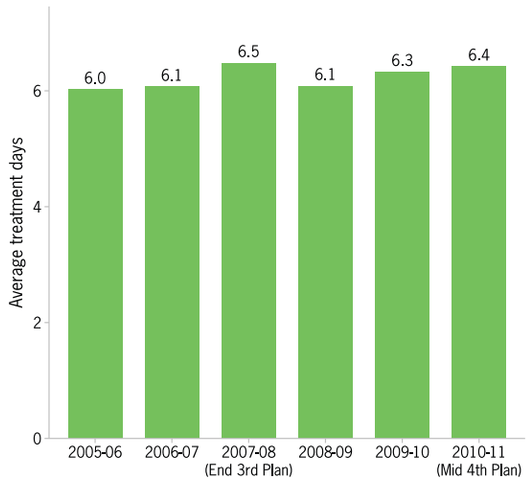
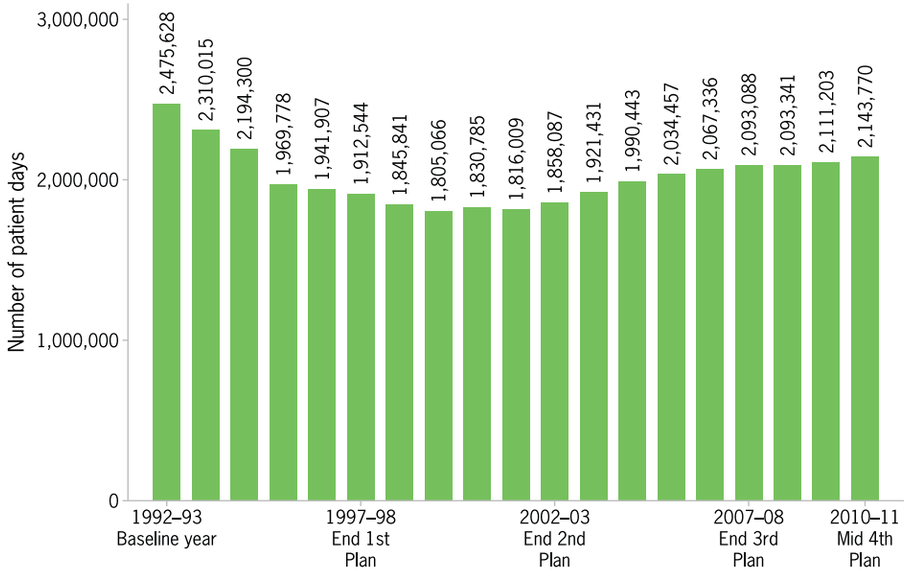


Figure 33
Total number of patient days in psychiatric inpatient settings, 1992-93 to 2010-11



2.5 Trends in private sector mental health services

KEY MESSAGES:

- There was significant growth in mental health care activity in private hospitals between 1992-93 and 2010-11. Bed numbers in specialist psychiatric units in private hospitals increased by 40%, the number of patient days increased by 106%, and the number of full-time equivalent staff increased by 87%. Expenditure by private hospital psychiatric units grew by 142% between 1992-93 and 2010-11.

- Medicare Benefits Schedule (MBS) expenditure on mental health services increased significantly with the introduction of the Better Access program. Better Access provided a rebate on the MBS for selected services provided by general practitioners, psychiatrists, psychologists, social workers and occupational therapists. In 2006-07, MBS expenditure on mental health services had reached a low of $474 million. In 2007-08, the first full year of Better Access, there was a sharp increase to $583 million, and by 2010-11 the overall MBS mental health specific expenditure figure rose to $852 million, accounting for 35% of overall Australian Government mental health spending.

- In 1992-93, services provided by psychiatrists and general practitioners accounted for all of the MBS expenditure on mental health services. By 2010-11, MBS-subsidised services provided by medical practitioners were complemented by services delivered by clinical psychologists, registered psychologists and other allied health professionals who accounted for 41% of MBS mental health specific expenditure.

- In 2011-12, 1.6 million people received mental health services subsidised by the Medicare system, some from several providers. In total, 7.9 million mental health services were provided in that year.

Reform of public sector mental health services was the principal focus of the National Mental Health Strategy in its first five years. Services provided outside the public sector were not originally considered within scope, but governments have become increasingly aware of the importance of partnerships with service providers operating in Australia's private sector.

The private sector plays a key role in overall service delivery. In 2010-11, the sector:

- provided 20% of total psychiatric beds;
- engaged or employed approximately 17% of Australia's health professional workforce delivering mental health services; and
- provided services to eight out of every 10 people who were recorded as receiving mental health specific health services.

This section reviews the provision of services provided through the private sector, both in private hospital settings and through services primarily funded under the Australian Government Medicare Benefits Schedule (MBS).

Private hospital care

Private psychiatric hospitals have focused primarily on the provision of inpatient care. This reflects both the history of mental health services in Australia and the predominant way in which health insurance funds have paid benefits for mental health care. More recently, innovative community models of service delivery are being established that either substitute for or complement inpatient care. The datasets used for the *National Mental Health Report* do not currently contain accurate data on these, so, apart from acknowledging the emergence of these new services, little other information can be provided.

This section summarises information compiled by the Australian Bureau of Statistics (ABS) over key years in the National Mental Health Strategy, using data from its Private Health Establishments collection (PHEC). The ABS did not conduct a private hospital survey in 2007-08, the final year of the *Third National Mental Health Plan*. It also draws on an alternative source of private hospital data, auspiced by the Private Mental Health Alliance (PMHA) to supplement the information compiled from the ABS collection.[30]

Table 6 describes the activity in private hospitals from 1992-93 to 2010-11. The number of private hospitals reporting a specialist psychiatric unit has increased steadily over the course of the Strategy. Forty nine private hospitals providing psychiatric services in 2010-11 reported to the ABS PHEC compared with 33 in 1992-93.[E]

There has been growth in the number of psychiatric beds in private hospitals over time. In 1992-93 there were 1,260 beds and in 2010-11 there were 1,768, an increase of 40%. In per capita terms, these figures equate to 7.2 beds per 100,000 in the former year and 7.9 per 100,000 in the latter.

The number of patient days spent in private psychiatric units has also increased. In 1992-93, 328,100 patient days were recorded. In 2010-11, this figure had risen by 61% to 676,654. In population terms, these figures translate to 19 patient days per 100,000 in 1992-93 and 30 patient days per 100,000 in 2010-11.

Staffing of private hospital psychiatric units has increased alongside bed numbers and patient days. In the baseline year, there were 1,222 full-time equivalent staff working in psychiatric units in private hospitals Australia-wide (seven per 100,000). By 2010-11, there were 2,290 (10 per 100,000). This represents an increase of 87% in absolute terms.

[E] Data from the PMHA collection (see www.pmha.com.au) suggests that this may be a slight undercount. The PMHA's Annual Statistical Report suggests that there were 53 private hospitals with specialised psychiatric units operating in 2010-11.

Table 6
Activity in private hospitals with psychiatric units, 1992-93 to 2010-11

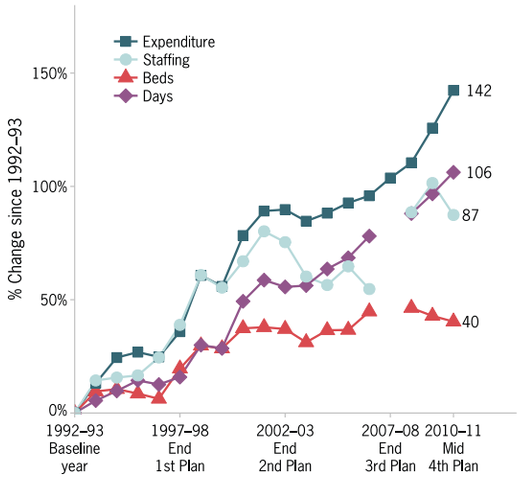
	1992-93 (Baseline year)	1997-98 (End 1st Plan)	2002-03 (End 2nd Plan)	2007-08 (End 3rd Plan)	2010-11 (Mid 4th Plan)
Hospitals	33	39	46	n.a.	49
Beds	1,260	1,507	1,727	n.a.	1,768
Beds per 100,000	7.2	8.1	8.7	n.a.	7.9
Patient days	328,100	380,117	510,634	n.a.	676,654
Patient days per 100,000	18.7	20.4	25.8	n.a.	30.1
Staff (FTE)	1,222	1,697	2,143	n.a.	2,290
Staff (FTE) per 100,000	7.0	9.1	10.8	n.a.	10.2

About one third of the growth (31%) in patient days in private psychiatric hospitals was accounted for by a substantial rise in same-day admissions, which increased nearly twelve fold between 1992-93 and 2010-11. Same-day admissions accounted for 78% of all discharges from private psychiatric hospital units in 2010-11 and represent the most frequent type of service provided. Same-day admissions across the broader private hospital sector have also increased significantly, but at a much lesser rate than in the psychiatric units that form part of the sector. Total same-day admissions increased approximately four fold in all private hospitals (including freestanding day facilities) between 1992-93 and 2010-11 and accounted for 64% of total separations in 2006-07.

Same-day care in the general health field refers to patients admitted to hospital for a medical, surgical or diagnostic procedure who are discharged on the day of admission. In the mental health field, most same-day admissions to private hospitals represent individual days of care that fall within planned episodes of ambulatory mental health care. In its Annual Statistical Report Series, the PMHA reported that Australia's private hospital psychiatric units delivered 13.335 episodes of ambulatory mental health care in 2010-11, with an average of 11 days of care per episode.[30] These episodes typically involve participation by consumers in structured, group-based psychotherapeutic programs, run by allied health professionals or nurses with formal training in these forms of therapy. A relatively small proportion of same-day admissions to psychiatric hospital units are for electroconvulsive therapy, most usually provided to consumers with recurrent severe major depression.

Activity data relating to private hospital psychiatric units are considered in the context of expenditure data in Figure 34. Estimated recurrent expenditure by private psychiatric units in 2010-11 was $307 million, an increase of 142% since 1992-93. This increase in expenditure outweighs the increases in beds, patient days and staffing, described above.

Figure 34
Selected indicators of change in the private psychiatric hospital sector, 1992-93 to 2010-11



Medicare Benefits Schedule funded private mental health care

Most previous *National Mental Health Reports* confined their coverage of Medicare Benefits Schedule (MBS) funded services to the activities of consultant psychiatrists working in the private sector. The 2010 report extended this scope to incorporate new MBS-subsidised services provided by general practitioners and allied health professionals that were introduced through Australian Government initiatives under the 2006 *National Action Plan on Mental Health*.

These services became available through the initiative known as Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access), which was introduced in November 2006 in response to low treatment rates for common mental disorders (for example, anxiety, depression and substance use disorders). Better Access introduced a series of new item numbers on the Medicare Benefits Schedule to provide a rebate for selected services provided by general practitioners, psychiatrists, psychologists, social workers and occupational therapists.

Figure 35 shows that MBS expenditure on mental health services has increased significantly in line with the introduction of Better Access. In 1992-93, an estimated $521 million was spent on MBS-funded services, accounted for by services provided by GPs and consultant psychiatrists. This figure rose incrementally until the mid-1990s, reaching $576 million in 1995-96, and then dipped into the mid-2000s. In 2007-08, the first full year of Better Access, expenditure rose to $583 million and by 2010-11 the overall MBS mental health specific expenditure figure reached $852 million, accounting for 35% of overall Australian Government mental health spending.

Figure 35
MBS expenditure on mental health services ($millions), 1992-93 to 2010-11

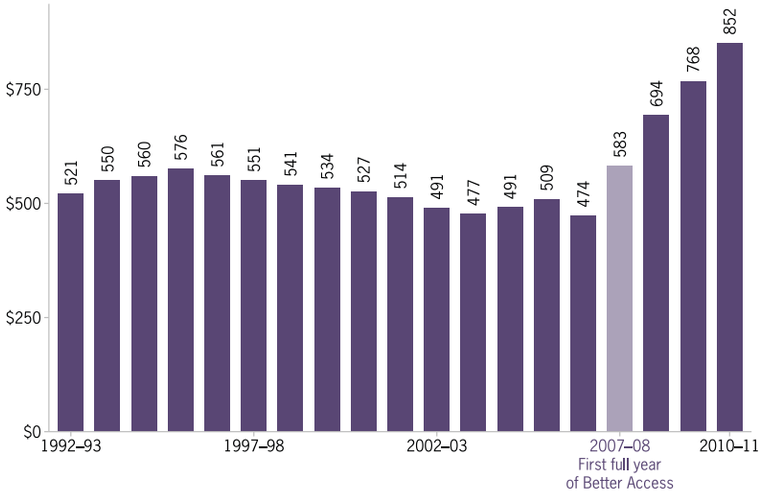


Figure 36 shows the distribution of expenditure across the different provider groups over time. In 1992-93, services provided by psychiatrists and general practitioners accounted for 57% and 43% of overall MBS expenditure on mental health services, respectively. As Better Access was rolled out in 2007-08, the share of expenditure on services delivered by psychiatrists and general practitioners in that year reduced, with the former accounting for 43% and the latter tallying 25%. In that year, 13% of expenditure covered services delivered by clinical psychologists, and 19% covered services delivered by registered psychologists and other allied health professionals. The proportion of expenditure dedicated to services delivered by each of these groups has continued to grow, and in 2010-11 it collectively made up 41% of all expenditure on MBS-funded mental health services.

Figure 36
Distribution of MBS expenditure on mental health services, 1992-93 to 2010-11

In total, one million people received mental health services subsidised by the Medicare system in 2007-08 (see Figure 37). This number climbed steadily during the first five full years of Better Access, and reached 1.6 million in 2011-12.

