

# **Fifth National Mental Health Plan**

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Draft for Consultation

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## SUMMARY OF PRIORITY AREAS, AIMS AND ACTIONS

The Fifth National Mental Health Plan (the Fifth Plan) sets out a national approach for collaborative government effort over the next five years. It is underpinned by a vision and seven priority areas, with supporting actions to enable change. These actions set the direction for change and provide a foundation for longer term system reform. They recognise that consumers and carers need to be at the centre of the way in which services are planned and delivered, and that a regional focus is a key platform of the change that is needed to address the fundamental shortcomings of the existing system.

### Vision

- ▶ More people will have good mental health and wellbeing.
- ▶ More people living with mental health issues will recover and have a meaningful and contributing life.
- ▶ More people living with mental health issues will have good physical health and live longer.
- ▶ More people will have a positive experience of care and support from a responsive and effective service system.
- ▶ Fewer people will suffer avoidable harm.
- ▶ Fewer people will experience stigma and discrimination.

## Priority Area 1: Integrated regional planning and service delivery

<b>Aim</b>	<b>Summary of actions</b>
<p>A service system that works in an integrated way at the regional level to plan and deliver services that are tailored to the needs of consumers and carers, is easier for consumers and carers to navigate, and is delivered in the most effective and efficient way possible.</p>	<ol style="list-style-type: none"><li data-bbox="628 398 1313 524">1. Governments will establish the enablers to support integrated planning and service delivery at the regional level.</li><li data-bbox="628 546 1313 725">2. Governments will work with Primary Health Networks and Local Hospital Networks to implement integrated planning and service delivery at the regional level.</li></ol>

## Priority Area 2: Coordinated treatment and supports for people with severe and complex mental illness

<b>Aim</b>	<b>Summary of actions</b>
<p>An integrated and sustainable service system that provides the right amount of tailored clinical and community supports, at the right time, for people with severe and complex mental illness.</p>	<ol style="list-style-type: none"><li data-bbox="611 439 1313 607">3. Governments will support coordinated service delivery for people with severe and complex mental illness through the development of national guidelines.</li><li data-bbox="611 636 1313 981">4. In consultation with key stakeholders, the Mental Health Drug and Alcohol Principal Committee will monitor and report to Health Ministers on emerging health and other related policy issues that may arise from the implementation of mental health reforms and the National Disability Insurance Scheme for people with severe and complex mental illness.</li><li data-bbox="611 1010 1313 1317">5. Primary Health Networks and Local Hospital Networks will work with health and social service agencies operating in their regions and the community sector to develop region-wide arrangements to ensure coordinated treatment and community support for people with severe and complex mental illness.</li></ol>

### Priority Area 3: Suicide prevention

<b>Aim</b>	<b>Summary of actions</b>
To reduce the incidence of suicide and ensure that people who have attempted suicide are given effective follow-up support.	<ol style="list-style-type: none"><li data-bbox="611 398 1315 663">6. Governments will work together to renew efforts to develop a nationally agreed approach to suicide prevention that aligns their respective activities, and improves identification of people at risk of suicide and the effectiveness of services and support available to them.</li><li data-bbox="611 685 1315 813">7. Governments will work to develop integrated, whole-of-community approaches to suicide prevention at the regional level.</li><li data-bbox="611 835 1315 1193">8. Governments will work with Primary Health Networks and Local Hospital Networks to prioritise the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for hospitals, specialised mental health services and primary care services.</li><li data-bbox="611 1216 1315 1395">9. Governments will work together to strengthen data collections relating to suicide and suicide attempts to strengthen the evidence base and improve quality of care.</li><li data-bbox="611 1417 1315 1597">10. Governments will develop suitable public health and communication strategies to better inform the community about suicide and suicide prevention.</li></ol>

**Priority Area 4: Aboriginal and Torres Strait Islander mental health and suicide prevention**

<b>Aim</b>	<b>Summary of actions</b>
<p>Culturally competent care through integrating social and emotional wellbeing services with a range of mental health, drug and alcohol, and suicide prevention services.</p>	<ol style="list-style-type: none"><li>11. Governments will work collaboratively to develop a joined approach to social and emotional wellbeing support, mental health, suicide prevention, and alcohol and other drug services, recognising the importance of what an integrated service offers for Aboriginal and Torres Strait Islander people.</li><li>12. Governments will work with Primary Health Networks and Local Hospital Networks to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander people at the regional level.</li><li>13. Governments will renew efforts to develop a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander people.</li><li>14. Governments will work with service providers, including Aboriginal Community Controlled Health Organisations, to improve Aboriginal and Torres Strait Islander access to and experience with mental health and wellbeing services.</li><li>15. Governments will work together to strengthen the evidence base needed to inform development of improved mental health services and outcomes for Aboriginal and Torres Strait Islander people.</li></ol>

## Priority Area 5: Physical health of people living with mental health issues

<b>Aim</b>	<b>Summary of actions</b>
The physical health care of people living with mental health issues is a national priority, and the life expectancy gap is reduced.	<ol style="list-style-type: none"><li data-bbox="624 398 1313 573">16. Governments will identify suitable guidelines and other resources for use by health services and health professionals to improve the physical health of people living with mental health issues.</li><li data-bbox="624 595 1313 909">17. Governments will work with Primary Health Networks and Local Hospital Networks to ensure that the physical health of people living with mental health issues is a priority in the development of regional health plans and service delivery, and that systems are developed for monitoring progress.</li><li data-bbox="624 931 1313 1102">18. Health Ministers will lead the work of commencing regular national reporting on the physical health of people living with mental health issues.</li></ol>



## Priority Area 6: Stigma and discrimination reduction

<b>Aim</b>	<b>Summary of actions</b>
<p>To reduce stigma and discrimination against people living with mental health issues, particularly people with severe mental illness.</p>	<p>19. Governments will broaden their efforts to reduce stigma and discrimination to include a focus on people with severe mental illness. This will be a shared endeavour between governments, consumers and carers, community groups and key organisations.</p> <p>20. Governments will work with key organisations to reduce stigma and discrimination in the health workforce through leadership and training, informed by the views and experience of people who live with mental health issues, and identification and exposure of discriminatory practice where it occurs.</p>

## Priority Area 7: Safety and quality in mental health care

<b>Aim</b>	<b>Summary of actions</b>
<p>A safe and high quality service system that is tailored to the needs of consumers and carers, is underpinned by continuous monitoring and improvement, and reports on outcomes in a transparent manner.</p>	<ol style="list-style-type: none"><li data-bbox="622 398 1315 622">21. Governments will develop a national mental health safety and quality framework to guide delivery of the full range of health and support services required by people living with mental health issues.</li><li data-bbox="622 645 1315 958">22. Governments will work with the Australian Commission on Safety and Quality in Health Care and the mental health sector to amend the National Standards for Mental Health Services to better reflect their intent in those health services where the National Safety and Quality Health Service Standards also apply.</li><li data-bbox="622 981 1315 1205">23. Governments will implement monitoring of consumer and carer experiences of care, including the Your Experience of Service survey tool, across the specialised and primary care mental health service sectors.</li><li data-bbox="622 1227 1315 1361">24. Governments will agree on a national statement of priorities to guide mental health information developments over the next ten years.</li><li data-bbox="622 1384 1315 1653">25. Governments will continue to build accountability by ensuring service delivery systems work to monitor the safety and quality of their services and make information about their performance on service quality indicators available to consumers, carers and other stakeholders.</li><li data-bbox="622 1675 1315 1886">26. Governments will undertake work to improve consistency across jurisdictions in policy underpinning mental health legislation, based on an understanding of their impacts on consumer and carers.</li></ol>

## Monitoring and reporting on reform progress

<b>Aim</b>	<b>Summary of actions</b>
<p>Accurate and timely information is available to allow consumers, carers, providers and governments to monitor mental health system reform and the implementation of commitments made in the Fifth Plan.</p> <p>All parts of the mental health service system are supported in using information to improve the experience of, and outcomes for, consumers and carers.</p>	<p>27. Governments will implement a set of national reform and system performance measures to monitor whether we are making a difference in mental health reform.</p> <p>28. Governments will work to develop additional performance measures in response to consumer, carer and community priorities. These will build on investments already made in data collection and performance measurement development.</p> <p>29. Governments will work to ensure that progress and reform are monitored in all parts of the mental health service system.</p> <p>30. Governments will report annually on the progress of mental health reform and implementation of the Fifth Plan.</p>

## SETTING THE SCENE

Mental health and wellbeing is an essential part of the fabric of our society.<sup>1</sup> When we have good mental health and wellbeing, we are able to realise our abilities, cope with the normal stresses of life, work productively and fruitfully, and better contribute to our community.<sup>2</sup>

### **Mental illness and suicide: the magnitude of the problem**

Mental illness is a major health and social policy issue, and mental health is one of the nine National Health Priority Areas agreed to by governments.

One in five Australians aged 16 to 85 years will experience a mental disorder each year and almost half will experience a mental disorder in their lifetime.<sup>3</sup> In addition, almost one in seven young people (aged 4 to 17 years) were assessed as having a mental disorder in the previous year.<sup>4</sup> Less than half of people living with mental health issues access treatment each year, with untreated mental illness incurring major personal suffering and economic costs.<sup>5</sup>

The experience of mental illness ranges across a wide spectrum. The most common experience is of a mild to moderate level of severity of mental illness (experienced by approximately three million Australians each year). Less common is the experience of severe mental illness (experienced by approximately 690,000 Australians each year).<sup>6</sup>

People living with mental health issues, particularly those with severe mental illness, are more at risk of experiencing a range of adverse health outcomes and have a lower average life expectancy than the general population.<sup>7,8</sup> The overall gap in life expectancy for people living with mental health issues compared against the general population is

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<sup>1</sup> New South Wales Mental Health Commission (2014), *Living Well: A Strategic Plan for Mental Health in NSW*. Sydney, NSW Mental Health Commission.

<sup>2</sup> World Health Organization (2014), *Mental health: a state of well-being*. [ONLINE] Available at: [World Health Organization definition of mental health](#). [Accessed 13 September 2016].

<sup>3</sup> Australian Bureau of Statistics (2008), *National Survey of Mental Health and Wellbeing 2007: Summary of Results*, ABS cat. no. 4326.0, Canberra, ABS.

<sup>4</sup> Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR (2015), *The Mental Health of Children and Adolescents: Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing*. Canberra, Department of Health.

<sup>5</sup> Whiteford H, Buckingham W, Harris M, Burgess P, Pirkis J, Barendregt J, Hall W (2014), *Estimating Treatment Rates for Mental Disorders in Australia*, *Australian Health Review*, 38: 80-85.

<sup>6</sup> National Mental Health Commission (2014), *The National Review of Mental Health Programmes and Services*. Sydney, NMHC.

<sup>7</sup> Western Australian Mental Health Commission (2015), *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*. Perth, Western Australian Mental Health Commission.

<sup>8</sup> The Royal Australian and New Zealand College of Psychiatrists (2016), *The economic cost of serious mental illness and comorbidities in Australia and New Zealand*.

almost 16 years for men and 12 years for women, with most causes of early deaths being due to physical health conditions.<sup>9</sup>

People living with mental health issues are also more at risk of experiencing a range of adverse social and economic outcomes, with stigma creating significant barriers. For example, people living with mental health issues are less likely to be employed compared to those without a mental illness<sup>10</sup>, and more likely to experience homelessness<sup>11</sup> and housing instability.<sup>12</sup> These factors may not only further contribute to their mental illness, but may also contribute to worsening health and social outcomes overall.

The impact of mental illness extends to our broader community and society. Mental illness is a significant contributor to the burden of disease in Australia, being the third largest cause of total disease burden and the leading cause of non-fatal burden.<sup>13</sup>

The cost to society of mental illness is also significant. It not only includes expenditure on providing services and other supports to people living with mental health issues, but also includes the cost of lost productivity and the personal cost impact on people living with mental health issues and their carers. It has been estimated that total direct health and non-health expenditure to support people living with mental health issues is \$28.6 billion per year, with this amount nearly doubling when indirect costs, such as productivity loss and absence through sickness, are added.<sup>14</sup>

**Mental illness costs the Australian economy almost \$60 billion per year, or around four per cent of Gross Domestic Product (GDP)**

Suicide is a tragedy, as well as a major health and social policy issue.

The majority of people know someone who has attempted or died by suicide.<sup>15</sup> In 2015, there were 3,027 deaths by suicide or an average of eight deaths by suicide each day. Approximately 75 per cent of people who die by suicide are male.<sup>16</sup>

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<sup>9</sup> Lawrence D, Hancock KJ, Kisely S (2013), The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *BMJ* 2013;346:f2539.

<sup>10</sup> Department of Health and Ageing (2013), National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011. Canberra, Commonwealth of Australia.

<sup>11</sup> Australian Bureau of Statistics (2016), Mental Health and Experiences of Homelessness, Australia, 2014, ABS cat. no. 4329.0.00.005, Canberra, ABS.

<sup>12</sup> Kamieniecki GW (2001), Prevalence of psychological distress and psychiatric disorders among homeless youth in Australia: a comparative review. *Australian and New Zealand Journal of Psychiatry*, Vol. 35, No. 3: 352- 358.

<sup>13</sup> Australian Institute of Health and Welfare (2016), Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. BOD 4. Canberra, AIHW.

<sup>14</sup> OECD (2015), Mental Health and Work: Australia, Mental Health and Work. Paris, OECD Publishing.

<sup>15</sup> Maple M, Kwan M, Borrowdale K, Riley J, Murray S, Sanford R (2016) *The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia*. Sydney, Suicide Prevention Australia.

Suicide is the leading cause of death for people aged 15 to 44 years and the second leading cause of death for people aged 45 to 55 years. It accounts for one in three deaths among people aged 15 to 24 years and over one in four deaths among people aged 25 to 34 years.<sup>17</sup> Suicide rates for Aboriginal and Torres Strait Islander people are twice as high as non-Indigenous Australians<sup>18</sup>, and rates are also higher for people who live in rural and remote regions.<sup>19</sup>

The number of people who plan or attempt suicide is more than twenty times the number who lose their life to suicide each day, with females much more likely than males to plan or attempt suicide.<sup>20</sup>

There is considerable cost associated with suicide and attempted suicide. Personal costs include loss, grief and trauma and a long lasting emotional impact on family, friends and the broader community. This creates a ripple effect in terms of mental health and wellbeing, and exposure to suicide is a risk factor for subsequent suicide.<sup>21</sup> It has been estimated that the total economic cost of deaths by suicide in 2012 was \$1.7 billion, noting that this amount excludes costs associated with attempted suicide.<sup>22</sup>

### **The mental health environment: systemic issues and a vision for change**

Australia's mental health service system is complex and involves multiple services, programmes, providers and funding streams.

While much is achieved by Australia's mental health service system, there are some areas where it is not working as well as it could. Key issues include fragmentation; unclear roles and responsibilities; inefficiencies and duplication; poor planning and coordination; unmet need and service gaps; and insufficient focus on promotion, prevention and early intervention. The workforce within the system is under pressure, with shortages, distribution issues, high rates of turnover, and challenges in recruiting appropriately skilled and experienced staff.<sup>23</sup> Services within the system are often difficult to navigate, and can be both stigmatising and stigmatised.<sup>24</sup>

There are ongoing calls for a better integrated mental health service system that focuses on the holistic needs of consumers and carers; responds to local needs and circumstances; rebalances efforts towards promotion, prevention and early intervention; and builds workforce capacity to support system change.<sup>25,26,27</sup> The Fifth Plan responds to these calls and seeks to provide a foundation for longer term system reform.

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<sup>16</sup> Australian Bureau of Statistics (2016), Causes of Death, Australia, 2015, ABS cat. No. 3303.0, Canberra, ABS.

<sup>17</sup> Australian Bureau of Statistics (2016), Causes of Death, Australia, 2015, op. cit.