Figure 38 provides a breakdown of the number of people seen by psychiatrists, general practitioners, clinical psychologists and other allied health professionals in 2011-12. Some of the individuals treated by MBS-subsidised mental health service providers in 2011-12 received services from more than one kind of provider, so the total exceeds 1.6 million. General practitioners saw the largest number of people (1.2 million), which reflects the fact that they not only provide mental health services themselves but also act as the referral conduit to other providers under the rules of Better Access. Registered psychologists and other allied health professionals saw nearly 500,000 people.

In total, 7.9 million mental health services were provided through Medicare in 2011-12, compared with 3.3 million provided in 2006-07 (an increase of 141%). Figure 39 shows the number of services provided by each of the four provider types, and demonstrates significant growth for services provided by general practitioners (0.6 million to 2.2 million), clinical psychologists (0.2 million to 1.4 million) and other allied health professionals (0.5 million to 2.3 million). Figure 39 suggests that in all three cases the growth is beginning to attenuate and that for other allied health professionals it may be beginning to reverse. An evaluation of Better Access suggested that the significant initial uptake of these new services reflected the high levels of previously unmet need for mental health care in the community.[31]

Figure 37
Number of people treated by MBS-subsidised mental health service providers, 2006-07 to 2011-12

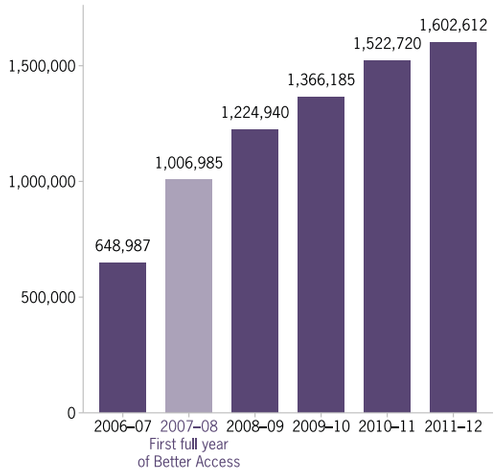


Figure 38
Number of people treated by MBS-subsidised mental health service providers, by provider type, 2011-12

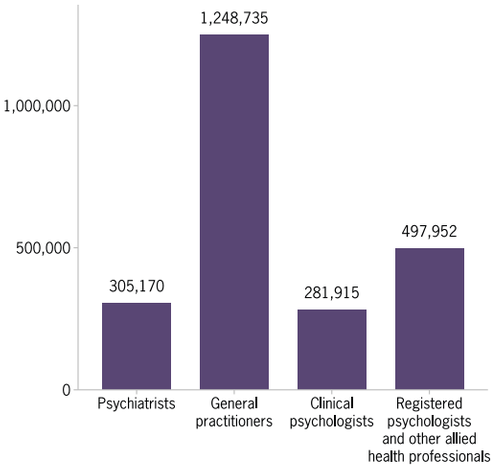
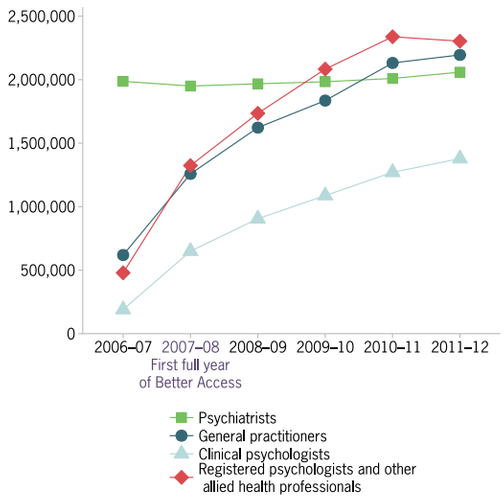


Figure 39
Number of MBS-subsidised mental health services provided, by provider type, 2006-07 to 2011-12



2.6 Consumer and carer participation in mental health care

KEY MESSAGES:

- In 2010-11, about half of Australia's state and territory mental health services had either appointed a person to represent the interests of mental health consumers on their organisational management committees or had a specific Mental Health Consumer/Carer Advisory Group established to advise on all aspects of service delivery. However, one quarter had no structural arrangements in place for consumer and carer participation.

- Significant proportions of state and territory mental health services also had some other arrangements in place for consumer and carer participation, although the extent to which organisations had established particular initiatives varied. Mechanisms for carer participation have been less developed than those for consumer participation, but the gap is closing.

- In 2010-11, there were 4.6 consumer and carer workers employed for every 1,000 full-time equivalent staff in the mental health workforce. This figure has risen by 33% since 2002-03, when it was 3.5 per 1,000.

- In recent times, there have been a number of consumer and carer developments that have had an increased emphasis on social inclusion and recovery. For example, the recently established National Mental Health Commission has produced its first *Report Card*, identifying and reporting on several areas that are important to consumers' ability to lead a contributing life. Moves are also underway to establish a new national mental health consumer organisation, auspiced by the Mental Health Council of Australia, that will ensure that a strong and consolidated consumer voice can contribute to more responsive and accountable mental health reform.

Consumer and carer participation in Australian mental health services underwent rapid maturation over the course of the *First National Mental Health Plan*. Inquiries conducted in the period preceding the National Mental Health Strategy pointed to abuses of the rights of consumers and advocated forcefully on their behalf for action to correct these. Governments responded with a number of proposals for change and, more importantly, consumers began to speak for themselves.

Initial concerns driving the Strategy revolved around concepts of protection from human rights abuses, but these concerns progressively evolved to incorporate more contemporary concepts of consumer empowerment and participation. This required that consumers and carers be given a place in discussions about the planning, delivery and evaluation of services designed to meet their needs.

The Strategy has advocated strongly for this position. Underpinning this is a view that such participation can empower and inform consumers and carers, destigmatise mental illness and ultimately improve mental health outcomes by promoting a recovery orientation in service delivery. Additionally, accountability to consumers at all levels of the mental health system provides an avenue to identify and resolve deficiencies in service quality that, historically, compromised the rights of people with a mental illness.

The early steps taken to promote consumer and carer participation are regarded as one of the hallmarks of the National Mental Health Strategy. Under the *First* and *Second National Mental Health Plans,* states and territories were required to establish advisory groups to provide direct consumer and carer input to mental health policy and service development. The *Third National*

Mental Health Plan promoted further development of opportunities for consumers and carers to take meaningful roles in building a better service system. The *Fourth National Mental Health Plan* has continued this direction.

At the national level, consumers and carers were included in all planning and advisory groups established under the Strategy. Considerable funds were allocated to strengthening their voice in mental health planning, policy and evaluation through representation on bodies such as the Mental Health Council of Australia.

Many other groups play important roles throughout Australia in representing consumers and carers in mental health. They have undertaken a substantial amount of work to increase participation by, and awareness of, the roles of consumers and carers in the mental health reform agenda.

The current report does not detail the contributions of all the individual parties, but focuses on updating previously published data on the extent to which mechanisms for consumer and carer participation have been established at the local service delivery level.

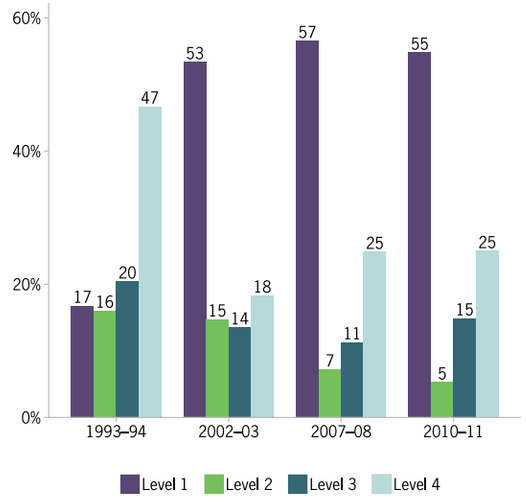
Consumer committee representation at the local service delivery level

The extent to which consumers are involved at the 'coalface' level of service delivery, where they have opportunities to influence the services they receive, is an important indicator of whether the National Mental Health Strategy has made a difference for consumers.

The principle of consumer participation in local services is reflected in the National Standards for Mental Health Services (National Standards). The National Standards set expectations that each service will involve consumers in the planning, implementation and evaluation of services, and that consumers will be active participants in the assessment and treatment planning that directly affects them. All states and territories are committed to full implementation of the Standards within the services under their control.

The annual data collection reported by states and territories has provided the means to monitor trends in the type of local arrangements in place for consumers to contribute to service planning and delivery. As in previous years, the 2010-11 collection required each organisation to describe its structural arrangements for involving consumers. Analysis of the survey data assigns each organisation into one of four levels, ranging from Level 1 (agencies where consumers were given a formal place in the local executive decision making structures or where a specific consumer group had been established to advise on all aspects of service delivery) to Level 4 (agencies with no specific arrangements for consumer participation).

Figure 40
Consumer committee representation within mental health service organisations, 1993-94 to 2010-11[a]



(a) Level 1: Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers. Alternatively, specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation.
Level 2: Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation.
Level 3: Consumers participate on a broadly based advisory committee that includes a mixture of organisations and groups representing a wide range of interests.
Level 4: Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required. Alternatively, no specific arrangements exist for consumer participation in planning and evaluation of services.

The results for 2010-11 are shown in Figure 40 and compared with the situations at the beginning of the National Mental Health Strategy, and at the end of the *Second* and *Third National Mental Health Plans*. They illustrate the considerable progress made over the first 10-year period. Between 1993-94 and 2002-03, the proportion of organisations with some formal mechanism in place for consumer participation (Levels 1 to 3) increased from 53% to 82%. However, the data also reveal that, at the national summary level, little advance has been made since then.

Eighteen years into national mental health reform, about half of Australia's mental health service organisations have consumer representation at the higher level (Level 1). One quarter remain without any basic structural arrangements for consumer participation.

Other local arrangements for consumer and carer participation

States and territories have expressed concern in previous years that exclusive reliance on the 'formal committees' approach to the assessment of consumer participation – the basis of Figure 40 – does not adequately describe the range of initiatives that can be taken to enable participation within mental health service structures and processes. Consumers and carers themselves have articulated similar views.

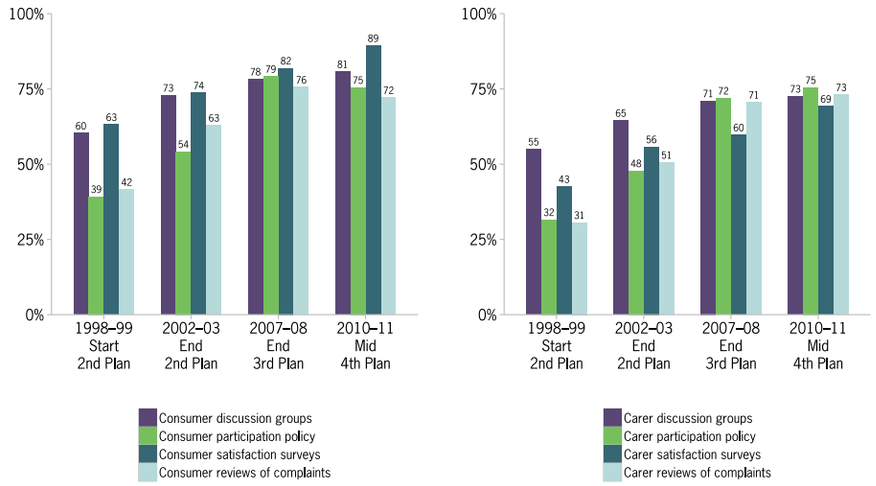
Commencing in 1998-99, the annual state and territory data collection was modified to explore a fuller range of options being pursued by local services, and requested that each mental health service organisation indicate whether such arrangements were in place. The options assessed in the survey are summarised in Table 7.

Figure 41 considers the extent to which mental health service organisations have implemented the last four of these strategies (the first strategy is considered separately below). Taken at face value, the data suggest considerable innovation by service providers in the approaches to building a consumer and carer oriented culture, although the extent to which organisations have established particular initiatives varies. As noted in previous reports, mechanisms for carer participation have been less developed than those for consumer participation, but the gap is closing.

Table 7
Additional consumer and carer participation strategies assessed in annual state and territory reporting

Additional consumer and carer participation strategies
1. Consumer/carer consultants are employed on a paid basis to represent the interests of primary consumers/carers and advocate for their needs.
2. The organisation holds regular discussion groups to seek the views of primary consumers/carers about the mental health services.
3. The organisation has developed a formal (documented policy) on participation by primary consumers/carers.
4. The organisation periodically conducts consumer/carer satisfaction surveys.
5. The organisation has a formal internal complaints mechanism in which complaints made by primary consumers/carers are regularly reviewed by a committee that includes primary consumers/carers.

Figure 41
Other participation arrangements for consumers and carers, 1998-99 to 2010-11



Employment of consumer and carer workers

Arguably, a stronger indicator of services' investment in consumer and carer participation is employing them in a paid role. In the early stages of the National Mental Health Strategy, consumer and carer consultants were employed as consultants to represent the interests of consumers and carers respectively, and to advocate for their needs. These consumer and carer consultants took on a variety of roles, including: investigating areas for improvement to local services, policy and procedures and advocating for change; participating in the selection of staff employed in local services; presenting consumer and carer perspectives in the evaluation of local services; and contributing to training programs for service delivery staff.

Consumers and carers valued this strategy as a means to promote services that are responsive to their needs, but argued that they had more to offer. As time went by, new roles for consumers and carers emerged. Some consumer and carer consultants had played a role in developing relationships with individual consumers and carers and communicating their needs to professional staff, and the new consumer and carer workers took this further. 'Recovery workers' and 'peer support workers' emerged, and the people who took on these roles began to work directly with consumers and carers, offering them support and guidance based on their own lived experience of mental illness. Today, the consumer and carer workforce includes both consumer and carer consultants and the newer type of consumer and carer workers.