<sup>18</sup> Australian Bureau of Statistics (2016), Causes of Death, Australia, 2015, op. cit.

<sup>19</sup> Parliamentary Library (2011), Suicide in Australia. Canberra, Department of Parliamentary Services.

<sup>20</sup> Australian Bureau of Statistics (2008), op. cit.

<sup>21</sup> Maple M et al. (2016), op. cit.

<sup>22</sup> KPMG (2013), The Economic Cost of Suicide in Australia.

<sup>23</sup> National Mental Health Commission (2014), op. cit.

<sup>24</sup> Victorian Government (2015), Victoria's 10-Year Mental Health Plan. Melbourne, Department of Health and Human Services.

<sup>25</sup> National Mental Health Commission (2014), op. cit.

<sup>26</sup> New South Wales Mental Health Commission (2014), op. cit.

## **Mental health and broader reforms**

Significant reform effort has been invested in mental health and suicide prevention over the past three decades.

The national direction for reform has been guided by the National Mental Health Strategy, which has included the National Mental Health Policy, the Mental Health Statement of Rights and Responsibilities, and four successive National Mental Health Plans. The National Mental Health Strategy has been complemented by a series of work that addresses key areas such as suicide prevention; multicultural mental health; promotion, prevention and early intervention; safety priorities; and information and performance.

To date, there has been a number of notable achievements arising from mental health and suicide prevention reforms. These include a major reorientation of care away from hospital settings to community settings, increased recognition of the need to involve consumers and carers in decisions, and greater community understanding of mental illness and suicide.<sup>28,29</sup> While it is vital that these reforms continue, there are other systemic issues that need to be addressed.

The Fifth Plan has been developed at a time when major change is taking place in relation to mental health and suicide prevention, and the broader health and social policy environments. Some key changes include implementation of mental health and suicide prevention reforms following the National Mental Health Commission's (NMHC) 2014 Review of Mental Health Programmes and Services; implementation of state government suicide prevention initiatives; implementation of the National Disability Insurance Scheme (NDIS); continued decentralisation of planning and decision making to Primary Health Networks (PHNs) and Local Hospital Networks (LHNs); and implementation of initiatives that are seeking to move beyond traditional approaches to commissioning and service delivery. These changes will interact with the actions outlined in the Fifth Plan and it will be important to monitor their impact as the Plan progresses.

## **A national approach for collaborative government effort: the purpose and scope of the Fifth Plan**

The Fifth Plan builds on the foundation established by previous reform efforts and sets out a national approach for collaborative government effort over the next five years.

The Fifth Plan acknowledges that it is not possible to fix everything at once or for all population groups, and that it is important to focus on the most significant issues that need to be addressed as part of a national approach. It is therefore underpinned by several targeted priority areas, which were developed taking into account feedback from key stakeholders, and supporting actions that enable change. The supporting actions are not intended to solve all problems within the five year period of the Fifth Plan, but are instead intended to set the direction for change and provide a foundation for longer term system reform.

The Fifth Plan recognises that state and territory mental health and suicide prevention plans are important in terms of driving specific reform activities. It therefore seeks to

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<sup>27</sup> Western Australian Mental Health Commission (2015), *op. cit.*

<sup>28</sup> Commonwealth of Australia (2009), Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009-2014.

<sup>29</sup> National Mental Health Commission (2014), *op. cit.*

complement state and territory plans, and focuses on areas where a national approach is needed and where outcomes are best achieved by governments working together. It also sits alongside more broadly relevant government strategies, including alcohol and other drug strategies, and initiatives to close the gap in outcomes between Aboriginal and Torres Strait Islander people and other Australians.

While the Fifth Plan is focussed on achieving change within the mental health service system, it is mindful that change will need to occur in other service systems to truly achieve better outcomes for people living with mental health issues and people who have attempted or are at risk of suicide.

In reading the Fifth Plan, it is important to note that governance arrangements differ across jurisdictions. In some jurisdictions, the Minister for Mental Health will be responsible for some or all of the actions in the Fifth Plan. In other jurisdictions, actions will solely be the responsibility of the Minister for Health. It is also important to note that arrangements for regional devolution differ across jurisdictions, and that the Mental Health Commission within some jurisdictions has a commissioning role. References to LHNs in the Fifth Plan may therefore need to be broadened to include jurisdictional Mental Health Commissions, where appropriate.

There is often overlap in the issues that are relevant to each priority area of the Fifth Plan. Instead of taking a siloed approach to discussing these issues within each priority area, the Fifth Plan seeks to reduce duplication across priority areas in as practical a manner as possible. It is therefore important to read the Fifth Plan in its entirety.

## **People and communities at the centre of actions**

The Fifth Plan recognises that people need to be at the centre of the way in which services are planned delivered, evaluated and reformed. It acknowledges that the mental health service system must be reoriented away from the needs of providers and towards the needs of consumers and carers; the people who the system serves. It reflects that services need to work in a coordinated way to collaborate with people with lived experience to co-produce services and outcomes that meet their individual needs. It recognises the transformative value of bringing together the expertise of people with lived experience alongside service expertise to enable meaningful and active collaboration for people to shape their recovery, leading to better outcomes.

While previous reforms have been strong in their intent, they have not necessarily translated to change at the regional level because they did not address the needs of people in specific local circumstances. The Fifth Plan recognises that a regional focus is a key platform of the change that is needed to address the fundamental shortcomings of the existing system. It is at the regional level where practical, targeted, co-produced and locally appropriate action can be taken in partnership with community to drive efforts under this Plan. It is also at the regional level where strong community collaborations, engagement with people with lived lived experience, and partnerships can be formed to work together to achieve better outcomes for consumers and carers.

## **Beyond the mental health service system**

A person's mental health and wellbeing is influenced by many factors, including life experiences, social and economic conditions, and their broader environment. In particular, a person's mental health and wellbeing can be shaped by income, employment, housing, education, health care and social services.



Many people living with mental health issues will access a variety of service systems, such as healthcare, disability, housing, education and employment. These service systems are important in supporting the overall mental health and wellbeing of people living with mental health issues, including their recovery. For people who have attempted or are at risk of suicide, these service systems can be critical to achieving appropriate follow-up support.

If the needs of consumers and carers are truly at the centre of the way in which services are planned and delivered, and if all of their needs are to be met, it is important to look at change beyond the mental health service system. Making meaningful connections between service systems will ultimately improve consumer and carer experiences and outcomes.

### **Values that underpin the Fifth Plan**

The actions in the Fifth Plan are guided by a core set of values. In addition to these values, the specific needs of Aboriginal and Torres Strait Islander people; lesbian, gay, bisexual, transgender and/or intersex people; and people from culturally and linguistically diverse backgrounds should be considered when implementing the actions identified in the Fifth Plan.

#### **Uphold human rights and dignity**

Human rights belong to everyone, and should underpin all efforts to promote mental health and wellbeing. The rights and dignity of all people, including people living with mental health issues and people who have attempted or are at risk of suicide, should be respected and upheld.

#### **Co-production**

Consumers and carers have vital contributions, and should be partners in planning and decision-making. Consumers and carers should be at the centre of, and enabled to take an active role in shaping, the way in which services are planned, delivered and evaluated.

#### **Recovery**

There should be a focus on recovery and enhancing wellbeing, including by recognising each person's potential to live a fulfilling life and contribute to their own recovery.

#### **Promotion, prevention and early intervention**

Efforts should recognise the importance of promotion, prevention and early intervention in contributing to better mental health and wellbeing and longer term system sustainability.

#### **Equity**

All people should have the opportunity to achieve their best possible mental health and wellbeing, regardless of their age, gender, culture, sexual identity or where they live. All people living with mental health issues, and all people who have attempted or are at risk of suicide, should be equitably supported in their recovery.

**Evidence-based and high quality services**

Services should be underpinned by the best available evidence; deliver high quality, safe and effective care; and meet appropriate standards. There should be ongoing efforts to build the evidence base, and distil and promote any lessons learned.

**Innovation**

Innovation should be shared and harnessed, and emerging technologies should be embraced in revised models of care.

**Accountability**

Progress should be monitored and reported on, and there should be a commitment to ongoing review to determine whether efforts are directed in the right places and delivering desired outcomes.

## PRIORITY AREA 1: INTEGRATED REGIONAL PLANNING AND SERVICE DELIVERY

### What we aim to achieve

A service system that works in an integrated way at the regional level to plan and deliver services that are tailored to the needs of consumers and carers, is easier for consumers and carers to navigate, and is delivered in the most effective and efficient way possible.

### What will be different for consumers and carers?

- ▶ You will be at the centre of care, and enabled to take an active role in shaping the way in which services are planned and delivered.
- ▶ Services will work with you in a coordinated way to understand and holistically meet your needs, and achieve the outcomes that are important to you.
- ▶ Treatment, care or support will be personalised and provided by the right service, at the right place, at the right time.
- ▶ Your journey through these services will be smoother.

### Summary of actions

1. Governments will establish the enablers to support integrated planning and service delivery at the regional level.
2. Governments will work with Primary Health Networks and Local Hospital Networks to implement integrated planning and service delivery at the regional level.

### Overview

Integration is the pivotal theme underpinning the Fifth Plan. It is a priority area in its own right, and is interlinked with all other priority areas of the Plan. It represents the flagship of actions agreed by governments for ensuring that consumers and carers are at the centre of the way in which services are planned and delivered.

Internationally, integration is an aspiration pursued by most mental health plans. It has been a goal of Australia's National Mental Health Strategy since its inception and incorporated in all previous National Mental Health Plans, albeit each with a different focus and actions. Whilst previous National Mental Health Plans have been strong in their intent to strengthen integration, they have been limited in their effectiveness on the ground. The exception is the First National Mental Health Plan, which targeted integration of state and territory funded clinical community and hospital services. This was largely achieved because it was in the control of a single level of government. The more complex integration objective requiring cooperation between multiple levels of government, and across portfolios, has remained elusive and there remain calls to address the fundamental problems in the integration of services for people living with mental health issues.

The NMHC's 2014 Review of Mental Health Programmes and Services concluded that mental health services are fragmented and delivered within a complex system that involves multiple providers and siloed funding streams, with the different parts of the service system often operating in isolation of each other and with people having a poor experience of care and unmet need. It highlighted service gaps, inefficiencies, duplication, and poor planning and coordination, compounded by a lack of clarity of roles and responsibilities by governments. It suggested that both levels of government too often make decisions about programmes and services without proper engagement, planning and co-design, and fail to address the critical issue of system design. It called for a better integrated, person-centred service system and identified particular opportunities to better integrate services for people with severe and complex mental illness, people who have attempted or are at risk of suicide, Aboriginal and Torres Strait Islander people, and children and young people.<sup>30</sup>

Similar problems and calls for action are echoed in plans released by state and territory governments. For example, the strategic plan released by the Mental Health Commission of New South Wales identifies a number of problems in the mental health service system (see Box 1) and concludes that service integration is a key priority of future reform.<sup>31</sup> Integration is also a key action area in the strategic plan released by the Western Australian Mental Health Commission, which notes that it is essential for services to work together, across sectors, in an integrated way to ensure that people do not fall through the gaps across the service continuum and that consumers receive the appropriate level of care and support to meet their needs.<sup>32</sup>

### Box 1

*“What we commonly refer to as the mental health system is an amalgam of state and Commonwealth government agencies and funding streams, along with community-managed organisations and private enterprise performing a variety of health service-related, community support, research and advocacy roles. The term ‘system’ could imply the presence of an overarching plan or design. The reality is that this ‘system’ has grown over time and is in part a rich tapestry of effort, commitment and innovation and partly a range of responses developed in an unco-ordinated way to meet immediate needs. This approach has produced a ‘system’ that achieves much for consumers but lacks integration, is difficult to navigate and is often inefficient.”*

Living well: A Strategic Plan for Mental Health in New South Wales

### Conceptualising integration

Integration is a multi-level and multi-faceted concept that can be interpreted in different ways. For the purpose of the Fifth Plan, integration is concerned with building relationships between organisations that are seeking similar aims to improve the outcomes and experiences of consumers. Integration can be implemented at different levels, ranging from information sharing through to pooling of funds and shared governance structures (see Figure 1). Integration at any level can deliver better experiences and outcomes for consumers and carers.

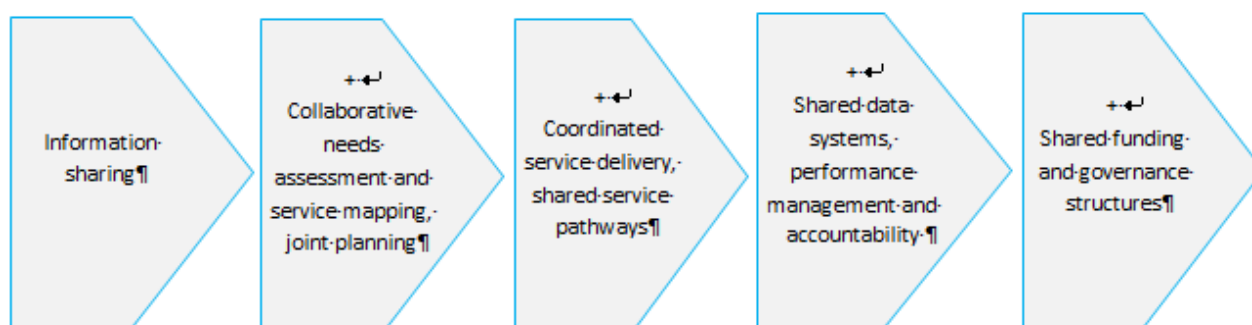
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<sup>30</sup> National Mental Health Commission (2014), op. cit.

<sup>31</sup> Mental Health Commission of New South Wales (2014), op. cit.

<sup>32</sup> Western Australian Mental Health Commission (2015), op. cit.

**Figure 1: Levels of integration between organisations**



Many people living with mental health issues interface with health care, social care, housing and other services. When conceptualising integration, it is therefore important to look beyond the mental health service system. If the needs of consumers and carers are truly at the centre of the way in which services are planned and delivered, there needs to be greater integration between mental health services and other services, and better recognition of the broader determinants of mental health and issues that affect people living with mental health issues. This means connecting mental health and areas such as healthcare, disability, housing, education and employment. It also means extending integration into prevention and early intervention efforts.

### **National leadership, regional implementation**

Previous National Mental Health Plan efforts to strengthen integration were largely directed at the national and state levels, and did not translate to regional and local service contexts. Recent reforms have laid the groundwork for a new approach that devolves responsibility for integration to the regional level, supported by an enabling national framework formed by governments working together to address systemic issues.

Both levels of government have devolved certain responsibilities to regional entities (see Box 2), creating real opportunity for change at the level of local service delivery. The establishment of these entities – PHNs and LHNs – has for the first time aligned Commonwealth and state and territory health planning boundaries, providing an unprecedented opportunity to align efforts at a regional level.

#### **Box 2**

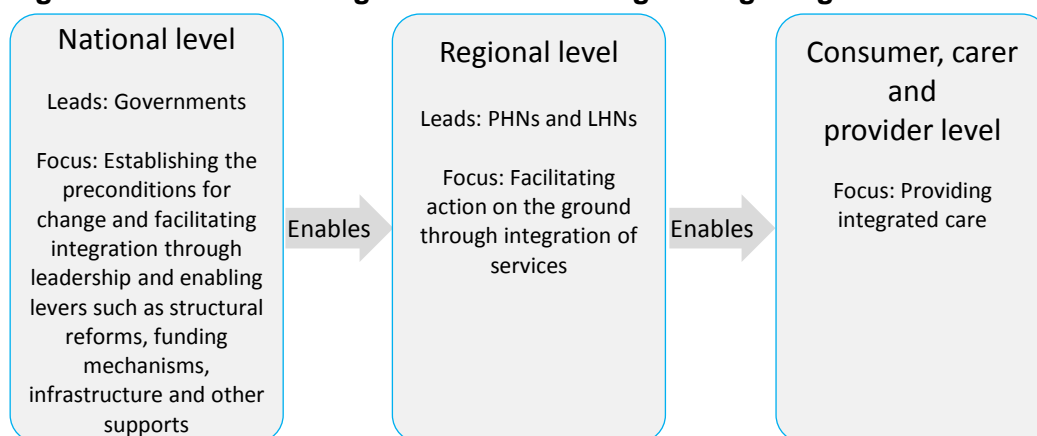
- ▶ PHNs were established by the Commonwealth. They plan and commission medical and health services within defined regional populations, and are expected to support service integration at the regional level.
- ▶ LHNs were established by states and territories. They manage public hospital services, may manage other health services funded by states and territories (such as community based health services), and support service integration at the regional level.

The Fifth Plan recognises that PHNs and LHNs provide the core architecture to support integration at the regional level. They will lead regional integration activities and work in partnership with regional stakeholders to build a consensus around what needs to change and when. Critical to success will be the involvement of consumers and carers, and building of relationships with community managed organisations, Aboriginal and Torres Strait Islander groups, general practitioners (GPs), and private sector providers.

The Fifth Plan also recognises that action must be taken at the national level to establish the preconditions for change, and ensure that PHNs and LHNs are not left in isolation to solve the problems that have eluded previous integration attempts. Governments need to work together to support regional level integration by providing leadership, planning tools, data and other supports. Governments also have a role in identifying and addressing systemic barriers to regional integration.

This approach represents a fundamental reconceptualisation of the role of a National Mental Health Plan as one that sets an enabling environment for regional action, instead of dictating change from the top down (see Figure 2). The Fifth Plan reflects the shared interest of governments in pursuing joint regional planning and initiatives, setting national directions and priorities, and establishing the framework for regions to undertake the work required.

**Figure 2: National and regional roles in strengthening integration**



**Action 1: Governments will establish the enablers to support integrated planning and service delivery at the regional level. This will include:**

- ▶ providing clarity on new and more flexible government roles and responsibilities in the mental health service system that will be structured to address systemic barriers to regional integration;
- ▶ developing planning tools, based on the National Mental Health Service Planning Framework, scaled for use at the regional level and built on an evidence-based stepped care model;
- ▶ making available key national data to inform regional planning and understanding of service gaps, duplication and areas of highest need; and
- ▶ a publicly transparent process for reporting on progress that facilitates shared accountability.

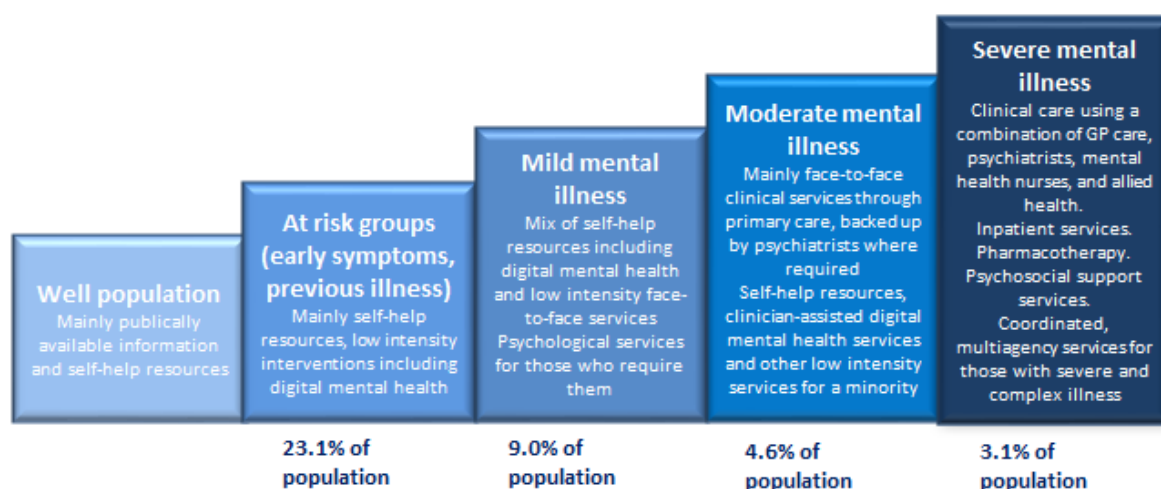
The pre-condition for strengthening integration is for governments to provide leadership and create the conditions that will foster high quality decision making at the regional level.

As part of their leadership role, governments will provide clarity on their roles and responsibilities in the mental health service system. This will involve identifying areas where there is duplication and blurred boundaries, areas that are best handled at a jurisdictional level, and opportunities for closer alignment to address areas that need to be a focus for regional integration. It will also involve developing a statement to guide regions on the degree to which there is flexibility to move beyond the restrictions imposed by traditional government boundaries in pursuing their integration efforts. This will improve clarity about future government roles and responsibilities in the mental health service system, and facilitate a more strategic approach to regional planning and decision making.

Nationally developed tools will strengthen regional planning and decision making. The National Mental Health Service Planning Framework (NMHSPF) can soon be applied at a regional level to support planning and resource allocation in a nationally consistent manner. The NMHSPF has been developed to guide evidence-based decision making about the right mix and level of services, and the workforce needed to meet local circumstances. This will be important in undertaking regional needs assessment, identifying service gaps and targeting resources to best respond to local need.

To complement the NMHSPF, regions will be provided with a range of supports on stepped care approaches to service planning. These will be a guide on the range of service delivery options of varying intensity to match an individual's level of need. Stepped care approaches define the various levels of need, based on best available epidemiological evidence, along with the services required at each level (see Figure 3). They also take into account linkages between clinical and other non-health supports required by people living with mental health issues. All of these factors need to be comprehensively considered in the development of regional mental health plans and are best guided by a nationally consistent approach.

**Figure 3: Mental health stepped care levels of need and services**



\* Adapted from *Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services* (November 2015).

\* Estimates of prevalence derived from National Mental Health Service Planning Framework modelling (unpublished).

Data on the prevalence and distribution of mental illness, along with information on current service use, will be critical to support regional integration. Extensive datasets are held by government health authorities, but have not previously been exploited as tools to guide integration. Collaborative work will be undertaken throughout the course of the Fifth Plan to make this data available to regions in a manner that supports regional needs assessment, planning, and cross-regional benchmarking.

It is important for governments to report on progress and commit to ongoing review. This will help governments determine whether efforts are directed in the right places and delivering desired outcomes. It will also guide decisions about where governments might need to target further strategies, and whether they need to identify and apply other enabling levers to support integrated planning and service delivery at the regional level.

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**Action 2:** Governments will work with Primary Health Networks and Local Hospital Networks to implement integrated planning and service delivery at the regional level. This will include:

- ▶ engagement of the local community, including people with lived experience, service providers, and Aboriginal and Torres Strait Islander community organisations;
- ▶ joint regional needs assessment and service mapping processes to identify gaps, duplication and inefficiencies in current service arrangements with a view to making better use of existing resources and improving overall sustainability;
- ▶ collection, sharing and utilisation of relevant data to inform planning and accountability;
- ▶ joint development of regional mental health plans and commissioning services according to those regional mental health plans;
- ▶ identifying opportunities and developing strategies through improved service integration to better serve people whose needs are poorly met by existing arrangements;
- ▶ establishing cross-service agreements between health service delivery agencies aimed at improving consumer and carer experiences of services; and
- ▶ working with health and social service agencies, the community sector, and service providers to improve integration through region-wide, multi-agency agreements, shared client pathways and information sharing protocols designed to better enable consumers and carers to navigate the system.

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The Fifth Plan recognises that a regional focus, supported by actions at the national level, is a key platform for the change that is needed to address the fundamental shortcomings of the existing system.

A regional focus is critical to efforts to achieve a better integrated service system. It is at the regional level where practical steps can be taken to drive integration across services. Regions hold the knowledge about local circumstances, and know how to best use and coordinate available resources to meet the needs of consumers and carers. It is the level where targeted and locally appropriate action can be taken to better integrate services, particularly for people with severe and complex mental illness, people who have attempted or are at risk of suicide, and Aboriginal and Torres Strait Islander people. It is also the level where targeted and locally appropriate action can be taken to connect



mental health and other services, and to extend integration into prevention and early intervention efforts.

PHNs and LHNs provide the infrastructure for implementing integrated planning and service delivery at the regional level. They can take action to lead regional integration, working in partnership with their local communities.

Leadership and good governance within regions will be vital to fostering integration and enabling change. It will ensure that a strategic direction is set and maintained, barriers are identified and removed, roles and responsibilities are clarified, collaboration is embedded, and resources are appropriately managed. Implementation of effective regional approaches will require challenging perceived dichotomies; and overcoming barriers between services, sectors and funding regimes. It will also require alignment of policies and procedures, synchronisation of funding arrangements, and working beyond traditional boundaries. It will be important for ongoing learning and reflection to occur, to identify where further actions may be required. It will also be important to build and nurture relationships and a culture of cooperation.

Local needs have to drive the integration process within each region. There will be different starting points and some regions may be further advanced in their integration efforts than others. It is also likely that the optimal level of integration will be different in different regions and for different populations. The process to achieve optimal integration will be long term, but the Fifth Plan will put in place the important components that will see a substantial change to the way in which services are integrated.

## PRIORITY AREA 2: COORDINATED TREATMENT AND SUPPORTS FOR PEOPLE WITH SEVERE AND COMPLEX MENTAL ILLNESS

### **What we aim to achieve**

An integrated and sustainable service system that provides the right amount of tailored clinical and community supports, at the right time, for people with severe and complex mental illness.

### **What will be different for consumers and carers?**

If you have severe and complex mental illness, you will have access to the clinical and community services you require to live a more contributing life.

### **Summary of actions**

3. Governments will support coordinated service delivery for people with severe and complex mental illness through the development of national guidelines.
4. In consultation with key stakeholders, the Mental Health Drug and Alcohol Principal Committee will monitor and report to Health Ministers on emerging health and other related policy issues that may arise from the implementation of mental health reforms and the National Disability Insurance Scheme for people with severe and complex mental illness.
5. Primary Health Networks and Local Hospital Networks will work with health and social service agencies operating in their regions and the community sector to develop region-wide arrangements to ensure coordinated treatment and community support for people with severe and complex mental illness.

### **Overview**

Despite ongoing efforts by governments and service providers, many people who experience severe and complex mental illness still do not receive the supports they need. Achieving a regionally integrated service system that reduces fragmentation, poor coordination of services and duplication of roles will provide a crucial platform for improving the lives of people with severe and complex mental illness and their families.

Approximately 690,000 people (three per cent of the population) have a severe mental illness. The needs of people with severe mental illness are not homogenous. Aside from the wide range of diagnoses and conditions, some people have episodic illness while others have more persistent forms of mental illness that can reduce their ability to function, experience full physical health or manage the day to day aspects of their lives.

Some people with severe mental illness can be supported through time limited clinical services in the primary care setting, while others require more acute, hospital based services and need some form of community support. Many people are high users of the hospital system and often have physical illnesses, disabilities or drug and alcohol problems that may be untreated or poorly managed. Mental Health Australia estimates that each year approximately 290,000 people with a severe mental illness require some form of community support.

The clinical and community supports a person may need are not the same. These supports will vary over time, in accordance with need, and can include GPs, medical specialists, allied health providers, housing and employment support, personal carers and other types of disability services.

The diversity and fractured coordination of government funding, policy frameworks and service systems can hinder the ability of services to adequately address need. This may leave consumers to navigate a system that is often complex, uncoordinated, and not tailored to their needs. This can result in vulnerable people being caught in cycles of prolonged illness and dependence, with serious repercussions for a person's relationships, education, housing and employment, and an over-reliance on support from families and carers to fund and resource recovery-based care. The cost to families, carers and the wider community, both in direct service provision and in lost productivity, can be very high.<sup>33</sup>

Current and unfolding reforms provide an opportunity for governments to work together to address the fragmentation and lack of coordination of services for people with severe and complex mental illness. Sector reforms seek to integrate the service system so that it is seamless and easy to navigate, based around a person's needs, provides the right care in the right place at the right time, and ensures effective and efficient use of available resources.

The shift towards devolved responsibility, through more localised planning and decision making, supported by the introduction of PHNs and their alignment with LHNs, provides the necessary regional architecture to give people with severe and complex mental illness care pathways that are tailored, coordinated and sustainable over the longer term.

Implementation of the NDIS represents an opportunity for people with severe and ongoing psychosocial disability to exercise greater choice and control over the design and delivery of a tailored package to address their disability support needs. Initial modelling estimated that approximately 57,000 NDIS participants would have significant and enduring primary psychosocial disability. The National Disability Insurance Agency (NDIA) has estimated that this number will increase to approximately 64,000 by 2019-20.

While still in its infancy, initial experiences emerging from NDIS trial sites suggests that those being provided with a psychosocial support package are generally achieving good early outcomes, with significant improvements in the levels and tailoring of supports. However, governments will need to continue to closely monitor consumer and carer experience as the NDIS transition phase continues. It will also be important to monitor the impact of the NDIS as implementation progresses to identify and respond to issues that may emerge. This includes considering the community mental health support needs of people who do not qualify to receive supports under the NDIS.

The efforts of the Fifth Plan are targeted at ensuring that safeguarding mechanisms are in place so that all people with severe and complex mental illness have access to, and do access, integrated services where they need them and when they need them. The Fifth Plan also recognises the maturation in recent years of e-mental health, and data sharing and information and communications technology platforms such as electronic health records, and the potential that these digital services may have over the life of the Plan to further support tailored individual care for people with severe and complex mental illness.

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<sup>33</sup> National Mental Health Commission (2014), op. cit.

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**Action 3:** Governments will support coordinated service delivery for people with severe and complex mental illness through the development of national guidelines that will:

- ▶ specify criteria to guide targeting service delivery to consumers;
- ▶ clarify roles and responsibilities across the health and community support service sectors;
- ▶ promote the role of single, multi-agency care plans as a vehicle for coordinating service delivery;
- ▶ outline best practice processes for consumer and carer participation; and
- ▶ highlight the role of data in supporting these activities.

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Governments will work together to develop a set of national guidelines that will support jurisdictions to deliver care pathways for people with severe and complex mental illness that are coordinated and integrated, and bridge the gaps between clinical and non-clinical services to offer person-centred wrap-around care for consumers.

These guidelines will provide PHNs and LHNs (as the respective bodies tasked with co-planning, co-design, and potentially co-commissioning services) with the policy mandate to agree and implement integrated care pathways and clinical information sharing protocols in their respective regions to ensure there is no 'wrong-door' for people with severe and complex mental illness to receiving the right amount of clinical and community support at the right time.

This work will need an agreed common vision, clarity around what the changes will mean, and strategies that will help ensure a smooth transition for all consumers. A focus will need to be on ensuring clinical services required for both mental and physical health are in place, as well as ensuring a seamless interface with the NDIS as its roll-out responds to changes on the ground. These are complex changes that will require governments and delivery agencies to be prepared to learn what works and what does not, through an open and collaborative process with clear governance and coordination arrangements.

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**Action 4:** In consultation with key stakeholders, the Mental Health Drug and Alcohol Principal Committee will monitor and report to Health Ministers on emerging health and other related policy issues that may arise from the implementation of mental health reforms and the National Disability Insurance Scheme for people with severe and complex mental illness.

The Council of Australian Governments Health Council (CHC) will continue to play a leadership role in overseeing implementation of reform activities, via the Mental Health Drug and Alcohol Principal Committee (MHDAPC), and may provide guidance and advice to regions in relation to service planning, mapping, governance, and safety and quality matters.

An important role will be the ongoing monitoring of the systems response to changes to ensure that new silos and gaps do not arise. A key element will be to collect, analyse and disseminate information related to services for people with severe and complex mental

illness. Over the life of the Fifth Plan, it is expected that increasingly rich data sources will enable more of this to happen.