Since 2002-03, mental health service organisations have been required to quantify the investments they have made in employing consumers and carers. To do this, organisations reporting that consumer and/or carer workers were employed in their organisations were required to provide substantiation, by reporting supplementary information on salary expenditure and numbers of full-time equivalent staff employed. This was designed to avert the situation where mental health service organisations might, for example, report they had employed a paid consumer consultant if a consumer was given a one-off payment for attending a meeting.

Figure 42 shows the national full-time equivalent tally for consumer and carer workers employed in state and territory mental health services from the end of the *Second National Mental Health Plan* to the middle of the *Fourth National Mental Health Plan* (i.e., between 2002-03 and 2010-11). The number of full-time equivalent consumer workers has fluctuated over time, but was at its lowest at 54 in 2002-03 and reached a peak at 69 in 2010-11. The number of carer workers began at a lower base rate but has risen steadily and, in 2010-11, reached about two thirds of the number of consumer workers. In absolute terms, the numbers of consumer and carer workers is still very low.

Another way of thinking about this is to consider the proportion of the total direct care workforce (clinical staff and consumer and carer workers) in state and territory mental health services that is accounted for by consumer and carer workers. Figure 43 shows that the number of consumer and carer workers employed in 2002-03 was 3.5 per 1,000 full-time equivalent direct care staff. By 2010-11, this had risen to 4.6 per 1,000. Although this represents a 33% increase, the penetration of consumer and carer workers into the overall workforce remains small.

The *Fourth National Mental Health Plan* advocates for substantial growth in the consumer and carer workforce and includes a specific indicator to monitor the extent to which this is occurring (Indicator 21). More detail about this indicator is provided in Part 3 of the current report.

Figure 42
Number of full-time equivalent consumer and carer workers employed in state and territory mental health services, 2002-03 to 2010-11

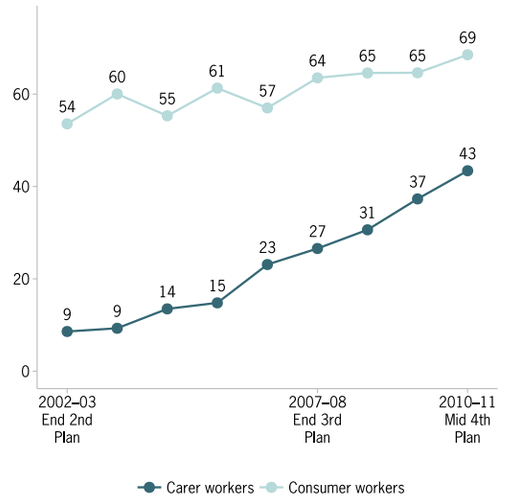
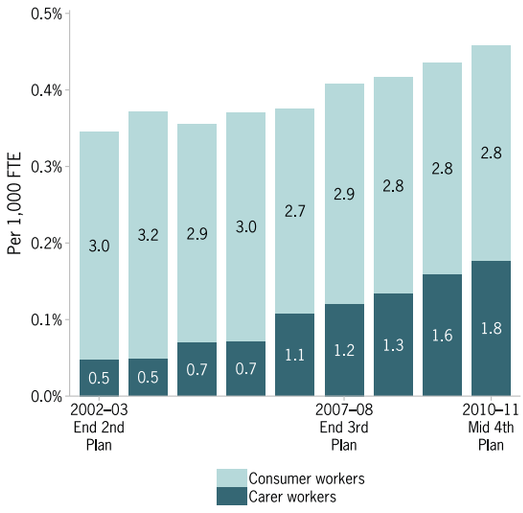


Figure 43
Consumer and carer workers employed per 1,000 full-time equivalent direct care staff, 2002-03 to 2010-11



Ongoing consumer and carer developments

The above indicators suggest that while some progress has been made in providing formal mechanisms for consumer and carer participation, a great deal remains to be done. The *Fourth National Mental Health Plan* reiterates the importance of continuing initiatives to build mental health service systems that are truly consumer and carer responsive.

Over and above this, there is a question about whether the kind of indicators described above are focusing on the issues that are of concern to consumers and carers. In its first *Report Card*,[28] the recently established National Mental Health Commission has identified and reported on six areas that stakeholders have indicated are important to consumers' ability to lead a contributing life. These are: the physical health of people with mental illness; approaches to care which are inclusive of carers; access to timely, appropriate, high quality care; participation in employment and community activities; having a safe, stable and secure home; and preventing suicide.

These concerns extend the newer emphases that distinguish the *Fourth National Mental Health Plan* from its predecessors, particularly the focus on social inclusion and recovery themes. A number of the *Fourth Plan* indicators described in Part 2 of this report address these areas and aim to measure progress. The Australian National Mental Health Outcomes and Classification Network is also developing a new measure of social inclusion known as the Living in the Community Questionnaire (LCQ). Funded by the Australian Government, this measure focuses on the consumer's participation in various life domains (for example, employment, education, housing and social activities) and is being designed for use by state and territory mental health services as part of the current arrangements in place for the regular collection of standardised data on consumer outcomes. Routine collection of data from this measure will allow changes in consumers' levels of social inclusion to be systematically tracked.

There are also other broader developments designed to ensure that the participation of people with lived experience of mental illness is central to mental health reform. At the national level, Australian Government funding ($4 million over the period 2011 to 2016) was provided to establish a new mental health consumer-led peak body. The national mental health consumer organisation will involve diverse mental health consumer groups, organisations and individuals, and represent a wide cross-section of experiences and views, in particular those views which are often under-represented. The new organisation will work towards a shared vision so that a strong and consolidated consumer voice can contribute to more responsive and accountable mental health reform. This will include the work of the National Mental Health Commission that is assessing system performance, described above.

The new organisation is being auspiced by the Mental Health Council of Australia to ensure it has the best possible chance of long term success and sustainability. A Mental Health Consumer Reference Group is advising the Council on planning and implementation of the new organisation, to ensure the voices and views of consumers are front and centre in informing this project. The Council and the Consumer Reference Group are working together to establish a diverse and inclusive membership base and are arranging mechanisms to ensure mental health consumers are involved fully throughout the process. The ultimate aim is to have an independent organisation built upon strong organisational governance and sustainable structures.

Part 3: Monitoring progress and outcomes under the *Fourth National Mental Health Plan*

3.1 Introduction

As noted in Part 1, the current *National Mental Health Report* can be distinguished from its predecessors by the inclusion of new outcome oriented indicators agreed for monitoring progress of the *Fourth National Mental Health Plan*. Part 3 presents the most current quantitative data on the *Fourth Plan* indicators, and draws on qualitative information about the progress of the actions agreed under the *Plan*. Part 3 is organised around the five priority areas of the *Fourth Plan*, namely:

- 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.

Quantitative indicators

The development of indicators under the *Fourth National Mental Health Plan* was underpinned by a number of principles. The 25 indicators were selected to be inclusive of all components of the mental health sector, including public, private and non-government agencies in both the primary care and the specialist mental health sector. They were also designed to go beyond this, and consider key intersections in cross-sectoral reform. There was a commitment to using existing national data wherever possible, and to specify the indicators in a manner consistent with currently recognised quality frameworks. Eleven of the 25 indicators were taken directly from the 12 indicators specified by the COAG *National Action Plan on Mental Health*, to ensure their continued publication given that reporting on the *National Action Plan* has now been completed. The need for extensive work to develop suitable data sources to populate some indicators was recognised, along with the fact that proxy indicators might need to be used in the interim where preferred data were not available.

As a preliminary exercise to reporting the *Fourth Plan* indicators in future *National Mental Health Reports*, work was undertaken to develop detailed specifications and identification of data sources through the then National Mental Health Information Strategy Subcommittee (now Standing Committee), which acts as an inter-governmental group and operates under the auspices of the Australian Health Ministers Standing Council on Health. The resulting document, *The Fourth National Mental Health Plan Measurement Strategy 2011*,[32] has guided the presentation of all indicators in the current report.

Table 8 provides an overview of the indicators. Three indicators (1, 2 and 20) are split because they require data from two different sources. This effectively means that the total number of indicators is 28, rather than 25. Data sources and specifications (including proxy measures) have been developed for 19 of these (1a, 2a, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 19, 20a, 21, 22 and 23, highlighted by a green traffic light symbol in the table). No current data sources are available for the nine remaining indicators, but work is in progress for seven of these (1b, 2b, 5, 17, 18, 24 and 25, highlighted by an amber traffic light symbol), and there is no foreseeable data source for two indicators (10 and 20b, highlighted by a red traffic light symbol). The first 19 are reported in Part 3 and will continue to be reported for the rest of the *Fourth National Mental Health Plan*. No further detail is provided on the remainder in the current report.

Data sources and explanatory notes for quantitative data presented in Part 3 are provided in Appendix 2.

Table 8
Overview of indicator status

Priority Area	Indicator		Indicator status
Priority area 1: Social inclusion and recovery	1a	Participation rates by people with mental illness of working age in employment: General population	●
	1b	Participation rates by people with mental illness of working age in employment: Public mental health service consumers	⊖
	2a	Participation rates by young people aged 16–30 with mental illness in education and employment: General population	●
	2b	Participation rates by young people aged 16–30 with mental illness in education and employment: Public mental health service consumers	⊖
	3	Rates of stigmatising attitudes within the community	●
	4	Percentage of mental health consumers living in stable housing	●
	5	Rates of community participation by people with mental illness	⊖
Priority area 2: Prevention and early intervention	6	Proportion of primary and secondary schools with mental health literacy component included in curriculum	●
	7	Rates of contact with primary mental health care by children and young people	●
	8	Rates of use of licit and illicit drugs that contribute to mental illness in young people	●
	9	Rates of suicide in the community	●
	10	Proportion of front line workers within given sectors who have been exposed to relevant education and training	◐
	11	Rates of understanding of mental health problems and mental illness in the community	●
	12	Prevalence of mental illness	●
Priority area 3: Service access, coordination and continuity of care	13	Percentage of population receiving mental health care	●
	14	Readmission to hospital within 28 days of discharge	●
	15	Rates of pre-admission community care	●
	16	Rates of post-discharge community care	●
	17	Proportion of specialist mental health sector consumers with nominated GP	⊖
	18	Average waiting times for consumers with mental health problems presenting to emergency departments	⊖
	19	Prevalence of mental illness among homeless populations	●
	20a	Prevalence of mental illness among people who are remanded or newly sentenced to adult correctional facilities	●
	20b	Prevalence of mental illness among people who are remanded or newly sentenced to juvenile correctional facilities	◐
Priority area 4: Quality improvement and innovation	21	Proportion of total mental health workforce accounted for by consumer and carer workers	●
	22	Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards	●
	23	Mental health outcomes for people who receive treatment from state and territory services and the private hospital system	●
	24	Proportion of consumers and carers with positive experiences of service delivery	⊖
Priority area 5: Accountability: Measuring and reporting progress	25	Proportion of services publicly reporting performance data	⊖

Key to indicator status: ● – Data sources and specifications developed; ⊖ – No current data sources available (including proxy measures) but work is in progress; ◐ – No foreseeable data source

Qualitative data sources

The *Fourth National Mental Health Plan* committed governments to collaborative action in 34 areas designed to achieve reform at a national level in each of the five priority areas. Twenty three of these actions are examined in the current *National Mental Health Report*, on the grounds that they are being pursued independently of broader national reforms (see 1.3). Each action is being led by a lead agency (generally a jurisdiction, or a working group established under the auspices of the Australian Health Ministers' Standing Council on Health). Each priority area has an overall lead which is required to report on the *Fourth Plan's* implementation process, and these reports are collated in the *Fourth Plan's Second Progress Report of Implementation Activity.* For the purposes of the current report, the most recent progress report to 2010-11, as endorsed by the Mental Health Drug and Alcohol Principal Committee, has been used as the primary source of information on progress of the specific actions of the *Fourth Plan*.

3.2 Priority area 1: Social inclusion and recovery

Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists seven actions that relate to social inclusion and recovery. Progress has been made on five of these (see Appendix 3). By way of example, considerable activity has occurred in relation to Action Area 4, which involves adopting a recovery oriented culture within mental health services that is underpinned by appropriate values and service models. A National Mental Health Recovery Framework that is designed to support implementation of a recovery oriented culture in all mental health services is being finalised. In addition, a National Recovery Forum was held in June 2012 at which three international experts gave keynote addresses. This enabled exchange about the implementation of a recovery oriented culture, and provided an opportunity to promote the development of the National Mental Health Recovery Framework.

Indicator 1a: Participation rates by people with mental illness of working age in employment: General population

KEY MESSAGES:

- In 2011-12, 62% of working age Australians with a mental illness were employed, compared to 80% of those without a mental illness.
- Employment participation rates for this group ranged from 52% in Tasmania to 73% in the Australian Capital Territory.
- Nationally, employment rates for this group decreased slightly from 64% in 2007-08 to 62% in 2011-12.

Mental illness can reduce participation in the workforce in two broad ways. For those in employment, untreated mental illness can diminish engagement and activity in the workplace. Annual losses to national productivity caused by untreated mental illness in the Australian workforce have been estimated at $5.9 billion.[33]

For those not in the workforce, mental illness can act as a barrier to gaining or holding a job. Additionally, the absence of meaningful vocational roles can compromise recovery from mental illness through the associated impacts of social exclusion, welfare dependency, unstable housing and long term poverty.

An increasing body of evidence is accumulating that suggests that vocational outcomes for people affected by mental illness can be improved substantially, leading to better health outcomes.