The early transition phase of the NDIS means that there is not yet a full picture on the numbers and experiences of consumers with a severe mental illness who have or will test their eligibility for the NDIS.

During this mental health reform transition period, including the NDIS rollout, opportunities to obtain ongoing consumer and carer feedback on service quality and planning must be developed by regions and supported across PHNs, LHNs, the NDIA, service providers and community organisations. This will help ensure that service gaps, issues and barriers are identified and can be managed in a timely and coordinated manner.

Understanding the experience of people with psychosocial disability will be critical to ensuring pathways are appropriate, sustainable and effective. Support for consumers to access the NDIS is essential to facilitate enrolment for those who meet the criteria and ensure they receive all available care. For people who are not eligible for the NDIS, the supports they need should be accessed through mainstream services, and data on the experience of consumers and carers will be used to inform the planning and commissioning process going forward.

The MHDAPC will also report to Health Ministers , through an annual report, on issues that may arise from the implementation of new mental health reforms and the NDIS.

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**Action 5:** Primary Health Networks and Local Hospital Networks will work with health and social service agencies operating in their regions and the community sector to develop region-wide arrangements to ensure coordinated treatment and community support for people with severe and complex mental illness.

Region-wide agreements provide an opportunity to foster close collaboration and effective use of resources between the health and community support sectors across regions to ensure the needs of people with severe and complex mental illness are being met. These agreements will consider:

- relative roles and responsibilities, including shared care pathways;
- processes to support single, multi-agency care plans designed to ensure people with severe and complex mental illness receive the right amount of clinical and community supports at the right time; and
- arrangements for consumers and carers to provide continuous feedback on service quality and participate in regional service planning activities for people with severe and complex mental illness.

## PRIORITY AREA 3: SUICIDE PREVENTION

### What we aim to achieve

To reduce the incidence of suicide and ensure that people who have attempted suicide are given effective follow-up support.

### What will be different for consumers and carers?

- ▶ If you are at risk of suicide, you will have timely access to support and be clear about which services in your area are responsible for providing you with care and support.
- ▶ Services will actively follow up with you in the event that you are at a higher risk of suicide, including after a suicide attempt.

### Summary of actions

6. Governments will work together to renew efforts to develop a nationally agreed approach to suicide prevention that aligns their respective activities, and improves identification of people at risk of suicide and the effectiveness of services and support available to them.
7. Governments will work to develop integrated, whole-of-community approaches to suicide prevention at the regional level.
8. Governments will work with Primary Health Networks and Local Hospital Networks to prioritise the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for hospitals, specialised mental health services and primary care services.
9. Governments will work together to strengthen data collections relating to suicide and suicide attempts to strengthen the evidence base and improve quality of care.
10. Governments will develop suitable public health and communication strategies to better inform the community about suicide and suicide prevention.

### Overview

As outlined earlier in the Fifth Plan, suicide is a significant health and social policy issue. Despite ongoing work to improve suicide prevention in Australia, there has been no significant reduction in the suicide rate over the last decade.<sup>34</sup>

The personal impact of suicide, attempted or completed, is profound. It has a significant impact on families, communities and society. There is a clear need to reduce the number of people who die by suicide or attempt suicide each year, and to reduce the human suffering associated with these actions.

The causes of suicide and suicide attempts can be complex and multifaceted. While some mental illnesses can be linked to an increased risk of suicide, not everyone who

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<sup>34</sup> Australian Bureau of Statistics (2016), Causes of Death, Australia, 2015. op. cit.

dies by suicide will have a mental illness. Suicide attempts are often linked to feelings of helplessness or being overwhelmed by a situation. These stressful life events can include relationship difficulties, social isolation, loss of a job or income, and financial or housing stress.

Some population groups have consistently higher rates of suicide attempts or deaths due to suicide. These groups may experience a combination of risk factors that make them particularly vulnerable and consideration should be given to how they can be provided with extra support.

There has been significant investment across Australia in developing and providing suicide prevention services and programmes. Australia has many highly regarded suicide prevention programmes that have been guided by the range of suicide prevention strategies and plans developed by each jurisdiction.

However, there is scope for improved national coordination in the planning and funding of suicide prevention programmes. The current approach has been criticised as being fragmented and lacking a national focus, with unclear roles and responsibilities across governments.<sup>35</sup> This has led to duplication and gaps in services for consumers. Where there are competing or overlapping services, there is a lack of clarity about which services are most effective or efficient.

A national approach will seek to support those at risk through regional suicide prevention planning and funding. This will allow services to recognise the groups of people in each area that are at risk, plan and coordinate appropriate services, and respond to local needs.

A previous suicide attempt is the most reliable predictor of a subsequent death by suicide.<sup>36,37</sup> Suicide prevention efforts need to consider how services respond to people who have attempted suicide or are at risk of suicide. By providing intensive follow-up care during the days and weeks after a suicide attempt or following discharge from inpatient psychiatric care, it is possible to reduce the risk of future suicide attempts.

There is currently no nationally or regionally consistent approach to follow-up care after a suicide attempt. Clear roles and responsibilities of services across the continuum of the patient pathway, with clear accountabilities for coordinated follow-up care, could have a significant positive impact. This would also empower consumers and carers when making decisions about options for their treatment, care or support.

Access to accurate and timely data will be essential to establishing improved suicide prevention planning, service delivery and evolution of programmes. The focus of current data collected on suicide is on establishing long term trends and rates of completed suicides for whole-of-population monitoring. With improved data collections, there is an opportunity to collect and use data to monitor real time trends to inform appropriately targeted intervention at the local level. In order to realise this opportunity, data needs to be more timely and granular. For example, the data could help to identify early warning

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<sup>35</sup> National Mental Health Commission (2014), *op. cit.*

<sup>36</sup> Department of Health and Ageing (2007), *Living Is For Everyone Framework*. Canberra, Commonwealth of Australia.

<sup>37</sup> Victorian Government (2016), *Victorian Suicide Prevention Framework 2016-25*. Victoria, Department of Health and Human Services.

signs in particular communities or population groups, allowing PHNs, LHNs and relevant services to coordinate an appropriate response and effectively focus their resources.

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**Action 6:** Governments will work together to renew efforts to develop a nationally agreed approach to suicide prevention that aligns their respective activities, and improves identification of people at risk of suicide and the effectiveness of services and support available to them. This will include:

- ▶ establishing a new intergovernmental advisory group that will report to Health Ministers and set the direction for future efforts through joint planning and informed investment;
  - ▶ reviewing and updating the Living is for Everyone Framework;
  - ▶ developing a whole-of-government national suicide prevention plan; and
  - ▶ combining evaluation efforts to better harness synergies and learnings.
- 

The current approach to how governments commission suicide prevention services in Australia has led to a system that has been described as complex and fragmented.

A nationally agreed approach will provide a strong national direction backed by comprehensive and coordinated planning and implementation at a regional level. Governments will work together to align investments in suicide prevention programmes, reduce duplication of services, and ensure that services are better coordinated.

Governments will seek to address this by working together to develop a nationally agreed approach to suicide prevention. A strong and consistent national direction that enables alignment of whole of government efforts is required, while still allowing mental health planning that is responsive to the diverse local needs across Australia.

A new intergovernmental advisory group will be established to provide advice to Health Ministers on maximising the efficiency and effectiveness of investment in suicide prevention programmes. This group will aim to align government funded programmes across Australia by identifying and addressing gaps, and reducing unnecessary duplication.

The advisory group will be tasked with updating Australia's national suicide prevention framework – the Living Is For Everyone (LIFE) Framework. The updated LIFE Framework will provide professionals and the community with information on the best available evidence and resources about suicide and suicide prevention activities. In particular, this will include the interventions developed within a systems approach.

In the longer term, the advisory group will have responsibility for developing a whole-of-government national suicide prevention plan. Acknowledging that many of the factors that impact on a person's decision to suicide lie outside the health domain, the national plan will set the direction for how governments will collectively seek to better support people at risk of suicide to reduce the number of suicide attempts and deaths by suicide, as well as how to best provide support to people affected by suicide in Australia. It will work in conjunction with the intergovernmental group established under Priority Area 4 to refocus efforts to prevent suicide in Aboriginal and Torres Strait Islander communities, and take



into consideration the recommendations of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

The advisory group will be in a unique position to support the building of a new continuous improvement approach to suicide prevention programmes in Australia. As new programmes are funded by governments, opportunities will be sought to combine evaluation efforts, meaning that there will be greater knowledge of what works and what does not.

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**Action 7:** Governments will work to develop integrated, whole-of-community approaches to suicide prevention at the regional level that will include:

- ▶ collaborative planning and funding of suicide prevention activities, including engaging with community based organisations;
- ▶ improving the responsiveness of providers in health and other sectors so that when individuals are identified as at risk, health and other systems respond in a timely and effective way;
- ▶ improving responsiveness by providers in health and other sectors to the needs of families and carers; and
- ▶ building community knowledge of the range of available services and how to access them.

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Regional planning and provision of services will allow suicide prevention programmes to be responsive to the diverse local needs of the different communities across Australia.

Governments will work with PHNs and LHNs to undertake planning with local services to address local needs. This will foster a shared understanding of local issues and sense of responsibility, while building knowledge of locally available networks and services. This approach will facilitate a planned and agile approach to suicide prevention at the regional level. It will seek to avoid unnecessary duplication of services and support redirection of funds to the areas there they are most needed.

PHNs have been tasked with leading mental health and suicide prevention planning and integration at a regional level, in partnership with LHNs and other key local organisations. This includes a particular focus on suicide prevention activities for Aboriginal and Torres Strait Islander people.

Initial work by PHNs on assessing local mental health and suicide prevention needs and undertaking planning began in 2015-16. PHNs are establishing new arrangements and procedures to support future work in this area, and their role in both mental health and suicide prevention will continue to grow over the life of the Fifth Plan.

PHNs will lead the development of a more substantial regional mental health and suicide prevention plan, in partnership with LHNs and regional stakeholders. This will include how PHNs will gain formal agreement to longer term suicide prevention activities from key local partners.

Through this process, it is expected that PHNs and LHNs will be able to improve the responsiveness of providers to people at risk of suicide, as well as their families and carers. A key component of this work will be to build community knowledge of what

services are available and how to access them. PHNs will map the services that are available in their regions and provide this information to the community in a way that will make it easier for people to know where to find help when they need it.

As part of working towards an overall downward trajectory in suicides during the life of the Fifth Plan, LHNs will aim to achieve zero suicides within health care settings. As detailed under Action 8, PHNs and LHNs will also be asked to work collaboratively to prioritise the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide. This regional approach will allow services to be tailored to reflect local needs and resources, and ensure that the region's services have clearly defined roles and responsibilities with respect to suicide prevention.

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**Action 8:** Governments will work with Primary Health Networks and Local Hospital Networks to prioritise the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for hospitals, specialised mental health services and primary care services.

Consistent and timely follow-up care for people who have previously attempted suicide or are at risk of suicide is a crucial component of a suicide prevention strategy.

There is strong evidence that people who have attempted suicide are at a much higher risk of dying by suicide. In addition, people who have attempted suicide and those who are experiencing mental illness are at higher risk of suicide immediately following discharge from mental health care or emergency departments, particularly when this treatment involved involuntary admission.

Providing assertive and appropriate follow-up care during this time can significantly reduce the risk of suicide. This follow-up care needs to address the psychosocial stressors facing the consumer, seek to engage them in further treatment, and take into account the services available.

PHNs, in partnership with LHNs and other local stakeholders, will seek to prioritise follow-up care for people who have attempted suicide or are at risk of suicide. PHNs and LHNs will undertake planning at a regional level to ensure that follow-up care is timely and tailored to reflect local needs.

The new intergovernmental advisory group will provide guidance on the key principles that will underlie this follow-up care. This will ensure that the care is based on the most current evidence, and takes into account the Australian and regional context.

Local services will work towards ensuring that there is clarity about which services have responsibility for providing follow-up care after a suicide attempt. A clear understanding of the roles and responsibilities of each service involved will assist in ensuring integration of services, maintaining continuity of care through timely transfers of care, support discharge and treatment planning, and make it easier for the people to know where to go to ask for help.

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**Action 9:** Governments will work together to strengthen data collections relating to suicide and suicide attempts to strengthen the evidence base and improve quality of care.

Effective and ongoing national and regional suicide prevention planning is dependent on having access to timely and accurate data related to suicide and suicide attempts. This message is found consistently in Australian suicide prevention plans.

Governments will work together to strengthen the collection of data around suicide and suicide prevention. This data will build the evidence base and assist in ensuring that programmes are designed, implemented and evaluated in an effective manner. By improving the information that is available at the regional level, governments will support PHNs and LHNs to better target available resources and plan services that address local needs and priorities. This will include more detailed information on key at risk groups and suicide attempts.

In turn, PHNs and LHNs will be in a position to help improve data collection, adding to the evidence base of what is effective in reducing the number of suicide attempts. This will contribute to a continuous improvement approach that will inform future planning and suicide prevention strategies.

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**Action 10:** Governments will develop suitable public health and communication strategies to better inform the community about suicide and suicide prevention.

Public health and communication strategies will be developed to educate the public about suicide and suicide prevention, in line with the new nationally agreed approach to suicide prevention.

Raising awareness of suicide and suicide prevention has been found to reduce suicide attempts in a number of ways. Public awareness will increase understanding of the risk factors and warning signs of a suicide attempt, improve knowledge of what services are available, and encourage people to ask for help by reducing stigma.

Family and friends play an important role in preventing suicide attempts. They need to know what to do, and what not to do, if they are concerned that someone they care for is thinking about suicide.

How to best provide this information will be determined by governments, in consultation with the new intergovernmental advisory group on suicide prevention and experts in public health messaging and communication.

## PRIORITY AREA 4: ABORIGINAL AND TORRES STRAIT ISLANDER MENTAL HEALTH AND SUICIDE PREVENTION

### What we aim to achieve

Culturally competent care through integrating social and emotional wellbeing services with a range of mental health, drug and alcohol, and suicide prevention services.

### What it means for consumers and carers?

You will receive culturally appropriate care.

Both your clinical and social and emotional wellbeing needs, and the needs of your community, will be addressed when care is planned and delivered.

### Summary of actions

11. Governments will work collaboratively to develop a joined approach to social and emotional wellbeing support, mental health, suicide prevention, and alcohol and other drug services, recognising the importance of what an integrated service offers for Aboriginal and Torres Strait Islander people.
12. Governments will work with Primary Health Networks and Local Hospital Networks to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander people at the regional level.
13. Governments will renew efforts to develop a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander people.
14. Governments will work with service providers, including with Aboriginal Community Controlled Health Organisations, to improve Aboriginal and Torres Strait Islander access to and experience with mental health and wellbeing services.
15. Governments will work together to strengthen the evidence base needed to inform development of improved mental health services and outcomes for Aboriginal and Torres Strait Islander people.

### Overview

Mental health and related conditions have been estimated to account for as much as 22 per cent of the health gap between Aboriginal and Torres Strait Islander people and other Australians, as measured in Disability-Adjusted Life Years. Mental health conditions are estimated to contribute to 12 per cent of the gap in the burden of disease, with another four per cent of the gap attributable to suicide and another six per cent to alcohol and other drug misuse.<sup>38</sup>

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<sup>38</sup> T Vos, B Barker, L Stanley, AD Lopez (2007), The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane, School of Population Health, The University of Queensland.

The 2012-2013 Australian Aboriginal and Torres Strait Islander Health Survey found that Aboriginal and Torres Strait Islander adults were almost three times more likely to experience high or very high levels of psychological distress than other Australians, are hospitalised for mental health and behavioural disorders at almost twice the rate of non-Aboriginal people, and have twice the rate of suicide than that of other Australians. The breadth and depth of such high levels of distress on individuals, their families, and their communities is profound.

Despite having greater need, Aboriginal and Torres Strait Islander people have limited access to mental health services and professionals. In 2012-2013, the most common Closing the Gap service deficits reported by organisations were around mental health and social and emotional wellbeing services.<sup>39</sup>

Issues such as rural and remoteness, and the diversity and fractured coordination of government funding, policy frameworks and service systems, play a role in hindering the ability of services to adequately and appropriately address the needs of Aboriginal and Torres Strait Islander people. It is also recognised that many services and programmes designed for the general population are not culturally appropriate within a broader context of social and emotional wellbeing as understood by Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander people embrace a holistic concept of health, which inextricably links mental and physical health within a broader concept of social and emotional wellbeing. A whole-of-life view, social and emotional wellbeing recognises the interconnectedness of physical wellbeing with spiritual and cultural factors, especially a fundamental connection to the land, community and traditions, as vital to maintaining a person's wellbeing.

Disruption to this holistic understanding of social and emotional wellbeing caused by dispossession, dislocation, and trauma over generations has, for some Indigenous Australians, created a legacy of grief and psychological distress.

Most Aboriginal and Torres Strait Islander people want to be able to access services where the best possible mental health and social and emotional wellbeing strategies are integrated into all health service delivery and where health promotion strategies are developed with Aboriginal communities to provide a holistic approach. This approach needs an appropriate balance of clinical and culturally informed mental health system responses, including access to traditional and cultural healing, to address mental health issues for Aboriginal and Torres Strait Islander people.

Many Aboriginal and Torres Strait Islander people also continue to experience high levels of exclusion and victimisation, discrimination and racism at personal, societal, and institutional levels. Racism continues to have a significant impact on Aboriginal and Torres Strait Islander people's decisions about when and why they seek health services, their acceptance of and adherence to treatment.<sup>40</sup>

While governments have been committed to supporting Aboriginal and Torres Strait Islander mental health and suicide prevention, Aboriginal and Torres Strait Islander people have regularly informed governments that much more could be done to improve

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<sup>39</sup> Australian Institute of Health and Welfare (2014), Aboriginal and Torres Strait Islander Health Organisations, Online Services Report 2012-2013, IHW 139. Canberra, AIHW.

<sup>40</sup> Department of Health and Ageing (2013), National Aboriginal and Torres Strait Islander Health Plan 2013-2023. Canberra, Commonwealth of Australia.

both the way in which services are structured and the range of services available. There is a need to better coordinate efforts and focus on achieving improved integration of culturally appropriate mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug services for Aboriginal and Torres Strait Islander people.

Leadership will involve better collaboration and coordination across governments, and set the direction for how services and programmes can better work together. It will assist in driving and embedding change towards a better joined up and whole-of-life approach to mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug services for Aboriginal and Torres Strait Islander people, to drive the actions that are needed to support better mental health and social and emotional wellbeing, and reduced incidence of suicide, for Aboriginal and Torres Strait Islander people.

The Fifth Plan recognises that self-determination is essential to overcoming the disadvantage that Aboriginal and Torres Strait Islander people experience. While governments have a critical role in providing leadership, actions will be developed in partnership with Aboriginal and Torres Strait Islander people and their communities to ensure that appropriate solutions are developed and key challenges are addressed.

Governments will work collaboratively to improve the cultural safety and capability of the mental health and social and emotional wellbeing workforce, including increasing the proportion of Aboriginal and Torres Strait Islander people working in this field, strengthening the Aboriginal and Torres Strait Islander community controlled health sector and developing the cultural competence of mainstream mental health services. An important factor in this collaborative process will be the inclusion of local Aboriginal and Torres Strait Islander communities in the design and implementation of culturally relevant mental health services. Supporting skill development to enable Aboriginal and Torres Strait Islander people to actively participate in, and conduct research relating to, their own cultures is also important.

Governments recognise the need to improve access to information on what has been shown to work in Aboriginal and Torres Strait Islander communities to improve social and emotional wellbeing, reduce the impact of mental illness and harms associated with alcohol and other drug use, and to prevent suicide.

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**Action 11:** Governments will work collaboratively to develop a joined approach to social and emotional wellbeing support, mental health, suicide prevention, and alcohol and other drug services, recognising the importance of what an integrated service offers for Aboriginal and Torres Strait Islander people. This will include:

- ▶ recognising that the right of Aboriginal and Torres Strait Islander communities to self-determination lies at the heart of community control in the provision of health services, and that there is a need to clarify the respective roles, responsibilities and governance of the full range of services provided to Aboriginal and Torres Strait Islander people;
- ▶ establishing a new intergovernmental advisory group, inclusive of Aboriginal and Torres Strait Islander representation, that will report to Health Ministers and set the direction for future efforts through joint planning and informed investment;
- ▶ promoting opportunities to co-locate social and emotional wellbeing, mental health, suicide prevention, and alcohol and other drug treatment services that focus on Aboriginal and Torres Strait Islander consumers; and
- ▶ identifying opportunities and developing innovative strategies, such as the use of care navigators and single care plans, to support improved service integration and connect Aboriginal and Torres Strait Islander people with community based (non-health) services.

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Mental health services need to take into account factors that underpin social and emotional wellbeing including a person's connection to country, spirituality, ancestry, kinship, and community.

To provide Aboriginal and Torres Strait Islander people with the best possible mental health and social and emotional wellbeing, strategies that bring greater integration of social and emotional wellbeing services with mental health, suicide prevention, and alcohol and other drug services into all health service delivery settings is needed.

The Fifth Plan provides a platform to drive change and better integrate services that are culturally safe and appropriate for Aboriginal and Torres Strait Islander people. Central to this will be for Aboriginal and Torres Strait Islander communities to lead and determine the provision of mental health care in the broader context of social and emotional wellbeing. It is important that Aboriginal and Torres Strait Islander people have leadership roles in service design and delivery.

A new intergovernmental advisory group, that includes Aboriginal and Torres Strait Islander representation, will be established to advise Health Ministers on setting the direction for future efforts and support integration at the regional level. The advisory group will consider mental health, suicide prevention, and alcohol and other drugs services in the context of social and emotional wellbeing to improve issues of fragmentation, lack of coordination of services and duplication. The advisory group will facilitate and support local change, led by Indigenous communities.

The promotion of opportunities to co-locate services that focus on Aboriginal and Torres Strait Islander consumers will maximise the full potential of holistic, person-centred care. The use of care navigators and coordinators will help connect people with health and

non-health services to navigate services and referral pathways, to facilitate follow-up and reduce post discharge suicide risk.

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**Action 12:** Governments will work with Primary Health Networks and Local Hospital Networks to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander people at the regional level. This will include:

- ▶ engaging Aboriginal and Torres Strait Islander communities in the co-design of all aspects of regional planning and service delivery; and
  - ▶ collaborating with service providers regionally to improve referral pathways between GPs, Aboriginal Community Controlled Health Organisations, social and emotional wellbeing services, alcohol and other drug services, and mental health services, including improving opportunities for screening of mental and physical wellbeing at all points.
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PHNs and LHNs are the core architecture for regional integration activities and service planning for Aboriginal and Torres Strait Islander people, and will be guided by Indigenous consumers and communities.

National leadership and collaborative action, including the identification, development and provision of planning tools and data, are necessary preconditions in supporting PHNs and LHNs in integrating services.

It is anticipated that the forthcoming National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017-2023 will consider how PHNs and LHNs can work with Indigenous specific organisations in service planning and delivery to improve outcomes for Aboriginal and Torres Strait Islander people.

The leadership and participation of Aboriginal and Torres Strait Islander communities and organisations will be critical in ensuring the success of regional planning and service delivery. The involvement of Aboriginal and Torres Strait Islander consumers and carers, and strong relationships with community managed organisations, Aboriginal and Torres Strait Islander groups, GPs and private sector providers, will also be critical.

The development of innovative strategies and new approaches will enable localised referral pathways that are well defined and easy to navigate, so that Aboriginal and Torres Strait Islander people are able to readily access the various services they require.

The Fifth Plan recognises the need for an approach that demonstrates an understanding not only of the person's mental and physical health, but also that their cultural, spiritual beliefs, connection to country and understanding of traditional approaches to healing are of equal importance. It will therefore take into consideration these unique elements for Aboriginal and Torres Strait Islander people, as well as physical health, mental illness, suicide prevention, and the reduction of lifestyle risk factors such as smoking, diet, and alcohol and other drugs.



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**Action 13:** Governments will renew efforts to develop a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander people. This will include:

- ▶ reviewing and updating the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy; and
- ▶ working with PHNs and LHNs to ensure locally relevant and culturally informed suicide prevention services are connected at the regional level.

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Governments are committed to reducing the suicide rate for Aboriginal and Torres Strait Islander people, and have agreed to a national approach to suicide prevention to reduce the prevalence and impact of suicide on Aboriginal and Torres Strait Islander people, their families and communities.

The new intergovernmental suicide prevention advisory group that will be established under Priority Area 3 will consider Aboriginal and Torres Strait Islander specific issues when advising Health Ministers on the development and implementation of government funded suicide prevention activities. Aboriginal and Torres Strait Islander people will be active participants of this advisory group. The group will consider current research and best practice in suicide prevention, and provide an agreed and evidence based national approach to reducing suicide by Aboriginal and Torres Strait Islander people. The advice will be developed in partnership with Aboriginal and Torres Strait Islander communities.

The national approach will include suicide prevention activities that are targeted at Aboriginal and Torres Strait Islander people and their communities. This will support the implementation of culturally appropriate activities, guided by the goals and actions identified within the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

It will also take into consideration the significant regional variations that exist in relation to Aboriginal and Torres Strait Islander suicide. While Aboriginal and Torres Strait Islander people have twice the suicide rate of non-Indigenous Australians, there are some regions in Australia that have dramatically higher rates.

Regionally tailored strategies will be guided by the national approach and be flexible to meet local needs.

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**Action 14:** Governments will work with service providers, including with Aboriginal Community Controlled Health Organisations, to improve Aboriginal and Torres Strait Islander access to and experience with mental health and wellbeing services by:

- ▶ increasing knowledge of social and emotional wellbeing concepts and improving the cultural competence and capability of mainstream providers;
  - ▶ recognising the importance of Indigenous leadership and supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration; and
  - ▶ training all staff delivering mental health services to Aboriginal and Torres Strait Islander people, particularly those in forensic settings, in trauma-informed care.
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The National Aboriginal and Torres Strait Islander Leadership In Mental Health Group launched the Gayaa Dhuwi (Proud Spirit) Declaration in 2015. The Declaration emphasises the importance of Indigenous leadership in addressing the mental health challenges faced by Aboriginal and Torres Strait Islander people (see Box 3).

### Box 3

**The Gayaa Dhuwi (Proud Spirit) Declaration<sup>41</sup> was developed and launched by the National Aboriginal and Torres Strait Islander Leadership in Mental Health in 2015. It provides a platform for governments to work collaboratively to embed culturally competent and safe services within the mental health system that are adaptable and accountable to Aboriginal and Torres Strait people.**

**The five themes of the Declaration are:**

- 1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and health should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.**
- 2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander people.**
- 3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programmes for Aboriginal and Torres Strait Islander people.**
- 4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander people for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.**
- 5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.**

While many governments recognise the Gayaa Dhuwi Declaration, all agree that the holistic concept of social and emotional wellbeing should guide all Aboriginal and Torres Strait Islander mental health and suicide prevention programmes. Governments recognise the importance of improving Aboriginal and Torres Strait Islander leadership in mental health and suicide prevention, and for Aboriginal and Torres Strait Islander people to determine their own care at a system and individual level.

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<sup>41</sup> National Aboriginal and Torres Strait Islander Leadership in Mental Health (2015), Gayaa Dhuwi (Proud Spirit) Declaration. [ONLINE] Available at: [National Aboriginal and Torres Strait Islander Leadership in Mental Health - Gayaa Dhuwi Declaration](#) [Accessed 5 October 2016].

Mental health care and clinical approaches must be combined with healing and restoring the whole-of-person wellbeing. Clinical responses will be culturally informed; incorporate healing; and address the stigma, racism and discrimination experienced by Aboriginal and Torres Strait Islander people.

Recognising that culturally valid approaches must shape the delivery of all services, and guide the care and management of Aboriginal and Torres Strait Islander peoples' wellbeing, will provide a strong foundation for better supporting a person's recovery journey. Valuing and utilising the cultural expertise available to Aboriginal and Torres Strait Islander people within their communities, from Elders, traditional healers, and Indigenous mental health workers, will help support greater accessibility to services and support communities to self-identify problems and approaches that are best suited to meeting their needs.

Attracting and retaining more Aboriginal and Torres Strait Islander staff in mental and related health services is one fundamental approach to increasing the understanding of cultural traditions, and providing service environments that reduce anxiety for Aboriginal and Torres Strait Islander people when using health services.

Governments will take collaborative action to increase training support to non-Indigenous mental health professionals to build cultural competency and associated clinical skills, including having all staff trained in recovery-oriented and trauma-informed care.

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**Action 15:** Governments will work together to strengthen the evidence base needed to inform development of improved mental health services and outcomes for Aboriginal and Torres Strait Islander people through:

- ▶ ensuring future investments in new or expanded services are properly evaluated to inform what works;
- ▶ establishing a clearinghouse of resources, tools and programme evaluations for all settings that facilitates the use of knowledge to support the development of culturally safe models of service delivery, including the use of cultural healing and trauma-informed care;
- ▶ reviewing existing datasets across all settings to explore opportunities for improved data collection on the mental health and wellbeing of, and the prevalence of mental illness in, Aboriginal and Torres Strait Islander people; and
- ▶ better harnessing and utilisation of available health services data and enhancing those collections to strengthen the focus on services delivered to Aboriginal and Torres Strait Islander people.

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Improving mental health and wellbeing outcomes for Aboriginal and Torres Strait Islander people must be supported by evidence about what works. Resources, tools, and programme evaluations for all settings are fundamental to supporting Aboriginal and Torres Strait Islander communities, service planners and policy makers to know whether people have adequate access to culturally safe and effective services, and to monitor the quality and appropriateness of care received.

This evidence is essential and must be a key design principle for all new government funded services and programmes. It will be critical that there are consistent approaches to the measurement, collection and reporting of outcomes for Aboriginal and Torres Strait

Islander social and emotional wellbeing, mental health, suicide prevention, and alcohol and other drugs programmes.

While a large amount of information about the provision of services exists, the analysis, reporting and utilisation of evidence is not used well to improve the quality and delivery of future services.

To better harness existing efforts, a clearinghouse will be established to support the dissemination of relevant and high quality information and other resources through a single portal. The information held by the clearinghouse will allow Aboriginal and Torres Strait Islander communities, governments, planners, policy makers and service providers to make decisions about the validity and utility of the information to make more effective decisions about the provision of services to ensure they meet the needs of Aboriginal and Torres Strait Islander communities.

Aboriginal and Torres Strait Islander people will be central to identifying what works and what does not work. The new Aboriginal and Torres Strait Islander intergovernmental advisory group will play a critical role in ensuring that the information included in the clearinghouse is of a high standard.

The clearinghouse will not duplicate or replace existing infrastructure that is already in place. It will instead bring together all evidence related to social and emotional wellbeing, mental health, suicide prevention, and alcohol and other drugs programmes into a single and easy to access location.

Strategies to support greater utilisation of system level data, such as voluntary Indigenous identifier data, at point of care, will be critical for identifying needs and to improve access to services through regional service planning, as well as supporting efforts to improve the quality of care Aboriginal and Torres Strait Islander people receive at the practitioner level.

Governments currently collect information on the health status of Australians, how they use health services, and what health issues are most of concern. This information, usually collected through surveys and health services data, helps guide the planning of services.

The Aboriginal and Torres Strait Islander intergovernmental advisory group will look at what data governments currently gather, and how this can be improved to give more useful information to those people who use this to improve the way services can be accessed.