Using data from the 2011-2012 National Health Survey (NHS) component of the Australian Health Survey (AHS),[34] Figure 44 shows that the 2011-12 employment rate for Australians aged 16-64 years with a self-reported mental illness[D] was 62%, only three quarters of the rate for people without a mental illness (80%). Employment rates for people with mental illness varied across states and territories, ranging from 52% in Tasmania to 73% in the Australian Capital Territory.

Lower employment rates should not be taken as an indicator that people with a mental illness cannot or do not wish to work. Additional 2011-13 AHS data indicate that 6% of people with a self-reported mental illness are unemployed (that is, they are not currently working but actively searching for work). This is double the percentage of people without a mental illness who are unemployed (3%).

[D] The approach to identifying mental illness used in the National Health Survey is based on the respondent self-reporting that he or she has a mental or behavioural problem that has lasted, or is likely to last, for six months or more. This approach yields lower prevalence estimates of mental illness than methods that rely on independent assessment against objective criteria (14% in 2011 compared with 20% found in the National Survey of Mental Health and Wellbeing of the adult population), because it does not include people who experience milder forms of mental illness that resolve within a six month period. See Appendix 2 for further details.

Figure 44
Percentage of people aged 16-64 years who are employed, nationally and in each state and territory, by mental illness status, 2011-12

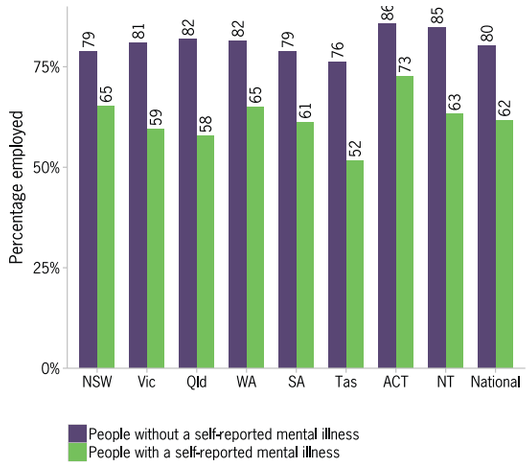
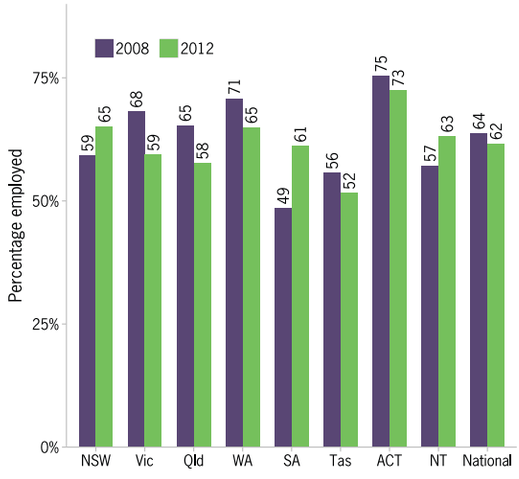


Figure 45
Percentage of people with a mental illness aged 16-64 years who are employed, nationally and in each state and territory, 2007-08 and 2011-12



The data also show that many working age Australians with a self-reported mental illness (32%) are not participating in the labour force (that is, they are neither employed nor looking for work), compared to 17% without a mental illness. Reasons for this are many, but include impaired capacity to work arising from the mental illness. In 2011, people with a mental illness comprised the largest proportion (30%) of the 820,000 Australians receiving a Disability Support Pension (DSP).[35] This equates to 16 in every 1,000 adults of working age being on a DSP due to mental illness. Rates vary across the states and territories.

Comparison of data from the 2007-08 NHS[36] and 2011-12 NHS in Figure 45 shows that, nationally, employment rates for working age people with a mental illness decreased slightly from 64% in 2007-08 to 62% in 2011-12. However, the amount and direction of change varied across states and territories, with employment rates increasing in New South Wales, South Australia and the Northern Territory.

A major driver of employment participation rates among people with a mental illness is severity of disorder. A report by the Organisation for Economic Cooperation and Development (OECD) showed that 49% of people with a severe disorder were employed, compared to 72% with a moderate disorder, and 81% with a mild or no mental disorder.[37]

Mental disorders make the largest contribution of all the major health conditions (cancer, cardiovascular, major injury, mental disorder, diabetes, arthritis) to health-related labour force non-participation rates. Averting the impact of mental illness has the greatest potential to lift labour force participation rates.[38] A body of evidence is now available to show that vocational outcomes for people with mental illness can be improved through the introduction of models of supported employment.[39] The optimal model of such interventions is an evolving science currently being debated by employment specialists.

Indicator 2a: Participation rates by young people aged 16-30 with mental illness in education and employment: General population

KEY MESSAGES:

- In 2011-12, 79% of Australians aged 16–30 years with a mental illness were employed and/or enrolled in study towards a formal secondary or tertiary qualification, compared to 90% of their same age peers.
- Employment and education participation rates for this group for most states and territories were within 10% of the national average.
- Nationally, employment and education participation rates for this group remained stable between 2007-08 and 2011-12.

Participation in employment and formal education provide important opportunities for social inclusion. Mental illnesses are particularly prevalent during early adulthood. Many disorders emerge during the late adolescent and early adult years, a period coinciding with important developmental milestones such as the completion of education or training and the commencement of employment. The onset of mental illness, particularly severe mental illness, often involves a decline in functioning leading to compromised academic performance, premature drop out from school or training, and failed or delayed transition between education and employment. These disruptions in education can negatively affect a person's career prospects, increase the risk of long term unemployment or reliance of welfare as their primary income source, and limit opportunities for social inclusion in the broader community.[40] Evidence from Australian studies shows that, among people with a mental illness, previous educational attainment is associated with current employment regardless of type of diagnosis.[41]

Using data from the 2011-12 National Health Survey (NHS),[34] Figure 46 indicates that, in 2011-12, 79% of people aged 16-30 years with a mental illness were employed and/or enrolled in study towards a formal secondary or tertiary qualification, one eighth lower than for people without a mental illness (90%). Employment and education participation rates for people with a mental illness varied across states and territories, being highest for South Australia and lowest for Western Australia, but all were within 10% of the national average. Data for the Northern Territory should be interpreted with caution due to small numbers in the 'self-reported mental illness' category.

Comparison of data from the 2011-12 NHS with the 2007-08 NHS[36] in Figure 47 shows that, nationally, the rate of participation in employment and education for people aged 16-30 years with a mental illness remained stable between 2007-08 (80%) to 2011-12 (79%). However, the amount and direction of change varied across states and territories. There were relatively large increases in South Australia and Tasmania, compared to a relatively large decrease in Western Australia. Again, small numbers in the Northern Territory mean that 2011-12 data should be interpreted with caution and 2007-08 data are unavailable.

Work and education play an important role in recovery from mental illness. There is increasing evidence that supported employment and education programs can improve employment outcomes and reduce welfare reliance among young people with mental illness.[42]

Figure 46
Percentage of people aged 16-30 years who are employed and/or enrolled for study, nationally and in each state and territory, by mental illness status, 2011-2012

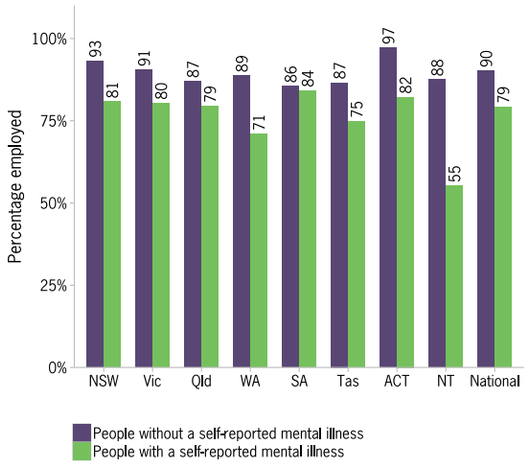
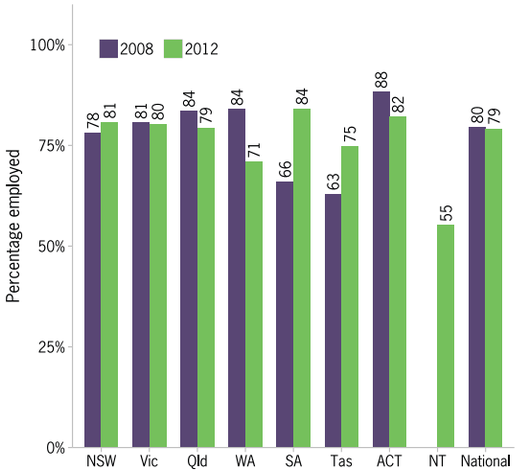


Figure 47
Percentage of people with a mental illness aged 16-30 years who are employed and/or enrolled for study, nationally and in each state and territory, 2007-08 and 2011-12



Indicator 3: Rates of stigmatising attitudes within the community

KEY MESSAGES:

- Social distance is a term used to indicate the willingness of people to interact with people experiencing mental illness. In 2011, on average, Australians rated themselves as relatively more 'willing' than 'unwilling' to interact socially with people with a mental illness. Stigmatising attitudes varied across the different types of mental illness, with the average desire for social distance being highest for chronic schizophrenia, followed by early schizophrenia, depression and depression with suicidal thoughts.
- Comparing the 2011 results with equivalent data from 2003·04, Australians' desire for social distance from people with depression with suicidal thoughts had decreased. However, their desire for social distance from people with depression without suicidal thoughts, early schizophrenia and chronic schizophrenia remained relatively unchanged.
- There is evidence that the efforts of organisations like *beyondblue* may have contributed to this improvement, at least in the case of depression.

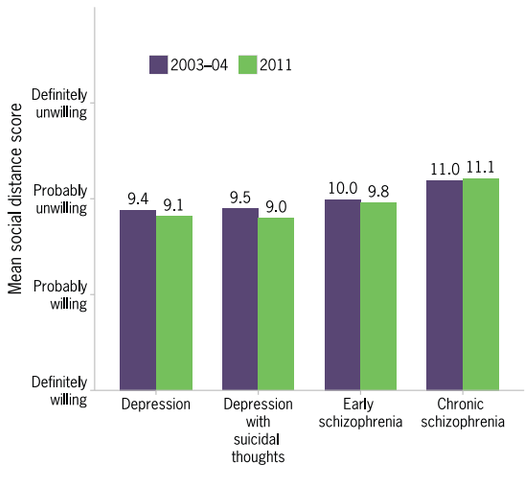
Stigma is often nominated as the issue of most concern by people who live with a mental illness. Stigmatising attitudes have the potential to inhibit help seeking, increase the experience of psychological distress and adversely impact upon the recovery process and achievement of educational and vocational goals.[43 44]

Data for this indicator are taken from the *National Surveys of Mental Health Literacy and Stigma*, conducted in 1995, 2003·04 and 2011.[45] These surveys assessed rates of stigmatising attitudes in Australia using measures of social distance, which are indicators of the willingness of Australians to interact with people suffering from a range of mental illnesses, in a variety of situations. Figure 48 provides data on social distance from the 2003·04 and 2011 surveys.

Data from the 2011 survey suggest that, on average, Australians rated themselves as relatively more 'willing' than 'unwilling' to socially interact with people with a mental illness. In 2011, the average desire for social distance was highest for chronic schizophrenia, followed by early schizophrenia, depression and depression with suicidal thoughts.[45 46]

Comparing these results with those from the 2003·04 survey, there is evidence that the Australian public has become more willing to interact with people showing symptoms of depression (with suicidal thoughts). People's willingness to interact with people with depression (without suicidal thoughts) and early schizophrenia also showed improvement in the right direction, but this did not reach statistical significance. Their willingness to interact with people with chronic schizophrenia remained the same across the two years.[45 46]

Figure 48
Average desire for social distance from the person described in the vignette, 2003·04 and 2011



There may be a range of reasons for the improvements observed above. Over the last decade Australia has invested considerable resources in reducing stigmatising attitudes in the community. For example, beyondblue: the national d*epression initiative* has been funded by the Australian Government and state and territory governments since 2000 with the goal of improving the Australian community's awareness of and response to depression and related disorders. Similarly, initiatives such as the federally funded MindMatters and Kidsmatter (described in more detail under Indicator 6) have promoted mental health literacy in schools. States and territories have also invested in their own anti-stigma campaigns.

Indicator 4: Percentage of mental health consumers living in stable housing

KEY MESSAGES:

- Nationally, the percentage of adult consumers of state and territory mental health services (aged 15-64) with no significant problems with their living conditions has been stable from 2007-08 to 2010-11 (sitting at around 78%). Consumers in the Australian Capital Territory were the least likely to report problems and those in the Northern Territory were the most likely to do so.
- The percentage of older adult consumers (aged 65+) with no significant problems with their living conditions has shown a slight improvement over time, rising from 79% in 2007-08 to 83% in 2010-11. Older consumers in New South Wales were the least likely to report problems, and those in Tasmania were the most likely to do so.
- Safe, secure and affordable accommodation is critical to recovery for people with living with a mental illness.

Mental illness can act as a risk factor for homelessness, and, in turn, unstable housing can exacerbate symptoms of mental illness. Good collaboration between mental health services, housing providers and accommodation support services can improve the housing prospects of people with mental illness and contribute to their overall wellbeing.

Proxy information on this indicator is available for consumers of state and territory mental health services. For adult consumers (aged 15-64) it is derived from the Health of the Nation Outcome Scales (HoNOS) and for older adult consumers (aged 65+) it is taken from the HoNOS65+. These measures are administered routinely at selected points during episodes of care in state and territory mental health services. Item 11 on the HoNOS and the HoNOS65+ requires the treating clinician to rate the consumer's problems with living conditions and is scored from 0 (no problem) to 4 (severe to very severe problem). These data provide an indicator of the housing status of consumers but should be interpreted with caution for several reasons. Item 11 on the HoNOS and HoNOS65+ relies on the clinician knowing the living circumstances of the consumer and is not optimally completed.