## PRIORITY AREA 5: PHYSICAL HEALTH OF PEOPLE LIVING WITH MENTAL HEALTH ISSUES

### What we aim to achieve

The physical health care of people living with mental health issues is a national priority, and the life expectancy gap is reduced.

### What will be different for consumers and carers?

- ▶ You will have the same access to, and quality of, physical health care as the general population.
- ▶ Better coordination of services at the local level will support you to address physical health care needs and improve your quality of life.
- ▶ Services at the regional level will be integrated, person-centred and easier for you to navigate.
- ▶ Health care providers will be better able to detect and treat your physical health conditions. This will include addressing your risk factors for poor physical health, such as smoking, poor diet, lack of exercise, and alcohol and drug use.

### Summary of actions

16. Governments will identify suitable guidelines and other resources for use by health services and health professionals to improve the physical health of people living with mental health issues.
17. Governments will work with Primary Health Networks and Local Hospital Networks to ensure that the physical health of people living with mental health issues is a priority in the development of regional health plans and service delivery, and that systems are developed for monitoring progress.
18. Health Ministers will lead the work of commencing regular national reporting on the physical health of people living with mental health issues.

### Overview

An individual's physical and mental health is closely linked, and people living with mental health issues have much poorer health than the general population. Studies in Australia and other developed nations indicate that people living with mental health issues are more likely to die prematurely<sup>42,43</sup> and their life expectancy is shortened by up to thirty per cent.<sup>44</sup> There is evidence this life expectancy gap is widening for some population groups, such as people with schizophrenia.<sup>45</sup> While there are many reasons for this unacceptable outcome, a lack of screening and inadequate medical care are key factors

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<sup>42</sup> Thornicroft G (2013), Premature death among people with mental illness. *BMJ* 2013;346:345–353.

<sup>43</sup> Lawrence D, Hancock KJ, Kisely S (2013), *op. cit.*

<sup>44</sup> World Health Organization (2013), *Mental health action plan 2013-2020*. Geneva, WHO.

<sup>45</sup> Saha S, Chant D, McGrath J (2007). A systematic review of mortality in schizophrenia: Is the differential mortality gap worsening over time? *Arch. Gen. Psychiatry* 2007;64(10):1123-1131.

in the poor health outcomes of many people living with mental health issues. Most of the causes of early death relate to physical illnesses, such as cardiovascular disease, respiratory disease, diabetes and cancer. The presence of serious physical conditions adversely affects quality of life and impedes recovery from mental illness.<sup>46</sup>

Compared to the general population, people living with mental health issues are:

- ▶ twice as likely to have cardiovascular disease;
- ▶ twice as likely to have respiratory disease;
- ▶ twice as likely to have metabolic syndrome;
- ▶ twice as likely to have diabetes;
- ▶ twice as likely to have osteoporosis;
- ▶ 50 per cent more likely to have cancer;
- ▶ 65 per cent more likely to smoke; and
- ▶ six times more likely to have a dental health issue.

(National Consensus Statement on Physical Health and Mental Illness, 2016)

In addition to the personal cost of physical illness for people living with severe mental illness, the total cost to the Australian health system has been estimated at \$15 billion per annum (0.9 per cent of GDP).<sup>47</sup> This includes the cost of health care, lost productivity and other social costs. For each person living with a co-existing long-term physical health condition and a mental health condition, the interaction between conditions raises the health care costs by an estimated 45 per cent.<sup>48</sup> Approximately half of people living with mental health issues have an additional two to three co-existing medical illnesses. Multiple comorbidities increase the cost of health care exponentially, yet much of this cost is avoidable. Effective mental health care in conjunction with quality physical health care, provided early, improves the quality of life for consumers and life expectancy, and takes pressure off the whole health system.

Physical health treatment rates for people living with mental health issues are reported to be around 50 per cent lower than for people with only a physical illness.<sup>49</sup> Their physical health needs are often overshadowed by their mental health condition, which is an issue further discussed in Priority Area 6. This leads to physical conditions being undiagnosed and untreated, which can prove fatal.

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<sup>46</sup> The Mental and Physical Health Platform (2013), Mental and physical health charter.

<sup>47</sup> Royal Australia and New Zealand College of Psychiatrists (2016), op. cit.

<sup>48</sup> Naylor C, Das P, Ross S, Honeyman M, Thompson J, Gilbert H (2016), Bringing together physical and mental health: A new frontier for integrated care. London, The Kings Fund.

<sup>49</sup> Royal Australian and New Zealand College of Psychiatrists (2015), Keeping Body and Mind Together: Improving the physical health and life expectancy of people with severe mental illness.

People living with mental health issues have the highest rate of early deaths due to heart disease, yet medical procedures to improve blood flow to the heart are undertaken far less frequently than the general population. Despite being a high risk group, it has been known for some time that people living with mental health issues are less likely to:

- be screened for high cholesterol;
- be prescribed evidence-based treatment to lower cholesterol;
- be hospitalised; and
- receive physical treatment when in hospital than the general population.<sup>50</sup>

Some population groups living with mental health issues are at a greater risk of physical ill health. For example, cardiovascular disease is the leading cause of death for people with a severe mental illness, such as schizophrenia.<sup>51</sup> An Australian national survey of people living with a psychotic illness found that over 25 per cent had heart or circulatory conditions.<sup>52</sup> This is five times the rate in the general population. Additionally, the burden of disease for Aboriginal and Torres Strait Islander people is two and a half times greater than the general community,<sup>53</sup> with mental illness and cardiovascular disease being the two leading causes.

Poorer physical health in people living with mental health issues is not inevitable, nor is poorer mental health for people living with physical health conditions. Better screening, early treatment and management of co-existing physical health conditions of people living with mental health issues will help people live a productive life and improve life expectancy, as well as helping to prevent mental illness for people living with chronic physical health conditions.

Since the 1990s, governments have implemented strategies in their attempts to address the poor physical health status of people living with mental health issues and reduce the life expectancy gap. Despite these efforts, people living with mental health issues continue to suffer poorer physical health and reduced life expectancy.

A new approach is needed to consider a whole-of-person, whole-of-life approach to screening, treatment and care, particularly for people with severe mental illness, people with chronic physical illness and vulnerable population groups such as Aboriginal and Torres Strait Islander people. Better screening and early detection will help identify the people in need so that health professionals can intervene and provide timely and appropriate care, including better medication management, advice on reducing smoking and other risk factors.

Whole-of-government leadership and engagement across all sectors is critical if Australia is to improve the health outcomes and life expectancy of people living with mental health issues and physical illness. The separation between primary and secondary care, and

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<sup>50</sup> Lawrence D, Coghlan RH (2002), Health inequalities and the needs of people with mental illness. *NSW Public Health Bulletin* 2002;13(7): 155-158.

<sup>51</sup> De Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, Leucht S (2011), Physical illness in patients with severe mental disorders: I: Prevalence, impact of medications and disparities in health care. *World Psychiatry*, 2011;10(1):52–63.

<sup>52</sup> Morgan VA, Waterreus A, Jablensky A, Mackinnon A et al (2012), People living with psychotic illness in 2010: The second Australian national survey of psychosis. *Aust N Z J Psychiatry* 2012;46(8): 735-752.

<sup>53</sup> Vos T, Barker B, Stanley L, Lopez A (2007), op. cit.

between mental health and physical health care, needs to be addressed. Better communication and coordination between these key health sectors will lead to role clarity and encourage health providers to work together and take on additional functions. This holistic approach will reduce service fragmentation and improve the quality of care.

There has been ongoing commitment from all levels of government, consumers and carers, and service providers to improve the quality of life of people living with mental health issues. In 2012, the Commonwealth Government introduced the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative. The initiative allows Medicare rebates to be made available to patients for selected mental health services provided by GPs, psychiatrists, psychologists, eligible social workers and occupational therapists. It establishes a platform for early intervention and evidence-based treatment, while state and territory governments continue to champion physical health care through their mental health plans.

In 2016, the NMHC led the development of a National Consensus Statement on Physical Health and Mental Illness.<sup>54</sup> The aim of the Consensus Statement is to call for better collaboration and coordination between governments, professional bodies, social and community services and other leaders in mental health to make the physical health of people living with mental health issues a national priority.

By working together, people living with mental health issues, including Aboriginal and Torres Strait Islander people and those living with severe mental illness, will receive better screening, early intervention, person-centred treatment and care. This will lead to improved health outcomes, including better management of co-existing mental and physical health conditions, reduced risk factors, and improved life expectancy.

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**Action 16:** Governments will identify suitable guidelines and other resources for use by health services to improve the physical health of people living with mental health issues. The guidelines will provide advice on:

- ▶ how to make physical health care checks part of routine care of people living with mental health issues;
- ▶ screening, detection, treatment and early medical intervention to those known to be at high risk of physical ill health; and
- ▶ the role of GPs, other primary care providers and specialist health providers in providing integrated physical and mental health care.

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It is acknowledged that many guidelines and resources have been developed by governments and professional bodies to improve the physical health of people living with mental health issues. Governments will work together to identify suitable guidelines that have a specific focus on the physical health care of people living with mental health issues with a view to providing guidance and support to regional planners, health service providers and clinicians. Consideration will be given to the appropriateness and relevance

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<sup>54</sup> National Mental Health Commission (2016), *Equally well: The national consensus statement of physical health and mental illness*. Sydney, NHMC.



to culturally and linguistically diverse groups, people with severe mental illness, and Aboriginal and Torres Strait Islander people.

The guidelines will be applicable to all health professionals who are involved in the physical health care of people living with mental health issues, including GPs, nurses, allied health, peer workers, primary care workers, mental health workers, consumers and carers. An important objective of the guidelines is to clarify the respective roles and responsibilities of health planners and service providers, including GPs, other primary care providers and specialist health providers.

The recommended screening and referral protocols for physical health conditions will help service providers to connect with other providers, increase productivity, reduce duplication and better utilise resources. Effective physical health checks will identify those at risk of developing mental ill health, such as people with chronic physical health conditions, to prevent, detect and treat mental illness as early as possible.

The interrelationship between poor physical health and mental health is evident and can require treatment using a wide variety of medications. The guidelines will support people with lived experience of mental health issues and their carers to better manage medication use to improve health outcomes.

It is acknowledged that consumers and carers have varying levels of skill and ability to support, design and share the responsibility for their health care. The guidelines will provide information for consumers and carers to further equip them with the knowledge and skills to navigate the health system, including on how to manage co-existing physical health conditions and reduce risk factors for poor physical health, such as smoking, poor diet, lack of exercise, and alcohol and other drug use.

Health services will implement the guidelines that consider physical health of people living with mental health issues, and normalise regular physical health care checks as part of routine care. Screening, detection, treatment and early medical intervention for people living with mental health issues will be part of integrated care addressing both physical and mental health care needs and improve life expectancy.

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**Action 17:** Governments will work with Primary Health Networks and Local Hospital Networks to ensure that the physical health of people living with mental health issues is a priority in the development of regional health plans and service delivery, and that systems are developed for monitoring progress.

As regional health planners and service providers and/or commissioners, PHNs and LHNs have joint responsibilities in supporting service integration at the regional level and are best placed to make the physical health care of people living with mental health issues a priority. The needs assessment and service planning processes will enable PHNs and LHNs to collaborate and identify service gaps and duplication, leading to better productivity and more efficient use of resources.

Governments have the policy levers to lead and drive change. The Commonwealth Government has mechanisms through the established governance arrangements with PHNs to support their needs assessments, service planning and commissioning, to ensure that physical health of people living with mental health issues is a priority. Equally, state and territory governments have similar mechanisms to support LHNs in their service

planning and provision. Communication and collaboration between these key organisations, GPs, other primary health care providers and specialist providers will ensure that people living with mental health issues are identified and their physical health care needs are met.

To enable the effective planning and collaboration between PHNs, LHNs and other service providers at the regional level, it is important that the roles of governments are clearly defined. This will support role clarification at the local level, which in turn will assist service planning processes and reduce service duplication, particularly in areas where services are provided by both levels of government. For example, there has been unintentional confusion among service users and providers in the area of severe mental illness where both the Commonwealth and state and territory governments are providing services. The service gaps caused by this confusion can be detrimental to people living with mental health issues, particularly those with severe, multiple, co-existing physical health conditions.

All levels of government will work with PHNs and LHNs to ensure that necessary systems are developed to better inform integrated service planning and delivery.

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**Action 18:** Health Ministers will lead the work of commencing regular national reporting on the physical health of people living with mental health issues.

It is recognised that large amounts of data are being collected and reported at multiple levels. At the national level, organisations such as the Australian Institute of Health and Welfare collect a host of data and information, including programme level data. State and territory governments have data on the services they provide, including LHN level data. Over time, the newly established PHNs will also generate valuable datasets at the regional level.

Health Ministers will lead the work of commencing regular national reporting on the physical health of people living with mental health issues. This will involve building on existing datasets and reporting mechanisms, identifying and addressing data gaps, and seeking opportunities to share data across traditional boundaries.

## PRIORITY AREA 6: STIGMA AND DISCRIMINATION REDUCTION

### What we aim to achieve

To reduce stigma and discrimination against people living with mental health issues, particularly people with severe mental illness.

### What will be different for consumers and carers?

- ▶ You will be more supported in your recovery.
- ▶ There will be a better understanding of mental illness and improved attitudes towards people who live with mental health issues.

### Summary of actions

19. Governments will broaden their efforts to reduce stigma and discrimination to include a focus on people with severe mental illness. This will be a shared endeavour between governments, consumers and carers, community groups and key organisations.
20. Governments will work with key organisations to reduce stigma and discrimination in the health workforce through leadership and training, informed by the views and experience of people who live with mental health issues, and identification and exposure of discriminatory practice where it occurs.

### Overview

Stigma is a complex social process that excludes, rejects, shames or devalues someone on the basis of a particular characteristic.<sup>55</sup> It can be conceptualised as including problems of knowledge (ignorance or misunderstanding), problems of attitudes (prejudice) and problems of behaviour (discrimination).<sup>56</sup>

Stigma exists on a number of levels that are interconnected and mutually reinforcing. It includes self-stigma (the stigmatising views that people living with mental health issues hold about themselves), social stigma (individual and collective stigmatising attitudes and beliefs about mental illness) and structural stigma (the policies and practices of social institutions that restrict opportunities for people living with mental health issues).<sup>57</sup>

Stigma against people living with mental health issues is prevalent in Australia, with almost three out of four people living with mental health issues experiencing stigma.<sup>58</sup> People living with mental health issues may be perceived or represented as violent, unpredictable, dangerous, prone to criminality, incompetent, undeserving or weak in character. Discriminatory behaviours may include avoidance, withholding opportunities or

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<sup>55</sup> Livingston JD (2013). Mental illness-related structural stigma: The downward spiral of systemic exclusion. Calgary, Mental Health Commission of Canada.

<sup>56</sup> beyondblue (2015), Information Paper: Stigma and discrimination associated with depression and anxiety.

<sup>57</sup> Livingston JD (2013), op. cit.

<sup>58</sup> SANE Australia (2013), A life without stigma: A SANE Report.

withholding support.<sup>59,60</sup> Stigmatising views about mental illness may be more entrenched in certain areas, such as in rural and remote regions, and culturally and linguistically diverse populations.<sup>61,62</sup>

The impact of stigma and discrimination against people living with mental health issues is far-reaching, and is compounded for groups who are already marginalised and who experience other forms of discrimination.<sup>63,64,65,66</sup>

Stigma and discrimination may lead to feelings of shame, helplessness, fear, worthlessness and self-doubt. It may discourage people from disclosing their mental illness, decrease the likelihood of seeking support and create additional distress. It may result in exclusion and isolation, adversely affect personal relationships, and affect opportunities for social interaction and community involvement. It may also create significant barriers to participating in employment, and adversely affect promotional opportunities and housing outcomes. Importantly, it can hamper the promotion of mental health and wellbeing, exacerbate mental ill-health and impede recovery.