Figure 49 provides national and jurisdiction-level data on the percentage of adult consumers who, on admission to care, had no significant problems with their living conditions. Nationally, the percentage has been stable from 2007-08 to 2010-11 at around 78%. Of all states and territories, the Australian Capital Territory performs the best, with figures close to 90% in the latter years of the period. Consumers in the Northern Territory are most likely to have difficulties in this area, with only 69% having no

significant problems with their living conditions in 2010-11, down from 81% in 2007-08.

Figure 50 provides equivalent data for older adult consumers. The total includes data from all states and territories, but individual figures for the Australian Capital Territory and the Northern Territory are not presented because of small numbers. Nationally, the percentage of older adult consumers with no significant problems with their living conditions has shown a slight increase over time, rising from 79% in 2007-08 to 83% in 2009-10 and 82% in 2010-11. Consumers in New South Wales appear to be the most likely to be rated as having no problems, peaking at 89% in 2009-10.

Governments have acknowledged the crucial role played by stable housing in promoting recovery from mental illness. The *Fourth National Mental Health Plan* emphasised the importance of developing integrated programs between mental health support services and housing agencies to provide tailored assistance to people living with a mental illness. The Council of Australian Governments (COAG) reinforced this in its recent endorsement of the *Roadmap for National Mental Health Reform*, 2012–2022.[1]

Figure 49
Percentage of state and territory mental health services consumers aged 15-64 years who are recorded at admission as having no significant problems with their living conditions

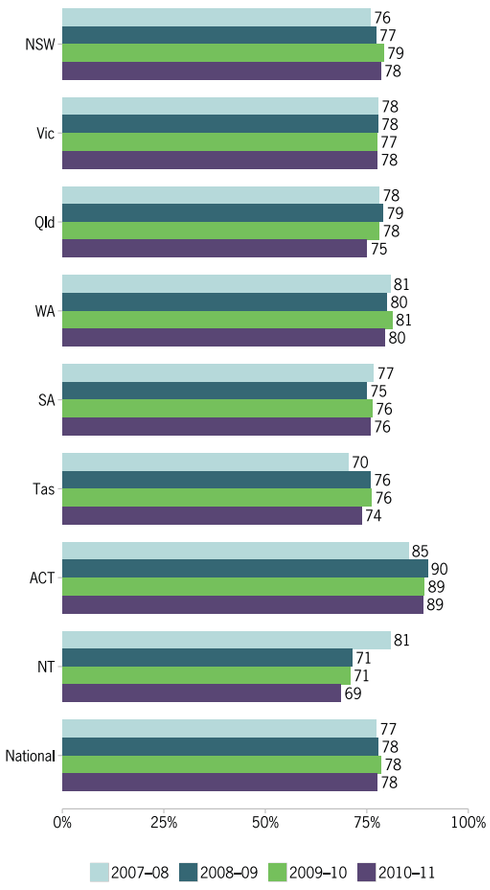
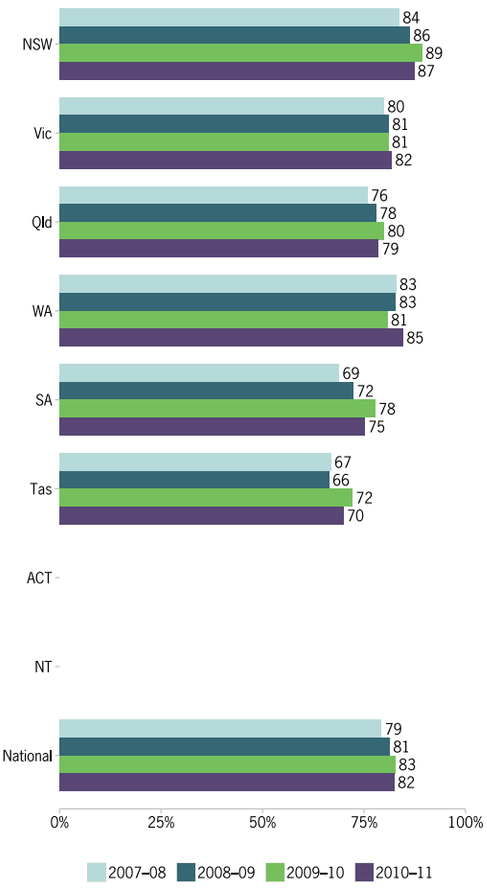


Figure 50
Percentage of state and territory mental health services consumers aged 65+ years who are recorded at admission as having no significant problems with their living conditions



3.3 Priority area 2: Prevention and early intervention

Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists eight actions that relate to prevention and early intervention. Progress has been made on five of these (see Appendix 3). A key example is the activity that has occurred in relation to Action Area 10, which involves expanding community based youth mental health services which are accessible and combine primary health care, mental health services and alcohol and other drug services. Funding was provided in the 2011-12 Federal Budget for 90 fully sustainable *headspace* sites across Australia by 2014-15. Seventy sites have been announced, and 40 are currently operational. When fully established, these sites will help up to 72,000 young people each year.

Indicator 6: Proportion of primary and secondary schools with mental health literacy component included in curriculum

KEY MESSAGES:

- Australia has invested significant resources in programs that promote mental health literacy in schools – notably MindMatters in secondary schools and Kidsmatter in primary schools.
- In 2011, 45% of schools had implemented a mental health framework, 60% were offering mental health programs, and 69% were providing mental health literacy resources.

There is a growing body of evidence that suggests that school-based mental health literacy programs can boost resilience in children and adolescents, assist school staff in identifying and intervening with students showing early signs of mental health problems, and encourage help seeking among students themselves.[47]

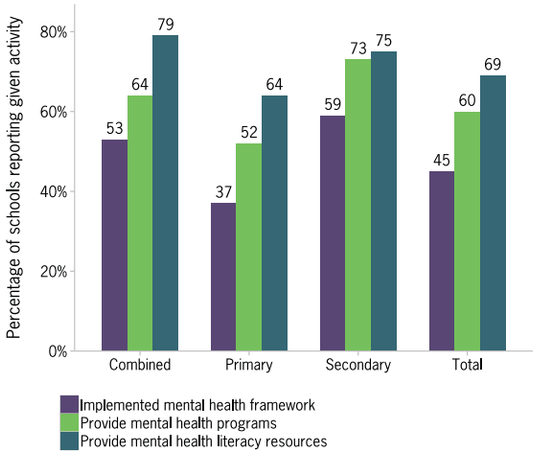
Commencing with the introduction of MindMatters in secondary schools in 1997-98, Australia has invested significant resources in organising frameworks that guide whole-of-school approaches to mental health issues. MindMatters provides a broad framework to assist secondary schools in promoting mental health and identifying and responding to mental health issues where they are present in the school community. Kidsmatter, which followed in 2006 and commenced with an initial pilot, provides a mental health and wellbeing framework specifically designed for primary schools and early childhood education and care services. Both support schools in promoting and protecting the mental health and social and emotional wellbeing of students and other members of the school community. Both have been evaluated positively by students and teachers.[48,49] In addition to MindMatters and Kidsmatter, a range of other mental health frameworks are in use by Australian primary and secondary schools.

Figure 51 shows the percentage of schools that include mental health literacy components in their curricula, using data from Principals Australia's National Market Research Survey which was conducted in 2011.[50] It shows that, in total, 45% of schools had implemented a mental health framework, 60% were offering mental health programs, and 69% were providing mental health literacy resources. 'Combined' schools (i.e., those which cater for both primary and secondary grade levels) generally fell somewhere in between primary and

secondary schools, except in the case of the provision of mental health literacy resources where their uptake rates were the highest.

The uptake of mental health literacy initiatives in schools is positive, but there is still scope for further expansion, particularly in primary schools. Schools appear to perform relatively well in terms of providing resources and offering relevant programs, but are perhaps less successful in embedding these activities within an overarching mental health framework. These activities are less likely to be effective if they are conducted in relative isolation, and should be integral to the school's ethos and environment and woven through its curriculum.[51]

Figure 51
Percentage of schools reporting implementation of mental health frameworks, programs and literacy resources, by school type



Indicator 7: Rates of contact with primary mental health care by children and young people

KEY MESSAGES:

- There was a three-fold increase in the number of children and young people receiving Medicare-funded primary mental health care services from 2006-07 (79,139) to 2011-12 (337,177). This represents an increase from 1.1% of children and young people receiving these services to 4.6% of children and young people doing so.
- The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%).
- This improvement is largely due to the introduction of the Better Access initiative in 2006.

Primary mental health care services have a central role to play in identifying and treating children and young people who are showing signs of mental illness. Childhood, adolescence and young adulthood are crucial developmental periods, and appropriate treatment at these life stages can not only have positive outcomes in the immediate term but can also help to avert or ameliorate problems in later life.

Medicare-funded mental health services provide the main vehicle for delivering mental health services in primary health care settings. Table 9 shows the number and percentage of children and young people making contact with Medicare-funded primary mental health care services from 2006-07 to 2011-12, broken down by age group. It shows that the absolute number of children and young people (aged 0-24) receiving these services has risen substantially over time, from a low of 79,139 in 2006-07 to a high of 337,177 in 2011-12. This represents an increase from 1.1% of children and young people receiving these services to 4.6% of children and young people doing so. The increase was most marked for those aged 18-24 (2.2% to 7.5%), followed by those aged 12-17 (1.1% to 5.5%).

This improvement is largely due to the introduction of the Better Access initiative in 2006. Better Access introduced a suite of new Medicare-funded services (provided by eligible allied health professionals) and expanded the existing range of services provided by GPs and psychiatrists. Annually, children, adolescents and young adults account for slightly over 20% of all users of Better Access.[52]

Several other primary mental health care initiatives of relevance to this group have been implemented under the National Mental Health Strategy. The most notable of these is *headspace*, which was first funded in 2006 and provides youth-friendly access to 12-25 year olds who may be developing, or are already experiencing, mental and/or substance use disorders. *headspace* operates through integrated service hubs and networks. Another example is Access to Allied Psychological Services (ATAPS) which offers similar services to those provided by Better Access, but is funded by the Commonwealth through Medicare Locals rather than via the Medicare Benefits Schedule fee for service system. ATAPS has been running since 2002, and in 2010 an initiative was added which specifically targets children and their parents and offers interventions like family therapy, training in behaviour management, and play therapy.

A range of other providers (for example, community health centres, school counsellors and health nurses, and university and TAFE counselling services) also offer primary mental health care services for children and young people. In addition, child and adolescent specialist public mental health services deliver some primary mental health care services, for example, in their work in school settings.

Taking into account *headspace*, ATAPS and relevant services provided in educational, community health and specialist mental health settings would boost the figures in Table 9, but their specific contribution is unknown. It is likely that there is considerable overlap between those who receive Medicare-funded services and those who see providers in these other settings. For example, a significant proportion of *headspace* clients are referred on to GPs or allied health professionals providing care under Better Access. Similarly, individuals who see an allied health professional through ATAPS require a referral from a GP, and the GP would typically bill Medicare using a Better Access item number.

Without a system of identifying unique individuals accessing all primary mental health care across service streams, it is not possible to include the broader group of services in the counts shown in Table 9. These numbers should therefore be regarded as a conservative estimate, but one which probably does account for the majority of children and young people in contact with primary mental health care.

Table 9
Number and percentage of children and young people receiving relevant Medicare-funded mental health services, 2006-07 to 2011-12 , by age group

		0-4 (Preschool)	5-11 (Primary school)	12-17 (Secondary school)	18-24 (Youth/young adult)	All children and young people aged <25 years
2006-07	Number	1,479	12,298	18,941	46,421	79,139
	%	0.1%	0.7%	1.1%	2.2%	1.1%
2007-08	Number	2,791	28,238	38,984	89,011	159,024
	%	0.2%	1.5%	2.3%	4.2%	2.2%
2008-09	Number	3,931	40,126	55,246	114,458	213,761
	%	0.3%	2.1%	3.2%	5.2%	3.0%
2009-10	Number	4,643	50,434	70,850	130,896	256,823
	%	0.3%	2.7%	4.2%	5.9%	3.5%
2010-11	Number	5,320	60,852	83,671	153,412	303,255
	%	0.4%	3.2%	4.9%	7.0%	4.2%
2011-12	Number	5,862	70,156	94,032	167,127	337,177
	%	0.4%	3.6%	5.5%	7.5%	4.6%

Indicator 8: Rates of use of licit and illicit drugs that contribute to mental illness in young people

KEY MESSAGES:

- Data from the National Drug Strategy Household Survey show that use of both licit and illicit drugs has decreased over time.
- In 2001, 47% of 14-29 year olds engaged in risky drinking in the previous year. This had reduced to 42% by 2010, the lowest figure recorded to date.
- In 1998, 36% of 14-29 year olds used cannabis. By 2010, this figure had halved (19%), although the latter figure represented a rise from 2007.
- Ten per cent of 14-29 year olds used amphetamines in 1998 compared with 4% in 2010. As with alcohol, these are the lowest figures recorded to date.

Agreement to this indicator in the *Fourth National Mental Health Plan* reflected concern at the level of government and at the broader community level about substance abuse in young people and its perceived contribution to increased rates of mental illness and associated demand upon health services. While national programs have been initiated under the National Drug Strategy, further targeted efforts were acknowledged as necessary to reduce substance abuse, particularly the use of illicit drugs that may contribute to mental illness, and to deal with the challenge of providing services to people presenting with comorbid mental health and substance abuse problems.

Regular updates on the level of substance abuse in young people are provided through the National Drug Strategy Household Survey. This survey is conducted every three years by the Australian Institute of Health and Welfare, and provides insights into whether patterns of drug and alcohol misuse by young people have changed over time. Three substances of major priority are considered below, namely alcohol, cannabis and amphetamines. Usage rates for each of these drugs by younger people are of particular concern due to the mental health problems often associated with them. Data on alcohol consumption are available from the National Drug Strategy Household Survey from 2001 to 2010, and data on use of cannabis and amphetamines are available from 1998 to 2010.

Alcohol is the most commonly used and abused substance in the Australian community, and is a major cause of death, injury and illness. Figure 52 profiles 'risky drinking' of alcohol by young people. 'Risky drinking' is defined as drinking any amount on a daily basis over the course of the previous year, or drinking at risky levels (i.e., more than four standard drinks on one occasion) at least once per month during that year. The percentage of young people aged 14-29 engaging in risky drinking dropped from 47% in 2001 to 42% in 2010. In each year, the proportion of 'risky drinkers' was higher among 20-29 year olds than among 14-19 year olds.

Cannabis is the most commonly used illicit drug in the community, across all age groups. Research evidence is accumulating that cannabis use may precipitate psychotic symptoms or the onset of schizophrenia in people who have a family history or other vulnerability to psychosis. Cannabis use may also exacerbate the symptoms of schizophrenia, but it remains unclear whether or not cannabis causes additional cases of schizophrenia. Cannabis use also poses a moderate risk for later depression, with heavy cannabis use also possibly conferring a small additional risk for suicide.

Figure 53 shows the 12 month prevalence of cannabis use for young people. In 1998, 36% of 14-29 year olds indicated that they had used cannabis in the past 12 months; by 2010 this figure had halved (19%). The drop was greater for 14-19 year olds (35% in 1998 to 16% in 2010) than for 20-29 year olds (37% in 1998 to 21% in 2010). In each group, 2007 was the lowest prevalence year.

Growth in the use of methamphetamines in the 1990s has been associated with a range of mental health and related problems. Symptoms of psychosis are one of the particularly troubling consequences of methamphetamine use and dependent methamphetamine users also suffer from a range of comorbid mental health problems.

Figure 54 shows the use of amphetamines by young people. As with alcohol use and cannabis use, there is evidence of a downward trend in the use of this class of drugs. In 1998, 10% of 14-29 year olds reported using amphetamines, whereas in 2010 only 4% did so. Again, the relative decline in use was greater for 14-19 year olds (from 6% in 1998 to 2% in 2010) than for 20-29 year olds (from 12% in 1998 to 6% in 2010).

The three substances selected here represent a range of licit and illicit drugs that contribute to mental illness in young people. It is positive to note that the use of all three substances has shown an overall decline over time in young people, although it should be acknowledged that use of ecstasy, not reported here, has increased. Various national programs that have been initiated under the National Drug Strategy may have played a role in this decline. Further targeted efforts are required to ensure that the downward trajectory continues.

Figure 52
Percentage of 14-29 year olds engaging in 'risky drinking' in the past 12 months, 2001-10

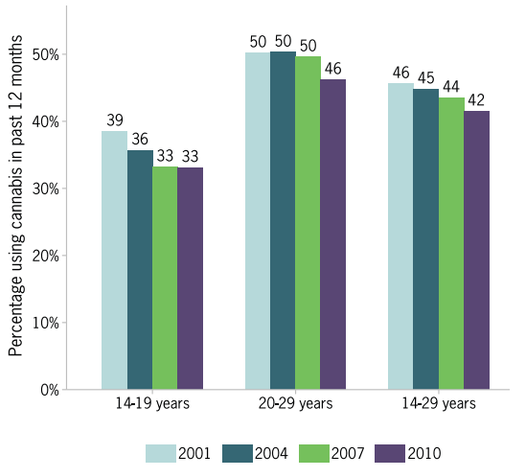


Figure 53
Percentage of 14-29 year olds using cannabis in the past 12 months, 1998-2010

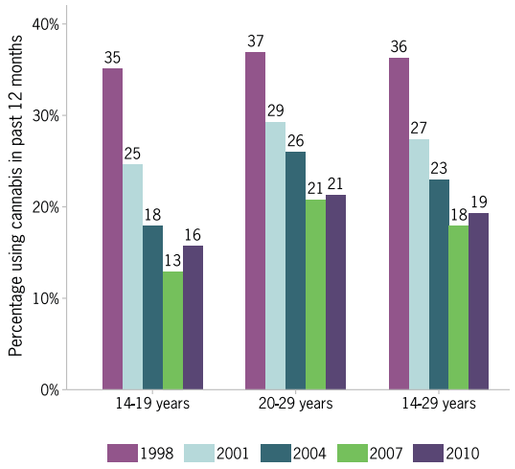


Figure 54
Percentage of 14-29 year olds using amphetamines in the past 12 months, 1998-2010

Indicator 9: Rates of suicide in the community

KEY MESSAGES:

- In 2011, there were 2,273 suicides in Australia, 76% of which were by males.
- Nationally, the average annual suicide rate for the period 2007-11 was 10.6 per 100,000 (16.3 per 100,000 for males; 4.9 per 100,000 for females). The Northern Territory stood out as having particularly high rates.
- The average suicide rate has remained stable since 2003-07. The rate is considerably lower than it was before Australia began its concerted efforts to address suicide through strategic national action.

Arguably, suicides are the starkest indicator of the mental health of the nation. In Australia, suicide ranks as the 15th leading cause of death overall, but it is the leading cause of death for younger people.[53] Suicide is a devastating event for the bereaved; it has been estimated that for every suicide at least six people suffer intense grief and between 80 and 100 more may be affected.[54]

In 2011, there were 2,273 suicides (see Table 10). Three quarters of these suicides (76%) were by males.[53]

Some caution should be exercised in interpreting suicide trends. The number of suicides can fluctuate considerably, and increases in a given year can be matched by commensurate decreases in the following year. These year-on-year changes can sometimes be misinterpreted as significant, when in fact the underlying trend may be relatively flat. This situation may be exacerbated in states and territories with relatively small numbers of suicides.
A common way of reducing the impact of temporal fluctuations in suicides is to convert them to age standardised rates and average them across several years. This allows for more meaningful interpretation of patterns across jurisdictions and over time.

Table 10
Number of suicides by state and territory, 2003-2011

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
2003	640	540	466	227	193	69	35	44	2,214
2004	587	521	453	194	178	88	26	51	2,098
2005	549	506	459	203	231	74	35	45	2,102
2006	577	485	494	245	180	72	32	33	2,118
2007	611	474	520	266	205	66	32	55	2,229
2008	620	545	553	300	175	73	36	38	2,341
2009	623	576	525	279	185	79	32	37	2,337
2010	639	536	583	315	197	64	41	45	2,420
2011	566	483	559	306	209	73	34	43	2,273

Figure 55 compares the average annual age standardised suicide rates in states and territories for the period 2006-10, using five year averages. In all states and territories, the rate for males was over three times higher than that for females. The Northern Territory stands out as having the highest rate, almost double the national figure (19.3 per 100,000 compared with 10.6 per 100,000). Tasmania's rate (14.1 per 100,000) was 33% higher than the national average, Western Australia's (13.1 per 100,000) was 24% higher, Queensland's (12.4 per 100,000) was 17% higher, and South Australia's (12.0 per 100,000) was 13% higher. Lower than average suicide rates were recorded in New South Wales (8.6 per 100,000), Victoria (9.6 per 100,000) and the Australian Capital Territory (9.9 per 100,000).[53] Relative numbers of Indigenous people and people living in rural and remote areas may contribute to these jurisdictional differences.

Figure 55
Average annual age standardised suicide rates (per 100,000 population) by state and territory, 2007-11

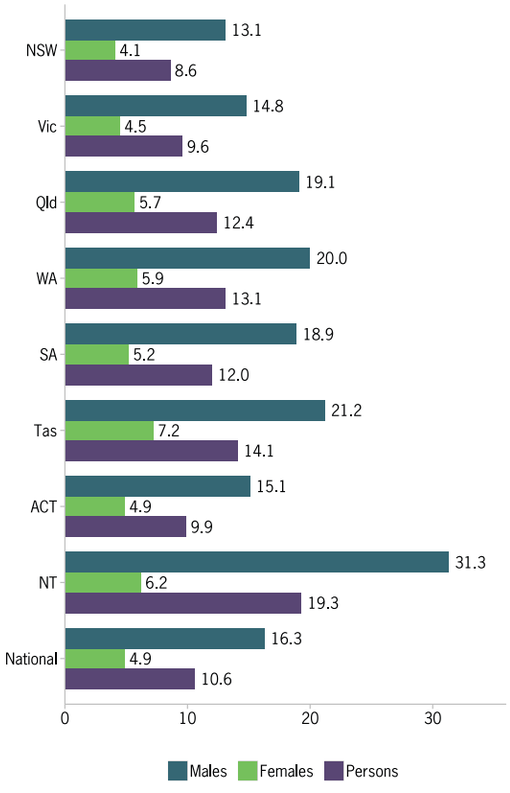
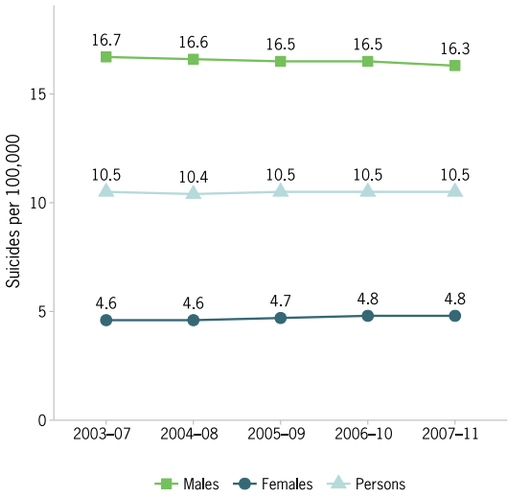


Figure 56 uses unpublished figures from the Australian Bureau of Statistics (ABS) and shows the national trend in suicide rates from 2003-07 to 2007-11, again using five year averages. The overall rate has been stable at 10.5 per 100,000, the male rate has declined slightly (from 16.7 to 16.3 per 100,000) and the female rate has increased slightly (from 4.6 to 4.8 per 100,000).

Figure 56
Average annual suicide rates (per 100,000 population) by five year period, 2003-07 to 2007-11[a]



(a) These figures are based on recent unpublished data provided by the Australian Bureau of Statistics. The 2007-11 figures vary slightly from those presented in Figure 55 due to a different upper age group being used in the calculation of each rate.

The ABS has drawn attention to significant data quality problems that impact on the apparent fluctuation in suicide rates, arising primarily from the increasing number of 'open cases' that are the subject of coronial inquiry. Commencing with its 2008 Causes of Death publication[55] (released in March 2010), the ABS introduced changes to its coding and reporting practices to reduce the impact of these problems and improve the accuracy of overall statistics on causes of death in Australia. These changes particularly affect suicide statistics. They include revisions to historical data back to 2007. The ABS has cautioned that, as a result of these changes, care should be taken when comparing recent data with earlier years.

Australia was one of the first countries to establish a national suicide prevention strategy, and the above suicide statistics should be considered in that context. In 1995, Australia

put in place the National Youth Suicide Prevention Strategy (Here for Life), which was broadened in 1999 with the introduction of the National Suicide Prevention Strategy to consider suicide and suicidal behaviours across the life span. The National Suicide Prevention Strategy has continued since that time, and it aims to: build individual resilience and capacity for self-help; improve community strength, resilience and capacity in suicide prevention; provide targeted suicide prevention activities; implement standards and quality in suicide prevention; take a coordinated approach to suicide prevention; and improve the evidence base and understanding of suicide prevention. The National Suicide Prevention Strategy comprises several components, most notably the Living Is For Everyone (LIFE) Framework which sets out an evidence-based strategic policy framework for suicide prevention that has been agreed to by the Australian Government and all states and territories. In 1998, the year before the National Suicide Prevention Strategy began, the age standardised suicide rate sat at 14.3 per 100,000.[56]

Australia's suicide prevention efforts are continuing. In late 2010, against the background of the National Suicide Prevention Strategy, the Australian Government invested an additional $274m over four years to reduce suicide via its *Taking Action to Tackle Suicide* package. The funding was directed at four key action areas, namely boosting frontline services to support those at risk, investing more in direct suicide prevention and crisis intervention, targeting men who are at heightened risk of suicide but unlikely to seek help, and promoting good mental health and resilience in young people.

Indicator 11: Rates of understanding of mental health problems and mental illness in the community

KEY MESSAGES:

- In 2011, nearly three quarters (74%) of Australian adults could recognise depression. This figure was even higher (86%) for depression accompanied by suicidal thoughts.
- Rates of recognition of early and chronic schizophrenia and post-traumatic stress disorder were lower, with only about one third of the population being able to recognise these disorders. Rates of recognition of social phobia were the worst at 9%.
- Rates of recognition of depression have improved since 1995, whereas rates of recognition of schizophrenia peaked in 2003-04 and have declined slightly since. Recognition of post-traumatic stress disorder and social phobia were only assessed in 2011, so no comparison data are available.