The impact of stigma and discrimination extends to broader communities and society due to lost productivity<sup>67</sup> and increases costs to the health system.<sup>68</sup>

Reducing stigma and discrimination is critical to improving the wellbeing of people living with mental health issues and their carers, and promoting better mental health within society. While there have been some improvements in knowledge about mental illness, there is still widespread misunderstanding and people living with mental health issues still experience significant stigma.<sup>69</sup> It will take a sustained and collective effort to dispel the myths associated with mental illness, change ingrained negative attitudes and behaviours, and ultimately support social inclusion and recovery.

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**Action 19:** Governments will broaden their efforts to reduce stigma and discrimination to include a focus on people with severe mental illness. This will be a shared endeavour between governments, consumers and carers, community groups and key organisations.

Significant action has been taken by governments and non-government organisations to reduce stigma and discrimination against people living with mental health issues. Some examples of current initiatives in Australia are illustrated in Box 4. There is also a range of

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<sup>59</sup> Livingston JD (2013), op. cit.

<sup>60</sup> SANE Australia (2013), op. cit.

<sup>61</sup> Senate Select Committee on Mental Health (2006), A national approach to mental health – from crisis to community: First Report. Canberra, Department of the Senate.

<sup>62</sup> Rickwood D (2006), Pathways of Recovery: Preventing Further Episodes of Mental Illness (Monograph). Canberra, Department of Health and Ageing.

<sup>63</sup> SANE Australia (2013), op. cit.

<sup>64</sup> beyondblue (2015), op. cit.

<sup>65</sup> Victorian State Government (2015), Stigma, discrimination and mental illness. [ONLINE] Available at: [Better Health Channel - Stigma, discrimination and mental illness](#). [Accessed 29 August 2016].

<sup>66</sup> National Mental Health Commission (2014), op. cit.

<sup>67</sup> beyondblue (2015), op. cit.

<sup>68</sup> National Mental Health Commission (2014), op. cit.

<sup>69</sup> SANE Australia (2013), op. cit.

international initiatives, including the Like Minds, Like Mine program in New Zealand; the Opening Minds initiative in Canada; the Time to Change initiative in the United Kingdom; and the See Me campaign in Scotland.

#### Box 4

**The Mindframe National Media Initiative** aims to encourage responsible, accurate and sensitive representation of mental illness and suicide in the Australian mass media. The SANE Media Centre is funded under the Initiative to provide the media and mental health and suicide prevention sector with guidance about the reporting and portrayal of mental illness and suicide related issues. The SANE Media Centre runs the StigmaWatch Program, which voices community feedback about media representations that stigmatise or inadvertently promote self-harm or suicide and representations that are accurate and responsible portrayals which help break down stigma and increase understanding of mental illness.

**beyondblue** provides information and support to help people achieve their best possible mental health. Key aims include reducing the impact of depression, anxiety and suicide and reducing people's experience of stigma and discrimination. Activities include national advertising campaigns and developing resources covering a range of population groups and settings; social media approaches to increase knowledge of depression and anxiety; the conversations project, which is a suite of digital resources to help people have a conversation about depression and anxiety; the STRIDE project, which commissions research projects to demonstrate the impact of digital interventions in reducing the stigma of anxiety, depression or suicide in men aged 30 to 64 years; workplace training programmes to raise awareness of depression and anxiety in the workplace; and a programme to reduce the discrimination experienced by people with depression and anxiety in the insurance industry.

**The Mental Health First Aid Program** provides training in how to help someone who is developing a mental health problem, or who is in a mental health crisis, until appropriate treatment is received or the crisis resolved. A key aim is to reduce the stigma attached to mental illness.

**MindMatters and KidsMatter** are school-based programmes that support the mental health and wellbeing of children through a whole-of-school approach where everyone has a part to play in shaping school culture through their attitudes, beliefs and behaviours around mental health. Promoting the values and ideas of the programmes is seen as an opportunity to reduce the stigma of mental illness.

To date, the majority of efforts have focussed on people with mild-moderate mental illness, with a particular focus on depression and anxiety. While there has been some improvement in community understanding of mental illness, there is still widespread misunderstanding and ignorance. In particular, severe mental illness tends to be poorly understood and attitudes towards people with severe mental illness are less positive.<sup>70,71</sup>

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<sup>70</sup> Wesley Mission (2007), Living with mental illness: Attitudes, experiences and challenges.

It is important to continue action to reduce stigma and discrimination, including opportunities to support a better community approach and work by governments to reduce structural stigma within their policy and practice settings. However, there is a need to broaden efforts to include a focus on people with severe mental illness. Governments will provide leadership by working collaboratively to determine potential approaches and priorities to guide these broadened efforts. It will be important to leverage off and build on existing initiatives, including examining the evidence base to determine the most appropriate and effective approaches and identifying ways to best harness synergies and opportunities.

This work will need to be a shared endeavour and collective effort involving consumers and carers, community groups and key organisations. Involving people with lived experience of mental health issues will be fundamental, both in terms of understanding the issues that need to be addressed and to enable approaches that have been shown to have a positive impact on attitude and behaviour through interpersonal contact. Community groups and key organisations have a key role to play in broadening efforts and will be able to provide valuable insights, including specific local factors that need to be addressed and ways to best leverage off and build on existing efforts. Media involvement, including social media, will be critical in assisting to debunk the misconceptions and myths associated with severe mental illness.

The process of changing community attitudes requires sustained effort in order to reduce stigma and discrimination. It will be important to monitor community attitudes over time, including understanding of severe mental illness and attitudes towards people with severe mental illness. It will also be important to continue to build and examine the evidence base on appropriate and effective approaches to reduce stigma and discrimination and reflect on lessons learned.

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**Action 20:** Governments will work with key organisations to reduce stigma and discrimination in the health workforce through leadership and training, informed by the views and experience of people who live with mental health issues, and identification and exposure of discriminatory practice where it occurs.

People living with mental health issues may experience stigma and discrimination by the health workforce, as well as by the broader community. This may include being advised by a health professional to lower their expectations for accomplishments in life, being shunned or avoided by a health professional, a health professional behaving differently after discovering that a person has a mental illness, or a health professional not being comfortable talking to a person with mental illness.<sup>72</sup> A particular issue is diagnostic overshadowing, where a health professional misattributes physical symptoms to a person's mental illness and subsequently provides inadequate diagnosis or treatment.<sup>73</sup>

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<sup>71</sup> Reavley NJ, Jorm AF (2011), National Survey of Mental Health Literacy and Stigma. Canberra, Department of Health and Ageing.

<sup>72</sup> Mental Health Council of Australia (2011), Consumer and carer experiences of stigma from mental health and other health professionals. Canberra, MHCA.

<sup>73</sup> Jones S, Howard L, Thornicroft G (2008), Diagnostic overshadowing: worse physical health care for people with mental illness. *Acta Psychiatrica Scandinavica* 118: 169-171.

Stigma and discrimination by the health workforce can have a significant impact on the wellbeing of people living with mental health issues and their recovery, resulting in poorer outcomes. It may decrease the likelihood of seeking help, exacerbate psychological distress and decrease the likelihood of adhering to treatment.<sup>74,75</sup> It may also impede early intervention efforts, exacerbate the progression of mental illness and have a cascading impact on broader health and social outcomes.

While professional bodies and other health professionals have taken action to reduce stigma and discrimination against people living with mental health issues, many activities have been aimed at improving community attitudes rather than attitudes within the health workforce itself.<sup>76</sup>

Governments will work with key organisations to build on existing efforts to reduce stigma and discrimination in the health workforce. It will be critical for activities to be informed by the views and experience of people who live with mental health issues in order to fully understand the issues that need to be addressed.

It will be important to consider where the issues are most systemic and what priorities need to be addressed. It will also be important to identify the factors that may be contributing to stigma and discrimination in the health workforce and to understand why people in the health workforce who stigmatise or discriminate against people living with mental health issues act in the way they do. This could include identifying the structures, systems, policies, procedures, behaviours, perceptions, culture and broader environmental factors that may be contributing to stigma and discrimination. It may also include examining the level of understanding in the health workforce about the lived experience of mental illness, the level of understanding and support for recovery oriented approaches, and broader attitudes towards the mental health workforce itself.

Stigma and discrimination against people living with mental health issues by the health workforce needs to be called out as unacceptable behaviour. Leadership will be essential to efforts to reduce stigma and discrimination in the health workforce, both in terms of affecting change and identifying and exposing discriminatory practice when it occurs. Champions could include people whose attitudes and behaviours influence others, as well as those within the health workforce who have lived experience of mental health issues. Education and training can also help challenge the misconceptions about mental illness and perceptions of outcomes for people living with mental health issues, including by emphasising recovery orientated approaches.

The issue of stigma and discrimination against people living with mental health issues extends beyond the health workforce and into areas such as disability, housing, education and employment. While the Fifth Plan focuses on actions to reduce stigma and discrimination in the health workforce, many people living with mental health issues interface with non-health services. It will therefore require a collective effort across other workforces to truly support the wellbeing and recovery of people living with mental health issues and ultimately improve their outcomes.

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<sup>74</sup> beyondblue (2015), op. cit.

<sup>75</sup> Mental Health Council of Australia (2011), op. cit.

<sup>76</sup> Mental Health Council of Australia (2011), op. cit.

## PRIORITY AREA 7: SAFETY AND QUALITY IN MENTAL HEALTH CARE

### What we aim to achieve

A safe and high quality service system that is tailored to the needs of consumers and carers, is underpinned by continuous monitoring and improvement, and reports on outcomes in a transparent manner.

### What will be different for consumers and carers?

- ▶ The treatment, care and support you receive will be safe and of a high quality.
- ▶ Information about the safety and quality of services will be available so that you are able to make informed decisions about treatment, care and support.

### Summary of actions

21. Governments will develop a national mental health safety and quality framework to guide delivery of the full range of health and support services required by people living with mental health issues.
22. Governments will work with the Australian Commission on Safety and Quality in Health Care and the mental health sector to amend the National Standards for Mental Health Services to better reflect their intent in those health services where the National Safety and Quality Health Service Standards also apply.
23. Governments will implement monitoring of consumer and carer experiences of care, including the Your Experience of Service survey tool, across the specialised and primary mental health care service sectors.
24. Governments will agree on a national statement of priorities to guide mental health information developments over the next ten years.
25. Governments will continue to build accountability by ensuring service delivery systems work to monitor the safety and quality of their services and make information about their performance on service quality indicators available to consumers, carers and other stakeholders.
26. Governments will undertake work to improve consistency across jurisdictions in policy underpinning mental health legislation, based on an understanding of their impacts on consumer and carers.

### Overview

Safety and quality are cornerstones of Australia's health system. A safe health system minimises or avoids potential or actual harm to consumers, and is a key pillar of a quality health system. A quality health system provides the right care to consumers, improves health outcomes for consumers, and optimises value.<sup>77</sup> When combined, the concepts of

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<sup>77</sup> Australian Commission on Safety and Quality in Healthcare (2014), Australian Commission on Safety and Quality in Healthcare Strategic Plan 2014-2019. Canberra, ACSQHC.



safety and quality promote a focus on the things that are right, as well as looking at what goes wrong, in health care.

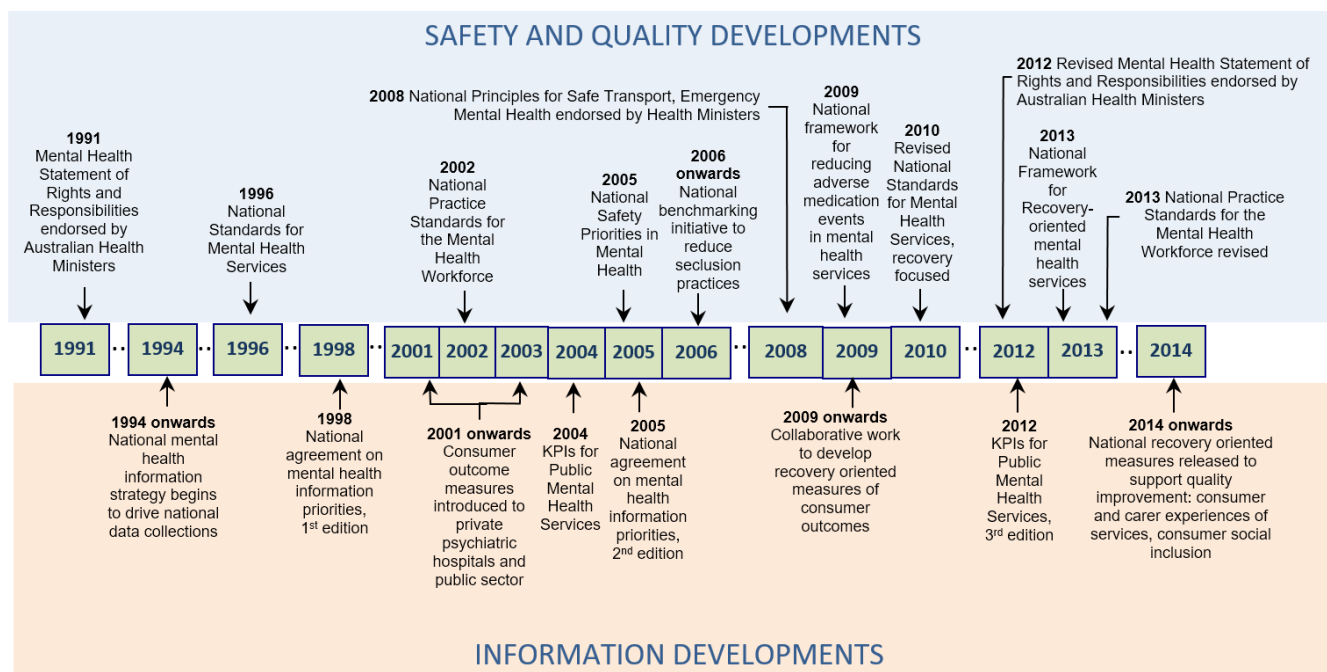
Safety and quality have been integral to mental health reform efforts over the past three decades, and the subject of significant collaboration between governments across wide ranging areas. Work undertaken early in the life of the National Mental Health Strategy focused on concerns about consumer rights. Later initiatives progressed to a broader focus on quality, including the development of standards for services and practitioners, and targeted action to improve the safety of mental health care in nationally agreed priority areas, including the reduction of seclusion and other restrictive practices that are of utmost concern to consumers and carers.

Most recently, the national focus has evolved to incorporate a consumer and carer-led framework, designed to embed recovery-oriented practice within all mental health services. Throughout these developments, consumers and carers have played an increasing role in directing the national work to those areas of most importance to them.

Any process designed to improve the safety and quality of health care is heavily dependent on the right information being available. A mental health information strategy was initiated under the First National Mental Health Plan. The strategy was designed initially to gather basic data on what services were delivered to whom, and progressively expanded to inform about the outcomes of services received by individual consumers. These initiatives put Australia at the forefront of international developments.

Later work established systems to support health service organisations in using information to review and compare their performance, learn and improve. A national performance framework was developed specifically for public sector mental health services and formed the basis of regular public reporting against key performance indicators. More recently, national information development has moved to incorporate measures of the experiences of consumers and carers, who are in the best position to report on the quality and outcomes of the services that they receive.

Throughout the course of the information development work, a priority has been to enhance the collection and use of data to drive safety and quality improvements. Key milestones over previous National Mental Health Plans in safety and quality, and the information collections to support change, are summarised in Figure 4.



**Figure 4: Timeline of selected milestones in mental health safety and quality, and related aspects of the national mental health information development work program**

Many of the early developments in safety and quality commenced under the National Mental Health Strategy pre-dated comparable initiatives in the broader health system. However, the past decade has seen a substantial change in the priority given to advancing safety and quality in the mainstream health system, with national structures set up specifically for this purpose. While these developments have added value to the previous mental health work, they have also introduced a level of complexity for the mental health sector in relation to how mental health specific initiatives can be taken forward, given there are many competing priorities in the broader health environment.