Mental health literacy can be thought of as the knowledge and beliefs about mental illnesses which aid their recognition, management and/or prevention. Accurately recognising the symptoms of a mental illness is a necessary first step in the process of seeking professional help, with failure to identify the problem leading to delays in treatment.[57] Research has demonstrated an association between extended duration of untreated mental illness and poorer outcomes in terms of response to treatment,[58 59] and suicidality.[60]

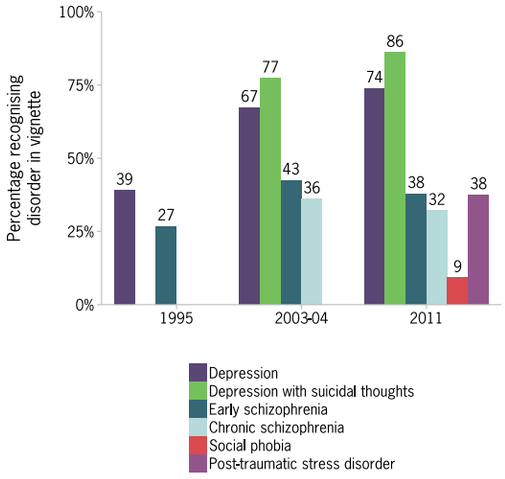
Data for this indicator come from the National Surveys of Mental Health Literacy and Stigma, conducted in 1995, 2003-04 and 2011, the same source as used for Indicator 3 (Rates of stigmatising attitudes within the community).

These surveys have used a vignette-based approach to investigate the ability of the Australian population to accurately identify a variety of mental disorders, namely depression and early schizophrenia (assessed in all years), depression with suicidal thoughts and chronic schizophrenia (assessed in 2003-04 and 2011), and social phobia and post-traumatic stress disorder (assessed in 2011).[46]

Figure 57 shows that in 2011, recognition rates for depression with and without suicidal thoughts were high (86% and 74%, respectively). Recognition rates for early schizophrenia and chronic schizophrenia were lower; 38% identified the former correctly, and 32% identified the latter. Recognition rates for post-traumatic stress disorder were similar to those for schizophrenia at 38%, and recognition rates for social phobia were the lowest at 9%.[46] Rates of recognition of depression have improved over time, whereas rates of recognition of schizophrenia peaked in 2003-04 and have declined slightly since.[46]

Australian initiatives such as *beyondblue*, MindMatters and Kidsmatter have focused considerable attention on improving the mental health literacy of the Australian population. Future efforts in this area might benefit from a focus on disorders other than depression. There is clearly still some way to go in terms of improving community understanding of schizophrenia, and other disorders – like anxiety disorders – might also be targeted. In addition, further monitoring is necessary to explore whether improvements in understanding of mental health problems translate into help seeking and, ultimately, whether they lead to gains in population mental health.

Figure 57
Recognition of the mental disorder experienced by the person described in the vignette, 1995, 2003-04 and 2011



Indicator 12: Prevalence of mental illness

KEY MESSAGES:

- In 1997, 18% of adults experienced a common mental illness (anxiety disorders, affective disorders and substance use disorders) in the past 12 months. In 2007, the figure was slightly higher at 20% but this may be explained by methodological differences in the way in which these prevalence figures were gathered.
- In both 1997 and 2007, young adults experienced higher rates of mental illness than older adults.
- In 1998, 14% of children and adolescents were affected by a clinically significant mental health problem. More current data will be collected in 2013.

Mental illness affects the lives of individuals, those close to them, and the wider community. The prevalence of mental illness provides a global indicator of the mental health of Australians.

As noted in Part 1, several major cross-sectional prevalence surveys have been conducted during the course of the National Mental Health Strategy. These include the National Surveys of Mental Health and Wellbeing (conducted in 1997 and 2007) which provide a picture of the prevalence of common mental disorders in adults,[4 8 9] and the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing (conducted in 1998) which profiles mental health problems among children and adolescents.[6]

Figure 58 summarises the findings from the National Surveys of Mental Health and Wellbeing at the two points in time. It shows that in 1997, 18% of adults experienced a common mental disorder (anxiety disorders, affective disorders and substance use disorders) in the 12 months prior to the survey. In 2007, this figure was slightly higher at 20%. Some caution should be exercised in comparing findings from the two surveys because they sampled from slightly different age ranges and used somewhat different approaches to gauge the presence of mental illness in the past 12 months. It may be the case that these methodological differences account for the small increase in overall prevalence over time.[9]

In both 1997 and 2007, rates of mental disorders diminished with age. Rates were highest in the early adult years, the period in which many people experience their first episode of mental illness. In 2007, the prevalence of mental disorders among 18-24 year olds (26%) was one third higher than the average for the total adult population. A similar pattern was evident from the 1997 figures.

Figure 58
Prevalence of common mental disorders in the Australian population, 1997/1998 and 2007

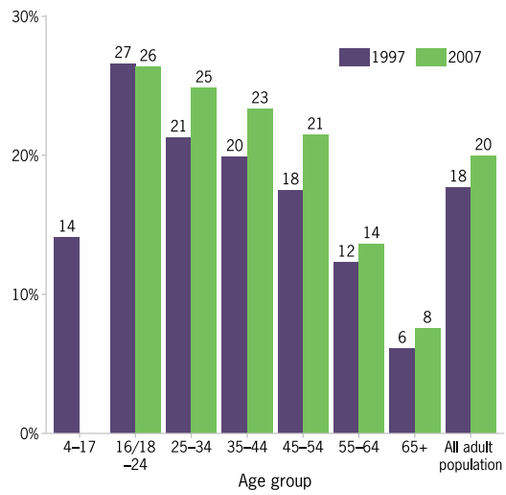


Figure 58 also provides a prevalence estimate from the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing. It shows that 14% of children and adolescents aged 4-17 years were affected by a clinically significant mental health problem. Updated figures are not yet available, but a new study of children and adolescents has been commissioned and will be conducted in 2013.

The available evidence indicates that we can protect individuals against mental illness by building resilience, particularly in young people. Steps can also be taken to minimise the impact of mental illness on the individual and his or her family and friends, by ensuring that high quality treatment and support is readily available. Evidence-based interventions are also available to minimise the likelihood of relapse following an initial episode by fostering coping strategies. Australian experiences also suggest that we can continue to work with the community to reduce the stigma surrounding mental illness, and put in place initiatives to promote social inclusion and recovery. The National Mental Health Strategy's population health approach encompasses all of these directions.

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

Progress of actions under this priority area

The *Fourth National Mental Health Plan* lists seven actions that relate to service access, coordination and continuity of care. Progress has been made on two of these (see Appendix 3). By way of example, substantial progress has been made on Action Area 16 which involves better targeting services and addressing service gaps through cooperative and innovative service models for the delivery of primary mental health care. The 2011-12 Federal Budget allocated resources to address service gaps in the delivery of primary mental health care, including doubling the funding for the Access to Allied Psychological Services (ATAPS) initiative and providing new funding for the Partners in Recovery program. ATAPS offers access to psychological services for people with common mental disorders like depression and anxiety, employing a service delivery model that is managed by Medicare Locals. Partners in Recovery aims to better support people with severe and persistent mental illness with complex needs and their carers and families, by encouraging collaboration between the multiple services with which they come into contact.

Indicator 13: Percentage of population receiving mental health care

KEY MESSAGES:

- The percentage of the population seen by state and territory community mental health services from 2006-07 to 2010-11 remained relatively stable at around 1.5%.
- The percentage of the population receiving mental health specific Medicare-funded services rose from 3.1% in 2006-07 to 6.9% in 2010-11. This increase was largely due to the introduction and uptake of services provided through the Better Access initiative.
- Targets for population coverage by mental health services are yet to be agreed but are expected to be advanced as part of the continuing development of the *Roadmap for Mental Health Reform*[1] agreed by the Council of Australian Governments (COAG) in December 2012.

Widespread concern about access to mental health care was a key factor that underpinned the COAG *National Action Plan on Mental Health* endorsed by governments in 2006, and was reinforced in the commitments made under the various *National Mental Health Plans*. The *Third* and *Fourth National Mental Health Plans* in particular have emphasised the need to improve access to primary mental health care, especially for people with common mental illnesses. For consumers, having access to the right services at the right time is of paramount importance.

First insights into the gap between need for mental health services and services actually delivered were provided by the National Surveys of Mental Health and Wellbeing undertaken in 1997 and 1998. The surveys revealed that only 38% of adults and one quarter of children and younger people with a mental illness received treatment from a health service. Of those who received services, the majority (77%) consulted their general practitioner, although about half also attended another health service. The implication is that, 15 years ago, about two

thirds of the one in five adult Australians who were experiencing a recent mental illness received no treatment for that illness from any part of the health system.

An updated picture on the extent of unmet need for mental health care in the adult population became available from the 2007 National Survey of Mental Health and Wellbeing. Conducted by the Australian Bureau of Statistics (ABS) in 2007, results released in October 2008 suggested that little change had occurred over the preceding decade in the overall rates of treatment for people with mental disorders, with approximately two thirds (65%) continuing to receive no treatment. Similar rates of treatment for mental illness have been reported in all population surveys conducted in other developed countries.

When the 2007 survey findings were scaled to the total population, they suggested that 2.1 million adult Australians experienced the symptoms of a mental illness but received no health care for their conditions. Treatment rates varied according to the severity of the person's condition and type of disorder. Approximately two thirds (64%) of those with disorders classified as severe according to the ABS methodology received some level of health care. About 39% of people with moderately severe disorders and only 17% of people with milder (but still clinically significant) disorders were found to receive mental health care. People with an affective disorder (mainly depression) were more likely to have received services for their mental health condition than those affected by one of the various anxiety disorders (59% and 38% respectively). These rates were similar to those observed in 1997.

Large scale population surveys like the National Surveys of Mental Health and Wellbeing provide snapshots of the level of mental illness in the community but cannot provide routine and regularly available information to monitor this indicator over time. To complement the periodic population surveys, for the purposes of this and related reports, health administrations within each jurisdiction agreed to pool data on the number of people receiving services through government-funded clinical mental health care streams. The Private Mental Health Alliance, covering private hospitals and other providers of mental health care, also agreed to contribute data on people treated in private hospitals.

Results at the national level over the period 2006-07 to 2010-11 are presented in Figure 59. Assuming minimal overlap between state and territory and Medicare-funded person counts, the data suggest that approximately 1.9 million people, or 8.5% of the population, received clinical mental health care in 2010-11, compared with 970,000 in the 2006-07.

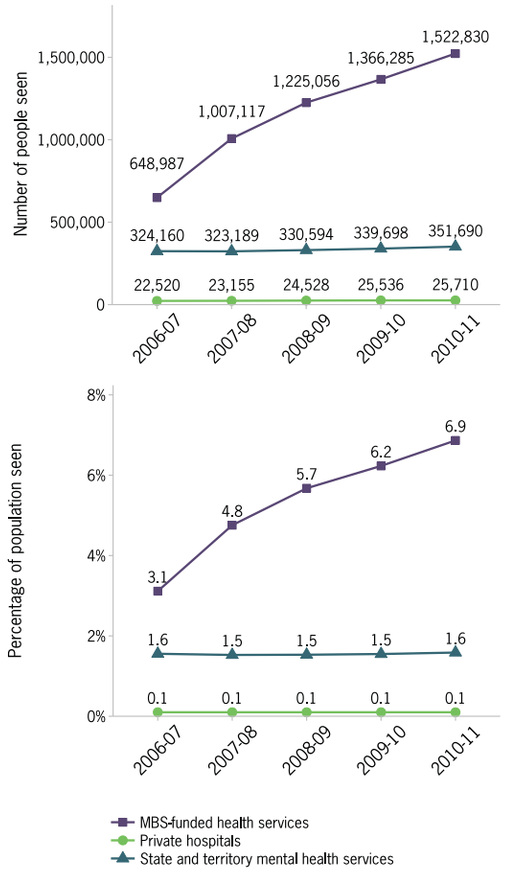
Overall, the percentage of people seen by state and territory mental health services has remained relatively stable, fluctuating between 1.5% and 1.6%. Growth in the number of people seen by Medicare-funded mental health services, rising from 3.1% of the population in 2006-07 to 6.9% in 2010-11, is the sole driver of overall growth in treatment rates over the five year period.

These figures highlight that the ABS estimates made in 2007 of access to mental health care are unlikely to reflect the population's current use of services. Analysis was undertaken by the Australian Government Department of Health and Ageing as part of the national evaluation of the Better Access program, and factored in the growth in the number of persons treated by Medicare-funded Better Access services and incorporated estimates from other service utilisation data.[31] The analysis suggested that the percentage of the population with a current mental illness who received care in 2009-10 was 46%, substantially higher than the 35% estimate found by the ABS in 2007. The growth occurring in 2010-11 evident in Figure 59 will have further increased treatment rates beyond those found in 2007.

Data on relative access figures across each of states and territories are provided in Part 4 of this report. Several caveats need to be considered when interpreting the data. First, assessing progress against this indicator is not as simple as adding together the percentages in Figure 59 for any given year due to the possibility that a sub-group of service users access both state and territory mental health services and Medicare-funded mental health services. Without a unique identifier that permits individuals to be 'tracked' across service sectors, all that can be said is that a minimum of 3.1% of the population received mental health care in 2006-07 and a minimum of 6.9% did so in 2010-11. The figures are likely to be higher than this, but the true percentages cannot be accurately ascertained. However, the trend is certainly in the right direction.[E]

Secondly, comparisons of relative coverage between state and territory mental health services and Medicare-funded services need to take account of differences in the type and intensity of services provided across these sectors, with states and territories having their main focus on treating people with severe mental disorders. Thirdly, the growth in Medicare-funded services is, in part, a function of the fact that the Better Access initiative commenced in the first year of the period examined in Figure 59. Fourthly, comparisons between state and territory services need to be made cautiously because jurisdictions differ in the way in which they count the number of people under care. Victoria in particular undercounts patients seen by clinical services when compared to other jurisdictions because it only reports people who are seen and accepted for case management.

Figure 59
Number of people and percentage of population seen by each of the major mental health service streams, 2006-07 to 2010-11



A final cautionary note is needed to guide interpretation of data on use of mental health services. Most people who meet diagnostic criteria for mental illness do not experience a need for professional assistance of any kind. The 2007 National Survey of Mental Health and Wellbeing reported that nine out of ten of those experiencing mental illness symptoms in the previous 12 months who were not receiving mental health care reported having no need for any of a range of services, including counselling, medication and information (see Table 11).[9 14] The implication is that the lack of health service use by people with mental illness may be more related to their perception of personal needs than to the actual availability of services. Further work is needed to tease out the extent to which this finding is a function of factors such as lack of recognition by the person that they have an illness, lack of awareness that effective treatments are available, negative experiences of previous service use, and continuing stigma associated with mental illness.

[E] Work is underway by the Australian Institute of Health and Welfare to use data linkage to more accurately estimate the extent of duplication in consumer counts between state and territory services and MBS-subsidised mental health care. This work is progressing with the assistance of jurisdictions and in compliance with ethical requirements.

Deciding on an appropriate target for population coverage by mental health services remains a challenge for all governments. The recent *Roadmap for Mental Health Reform* agreed by COAG in December 2012 foreshadowed the developments of targets in this area. As a broad indication of the scope of a possible target, lifting treatment rates for people with mental illness from the 35% found in the 2007 survey to 66% would require 12% of the population receiving mental health care each year.

Table 11
Percentage of people with a current mental illness who received no health services reporting no need for services, 2007

Type of service	% reporting no need
Information	94%
Medication	97%
Talking therapy	89%
Social intervention	94%
Skills training	96%
Any of the above	86%

Indicator 14: Readmission to hospital within 28 days of discharge

KEY MESSAGES:

- In 2010-11, the percentage of admissions to state and territory acute psychiatric inpatient units that were followed by a readmission within 28 days was 15% nationally. This figure has been stable since 2005-06.
- Two states had readmission rates lower than 10% in 2010-11: the Australian Capital Territory (5%) and South Australia (9%). South Australia's figures should be interpreted with caution because they may represent an undercount.
- There has been little movement over time in almost all states and territories, except in the Australian Capital Territory where the rate has more than halved since 2005-06.

Internationally, readmission rates are often used as a litmus test of the performance of mental health systems. High rates may point to deficiencies in hospital treatment or community follow up care, or a combination of the two. Of course, other factors may also be implicated in rapid readmissions, with some reflecting the episodic nature of mental illness. Notwithstanding the complexity of the indicator, it is used by many countries to monitor health system performance. It has special relevance to areas of health care that involve provision of services to people with longer term illnesses who need a combination of hospital and community-based treatment. The underlying standard is that, while multiple hospital admissions may be necessary over the course of a lifetime for some people with ongoing illness, a high proportion of unplanned readmissions occurring shortly after discharge largely reflects failures in the care system.

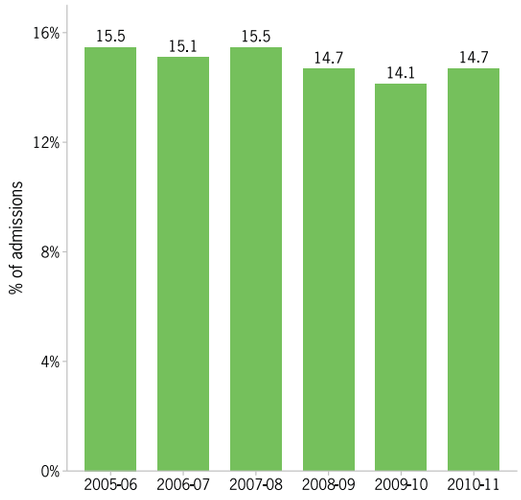
This indicator focuses on admissions to acute psychiatric inpatient units run by state and territory mental health services; comparable data for the private hospital sector are not available. Figure 60 presents the national average for each year from 2005-06 to 2010-11, and shows that with the exception of one year (2009-10) when it dropped to 14%, it has consistently sat at 15-16%.

More detailed jurisdiction-level information is available in Part 4. Variation between jurisdictions is evident, with 28 day readmission rates in 2010-11 being below 10% for the Australian Capital Territory (5%) and South Australia (9%). Within jurisdictions, there has been little movement over time except in the Australian Capital Territory where the rate has more than halved since 2005-06.

It should be noted that the estimates from some jurisdictions are more accurate than others. This is because accurate monitoring of 28 day readmission rates depends on a unique identifier information system that tracks the movement of people between hospitals. True readmission rates are likely to be underestimated in the absence of such a system, because a person who is discharged from one hospital and readmitted to another within 28 days will not be represented in the figures. In 2005-06, all jurisdictions except South Australia and Tasmania had such a system. Tasmania developed this capacity in 2007-08, but South Australia has not yet done so.

Considerable attention has been devoted to identifying ways of reducing readmission rates. For example, eight mental health services from around the country considered this issue when they participated in the National Mental Health Benchmarking Project, which began in 2005. Representatives from these services used a combination of methods to identify positive practices in this area. They concluded that seamless provision of care across inpatient and ambulatory services is required to improve readmission rates, as are good discharge planning and proactive community follow up. They also emphasised good governance, and consumer and carer engagement across the continuum of care.[61]

Figure 60
Percentage of admissions to state and territory acute inpatient units followed by a readmission within 28 days, 2005-06 to 2010-11



Indicator 15: Rates of pre-admission community care

KEY MESSAGES:

- In 2010-11, 47% of admissions to state and territory acute inpatient psychiatric units were preceded by community care in the seven days before the admission. This figure represents a small improvement over recent years.
- There is considerable cross-jurisdictional variability. The Australian Capital Territory is the only jurisdiction to have achieved rates above 70%, with 76% of its acute inpatient admissions in 2010-11 being preceded by community care in the seven days prior to admission.
- The 2010-11 figures for the other states and territories range from 27% in the Northern Territory to 63% in Western Australia.

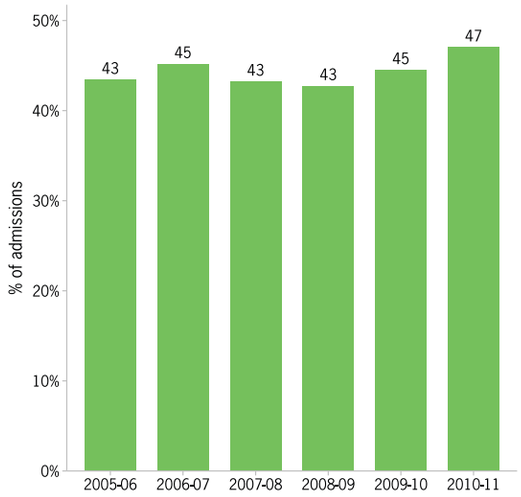
Much of the reform effort in the early years of the National Mental Health Strategy was aimed at creating integrated public sector mental health services, in which hospital and community-based services operate as a single service characterised by continuity of care, particularly when consumers move between treatment settings. Continuity of care has special relevance for the mental health sector because the enduring nature of many mental illnesses often means that care needs to be provided on an ongoing basis or intermittently over a considerable period of a person's life.

This indicator focuses on one aspect of continuity of care and looks at the extent to which consumers who require admission for inpatient care receive community care by clinical teams in the seven days leading up to the hospital admission. The indicator is complemented by Indicator 16 which looks at continuity of care following discharge from hospital.

Monitoring pre-admission community care rates is based on the fact that many consumers who are admitted to an acute inpatient unit are known to the local community mental health service, and the expectation that, where the person is a registered consumer of the service, community teams should be involved in their care in the period prior to admission. Contact by the community team is appropriate to assess the consumer's situation and ensure that admission is the most appropriate treatment option. Community mental health teams that have established a good relationship with the consumer are likely to be able to identify signs of deterioration in his or her condition, and, where required, smooth the way to an inpatient admission.

Figure 61 shows that in 2010-11, 47% of admissions were preceded by community care. Although this represents a small improvement over recent years, the contact rate remains relatively low.

Figure 61
Percentage of admissions to state and territory acute inpatient units where contact was provided by a community mental health team in the 7 days prior to admission, 2005-06 to 2010-11



Equivalent figures are provided for each state and territory in Part 4. The Australian Capital Territory had the highest pre-admission contact rates, with 76% of all its acute inpatient admissions in 2010-11 being preceded by community care, compared with 60% in 2005-06. The Australian Capital Territory is the only jurisdiction with rates above 70%; the 2010-11 figures for the other states and territories range from 27% in the Northern Territory to 63% in Western Australia.

Estimates from some jurisdictions are more likely to reflect the true picture than those from others. This is because some states and territories (notably Tasmania and South Australia) only have the capacity to determine whether an individual received pre-admission community care from the community team within the inpatient unit's catchment. Some people may receive community care from elsewhere and be referred from there to the inpatient unit, which means the rates in these jurisdictions may represent an undercount.

As a measure of performance this indicator cannot be looked at in isolation from other services (including non-government services or general practitioners). If people receive care from these services or providers prior to an admission, this will not be reflected in the above figures.

As with other related indicators, deciding on an appropriate target for pre-admission community contact rates remains a challenge for all governments. While 100% is not feasible, given that a proportion of admissions to hospital will continue to be unexpected and accounted for by people not known to the local community mental health team, the current national rate of 47% falls short of reasonable expectations. The *Roadmap for Mental Health Reform*,[1] agreed by the Council of Australian Governments in December 2012, foreshadows the development of targets in this area.

Indicator 16: Rates of post-discharge community care

KEY MESSAGES:

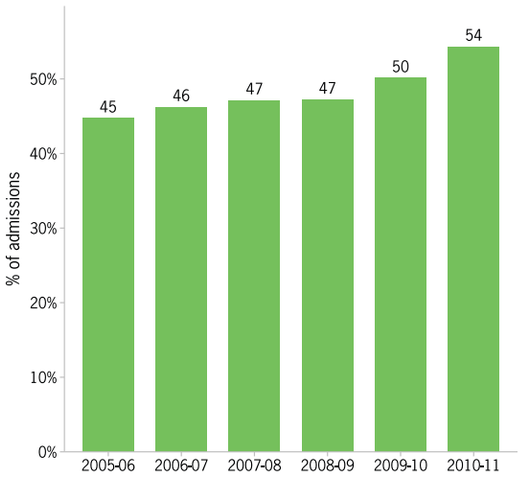
- In 2010-11, 54% of Australian admissions to state and territory acute psychiatric inpatient units were followed by community care (in the seven days after discharge). This percentage has been improving incrementally since 2005-06.
- There is substantial variation across jurisdictions, with 2010-11 one week post-discharge follow up rates ranging from a low of 19% (in the Northern Territory) to a high of 79% (in the Australian Capital Territory).

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental illness have heightened levels of vulnerability and, without adequate follow up, may relapse or be readmitted. The post-discharge period is also a period of great stress and uncertainty for families and carers.

Evidence gathered in recent years from a number of consultations around Australia suggests that the transition from hospital to home is often not well managed. The inclusion of this indicator as a measure of progress of the *Fourth National Mental Health Plan* targeted the performance of the overall health system in providing continuity of care, recognising the need for substantial improvement in this area. The standard underlying the measure is that continuity of care involves prompt community follow up in the vulnerable period following discharge from hospital.

Figure 62 shows that in 2010-11, 54% of hospital episodes were followed by community care in the week after discharge. This percentage has been improving incrementally since 2005-06, when it was 45%.

Figure 62
Percentage of discharges from state and territory acute inpatient units in which contact was provided by a community mental health team in the 7 days after discharge, 2005-06 to 2010-11



Equivalent figures are provided for each state and territory in Part 4. They reveal substantial variation across jurisdictions, with 2010-11 one week post-discharge follow up rates ranging from a low of 19% (in the Northern Territory) to a high of 79% (in the Australian Capital Territory). For most jurisdictions, follow up rates show gradual but small improvement over the six years for

which data are available, although greater improvement is evident in two jurisdictions with relatively low baseline rates (Tasmania and South Australia).

Work undertaken as part of the Australian Government-funded National Mental Health Benchmarking Project provided insights about the reasons organisations and jurisdictions may vary on seven day post-discharge follow up rates.[62] Accuracy of information systems in tracking the movement of people between hospital and community care, particularly across organisations, is critical. For example, two jurisdictions (Tasmania and South Australia) can only confidently determine whether community care was provided in the same area as the hospital from which the consumer was discharged. This is likely to lead to an undercount, because some people may receive community care from elsewhere once they are discharged. Lower follow up rates may also be the result of some consumers being managed outside the state and territory public system (for example, by general practitioners, private psychiatrists or, in the Northern Territory, by Aboriginal/remote health services). These activities are not captured by existing mental health information systems.

Overall, the variation in post-discharge follow up rates suggests important differences between mental health systems in terms of their practices. An observation made by organisations engaged in the benchmarking work was that, although there may be legitimate reasons for non-follow up of some consumers in the week after discharge (for example, perhaps in circumstances where there is follow up by general practitioners, private psychiatrists, non-government organisations etc.), this group is small and routine follow up should be the norm. The implication is that the current national rate of 54% is well below what would be expected from best practice services.

Setting a national target for this indicator is expected to be explored as part of the work to be progressed under the *Roadmap for Mental Health Reform*,[1] agreed by the Council of Australian Governments in December 2012.

Indicator 19: Prevalence of mental illness among homeless populations

KEY MESSAGES:

- Routinely collected data from the former Supported Accommodation Assistance Program (SAAP) suggests that, in 2010-11, 11% of SAAP clients sought accommodation because of mental health problems, 9% did so because of substance use problems, and 7% did so because of comorbid mental health and substance use problems.
- These figures are likely to underestimate the true prevalence of mental illness among homeless populations because they focus on clients whose referral to SAAP was associated with these problems. They do not take into account clients who may have underlying conditions that are not directly responsible for the referral.
- From July 2011, the Special Homelessness Services (SHS) collection will enable more accurate estimates of mental illness among homeless populations to be calculated.