The establishment of the Australian Commission on Safety and Quality in Health Care (ACSQHC) by the Australian, state and territory governments in 2006 was a significant development which was further enhanced in 2011 when it was set up as an independent statutory entity. Its role is to lead and coordinate national improvements in safety and quality in health care, with all governments jointly funding and endorsing the ACSQHC's work program annually.

Building on work undertaken by its predecessor, the Australian Council for Safety and Quality in Health Care, the ACSQHC has set the authoritative national framework for improving the safety and quality of health care. The early emphasis was on acute hospital services, which presented challenges for the mental health sector as it was not perceived as offering the comprehensive vision of recovery orientation across all service areas that was embedded in the National Standards for Mental Health Services (NSMHS).

In more recent years, the ACSQHC has commenced work to specifically address safety and quality issues in mental health care. This has included updating the National Safety and Quality Health Service (NSQHS) Standards to include a greater focus on mental health, work on recognising and responding to deterioration in a person's mental state, and examining substantial variation in interventions for mental health as part of the Australian Atlas of Healthcare Variation.

Complementing the national focus on improving safety and quality in health services, significant activity has also been undertaken within each state and territory. The development of supporting plans, frameworks, policies, processes and measures, in addition to substantial efforts to embed safety and quality in everyday practice, have occurred at the service delivery level. Work to reduce the use of involuntary seclusion is one example where collaborative effort, set by a national direction, has achieved results.

Future steps taken by the mental health sector to advance safety and quality need to align with the directions taken by the ACSQHC, while also acknowledging that additional work is needed to continue building a recovery-oriented culture across all health services involved in the delivery of mental health care. The actions agreed in the Fifth Plan recognise that this is a long term endeavour which needs to be at the heart of all safety and quality initiatives over the next decade. Achieving the vision of a safe and high quality mental health system expected by consumers and carers represents the most critical aspect of the unfinished agenda in national mental health reform.

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**Action 21:** Governments will develop a national mental health safety and quality framework to guide delivery of the full range of health and support services required by people living with mental health issues.

A National Mental Health Safety and Quality Framework will provide a foundation on which to progress the safety and quality of mental health care services. The framework will describe the national agenda and work program for safety and quality over the next five years, and will include:

- identification of new and emerging national safety and quality priorities, updating the 2005 statement of National Safety Priorities in Mental Health;
- a revised national mental health performance framework that extends beyond the scope of the 2012 Key Performance Indicators for Public Mental Health Services to support reporting on performance and quality across all mental health service sectors;
- a framework for consumers and carers that outlines how they can expect to participate in all aspects of what is undertaken within a mental health service so that their role in ongoing safety and quality initiatives is strengthened; and
- a process for revision of the NSMHS to better align with the NSQHS Standards mandated for use in all public and private hospital services (see Action 22).

The framework will cover all relevant service delivery sectors, including the primary mental health care, private and digital health sectors. Its development will be informed by consultations with relevant stakeholders.

The framework will build on safety and quality initiatives already developed through the National Mental Health Strategy and integrate with work undertaken by the ACSQHC, state and territory governments, and mental health commissions. It will also seek to link with work being undertaken in the broader health sector, including reviews of the National Health Performance Framework and the Performance and Accountability Framework.

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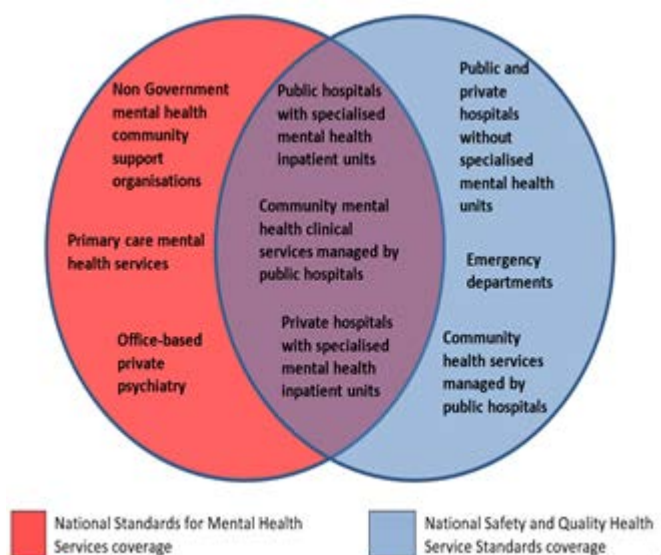
**Action 22:** Governments will work with the Australian Commission for Safety and Quality in Health Care and the mental health sector to amend

the National Standards for Mental Health Services to better reflect their intent in those health services where the National Safety and Quality Health Service Standards also apply.

Australia currently has two sets of national standards for mental health service provision, each developed independently to provide health services with a framework for the implementation of systems to deliver safe care and continuously improve the quality of the services that they provide.

- The NSMHS were first released in 1996 and updated in 2010. They were designed to be implemented across the full range of mental health services, including those in the public, private and community managed sectors. While endorsed by Health Ministers, accreditation against the NSMHS is not mandatory for mental health services nationally. However, some jurisdictions require this of their publically funded services.
- The NSQHS Standards were developed by the ACSQHC with the Commonwealth, states and territories. The Standards aim to protect the public from harm and improve the quality of health service provision. They were released in 2011 and endorsed by Health Ministers for mandatory implementation in all public and private hospitals, including mental health services managed by those hospitals.

**Figure 5: Applicability of National Standards for Mental Health Services and the National Safety and Quality Health Service Standards**



While there are areas of overlap between the NSMHS and the NSQHS Standards, they vary in terms of philosophy, language, structure and the range of services to which they apply (see Figure 5). A 2014 study by the ACSQHC, in collaboration with the NMHC, found that there were also a number of safety and quality gaps in the delivery of mental health services. The 2011 NSQHS Standards (version 1) did not address a number of key safety issues relevant to mental health, and implementation of the NSMHS was not

mandated in key healthcare settings used by people with lived experience of mental health issues.<sup>78</sup>

In response to the study and an evaluation of the first version of NSQHS Standards and national consultation, the ACSQHC has developed version 2 of the NSQHS Standards with new actions specific to mental health. Pending Ministerial endorsement, version 2 of the NSQHS Standards will be implemented in health service organisations from 2017 and assessed from January 2019. They will be mandatory in public and private mental health inpatient and community services and emergency departments managed by public or private hospitals, all key settings for the delivery of mental health care.

Concerns have been expressed within the mental health sector regarding uncertainty about the priority assigned within services to the NSMHS, given the compulsory nature of the NSQHS Standards and the lack of a mechanism to require implementation of the NSMHS. However, consumers and carers have strongly supported the NSMHS, having been at the forefront of the development of the revised standards to ensure that they reflect the values and principles that define both recovery-oriented service delivery and the vital role of carers. They view the NSMHS as a single point of reference for good quality mental health care across the full range of mental health services and do not want to see this diminished.

Health service organisations covered by the NSQHS Standards have also expressed concern about duplication of effort, and the financial and human burden associated with preparing for assessment against two sets of standards.

Acknowledging that there should not be two sets of standards applicable to any individual health service organisation, and to address the current uncertainty about the application of the NSMHS in practice, the NSMHS Standards will be amended to avoid duplication of effort for those health service organisations that are subject to version 2 of the NSQHS Standards. This revised NSMHS will be streamlined to remove the elements covered by version 2 of the NSQHS Standards and will sit as a supplement to the NSQHS Standards to guide implementation within public and private hospitals, including mental health services and emergency departments.

The existing NSMHS will be maintained to provide the authoritative reference point on good quality mental health care and for continuing use by those organisations not subject to the NSQHS Standards.

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**Action 23:** Governments will implement approaches to monitoring consumer and carer experiences of care, including the Your Experience of Service survey tool, across the specialised and primary care mental health service sectors.

Consumers and carers have strongly advocated that their experience of services should be at the centre of Australia's approach to measuring and improving service quality. Regular monitoring of consumer and carer experience of health care is therefore critical for understanding and improving health service performance.

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<sup>78</sup> Australian Commission on Safety and Quality in Health Care (2014), Scoping Study on the Implementation of National Standards in Mental Health Services. Sydney, ACSQHC.

Under the Fourth National Mental Health Plan, governments made a significant investment to develop a standardised, national measure of mental health consumer experiences of care that was grounded in recovery principles. The Your Experience of Service (YES) survey was refined through extensive consultation, consumer involvement, piloting and statistical testing.

Use of the survey tool has shown that it provides valuable insights into how an organisation is performing and fills a critical gap in the information previously available to organisations. All states and territories have agreed to work towards implementing YES, and several states have commenced data collection and reporting. The measure has been translated into 21 languages and two modified versions have been developed to support broader rollout, one suitable for use by community managed organisations and a short form which may be suitable for some additional service settings. In addition, the Carer Experience of Service (CES) measure has been developed and piloted, and is now available for take-up by services.

Substantial progress has also been made in Australia's private hospital mental health sector, which has developed and implemented a consumer experience measure specifically designed to meet the needs of that sector. Led by the Private Mental Health Alliance, it is estimated 60 per cent of private hospital mental health units are using the measure routinely.

The Fifth Plan provides an opportunity to continue these efforts by comprehensively implementing the YES and CES survey approaches in the public mental health sector and reporting publicly on results. Work will also be undertaken to extend the scope of coverage beyond public sector services into community managed organisations, and developing suitable approaches designed for primary mental health care and other areas of practice.

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**Action 24:** Governments will agree on a national statement of priorities to guide mental health information developments over the next ten years.

Two editions of the National Mental Health Information Priorities have been published, the first in 1999 and the second in 2005, providing guiding frameworks for governments to work together in an area that is made complex by the differing data environments and reporting requirements in each jurisdiction. The 1999 edition focused on building systems to monitor consumer outcomes within public sector services, along with a renewed effort to improve the collection and reporting of information on services delivered to consumers.<sup>79</sup> Both elements are critical to any national approach to improving safety and quality. The 2005 edition broadened the initial emphasis to the application and use of data to support improvements in safety and quality.<sup>80</sup>

Work under the Fourth National Mental Health Plan produced a new national tool (the Living in the Community Questionnaire), responding to calls by consumers and carers for outcome measures to be better aligned with recovery concepts. Designed to be completed by consumers about aspects of their lives that are fundamental to recovery,

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<sup>79</sup> Department of Health and Aged Care (1999), *Mental Health Information Development: National Information Priorities and Strategies under the Second National Mental Health Plan 1998-2003* (First Edition June 1999). Canberra, Commonwealth of Australia.

<sup>80</sup> Department of Health and Ageing (2005), *National Mental Health Information Priorities 2nd Edition*. Canberra, Commonwealth of Australia.

such as housing, social activities, work and education, the tool promotes a more holistic view of outcomes.<sup>81</sup> States and territories are currently considering how this might be introduced in to day to day service delivery within public mental health services.

The information foundation developed over the life of the National Mental Health Strategy to date requires continuing collaborative effort between governments, both to keep data sources up to date as well as responding to the changing service delivery environment. An updated statement of national mental health information development priorities will be developed to serve as a guide for future investment over the next ten years. This work will be underpinned by consultations with consumers and carers to understand the outcomes that are important to them, and to identify the most meaningful and relevant indicators that relate to these outcomes.

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**Action 25:** Governments will continue to build accountability by ensuring service delivery systems work to monitor the safety and quality of their services and make information about their performance on service quality indicators available to consumers, carers and other stakeholders.

The Fourth National Mental Health Plan advocated for systems of public reporting by service organisations on key performance measures to strengthen accountability at the service delivery level and ensure consistent monitoring and transparent reporting on the safety and quality of services, but there has been variable progress against this commitment. The Fifth Plan provides the platform for the more comprehensive and expansive adoption of transparent methods for public reporting at the regional, service and provider level.

Existing monitoring and reporting systems will be expanded to include the private office-based sector and private hospitals through the establishment of an opt-in mechanism for voluntary participation. To encourage uptake, and increase permeation in the private sector, these systems will be aligned to support revalidation requirements that may be introduced by the Medical Board of Australia. Improved consumer and carer access to these reporting systems will give people the opportunity to make informed decisions about the quality of their care.

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**Action 26:** Governments will undertake work to improve consistency across jurisdictions in policy underpinning mental health legislation, based on an understanding of their impacts on consumer and carers.

On 1 July 2016, the United Nations (UN) Human Rights Council adopted a Resolution on Mental Health and Human Rights. The resolution highlights:

- that ‘persons with mental health conditions or psychosocial disabilities, in particular persons using mental health services, may be subject to, inter alia, widespread discrimination, stigma, prejudice, violence, social exclusion and segregation, unlawful or arbitrary institutionalization, over-medicalization and treatment practices that fail to respect their autonomy, will and preferences’; and

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<sup>81</sup> Australian Mental Health Outcomes and Classification Network (2015), Development of the Living in the Community (LCQ) measure of social inclusion for use in mental health: Final Report, 2015.

- ‘the need for States to take active steps to fully integrate a human rights perspective into mental health and community services, particularly with a view to eliminating all forms of violence and discrimination within that context, and to promote the right of everyone to full inclusion and effective participation in society’.<sup>82</sup>

The Fifth Plan is being developed at a time when there is an opportunity to align national priorities to improve mental health care practices in Australia with this UN Resolution.

Legislation provides an important framework within which the human rights of mental health consumers are addressed, and shapes the way mental health services are delivered to uphold these rights.

While uniform mental health legislation would be an ideal goal, there are substantial barriers to achieving this across Australia’s federated system. However, all governments have a commitment to producing Commonwealth and state/territory legislation which integrates to form a consistent, reliable and safe service delivery environment for consumers.

In the past, different Mental Health Acts (and related legislation) in each state and territory, as well as different policies on investment in services, have made the seamless provision of care to people who move between states or territories difficult, and costly for both people and services, when the delays and difficulties in accessing and providing care are considered.

Given every jurisdiction’s Act has been prepared in response to local needs, there is considerable overlap in the principles underpinning the legislation. However, there are also opportunities to promote greater consistency in practice. For example, many, but not all, of the Acts recognise the key role of assessment of a person’s decision-making capacity in determining criteria for voluntary and involuntary treatment. Similarly, while all jurisdictions recognise that interstate agreements can promote consistency of care and reduce the difficulty of interstate recognition or transfer of mental health act orders if a person wishes to move interstate, the development and maintenance of contemporary interstate agreements is complex.

Within the last five years, all states and territories will have either introduced or begun preparation of a new or revised Mental Health Act. Building on these changes, there is an opportunity to enhance consumers’ rights and improve the experience of care for people subject to Mental Health Act orders by developing a national standardised approach to cross border (inter-jurisdictional) agreements for civil and forensic Mental Health Act orders. National benchmarking on the use of Mental Health Act treatment orders will also be undertaken to promote greater consistency in practice.

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<sup>82</sup> United Nations Human Rights Council (2016), Resolution on mental health and human rights. [ONLINE] Available at: [Human Rights Council Thirty-second Session](#). [Accessed 29 September 2016].



# MONITORING AND REPORTING ON REFORM PROGRESS

## What we aim to achieve

Accurate and timely information is available to allow consumers, carers, providers and governments to monitor mental health system reform and the implementation of commitments made in the Fifth Plan.

All parts of the mental health service system are supported in using information to improve the experience of, and outcomes for, consumers and carers.

## What will be different for consumers and carers?

- ▶ You will have access to an annual report on mental health reform and progress in implementing the actions outlined in the Fifth Plan.
- ▶ All mental health services that you access will work to understand your needs and improve the treatment, care or support that they provide.

## Summary of actions

27. Governments will implement a set of national reform and system performance measures to monitor whether we are making a difference in mental health reform.
28. Governments will work to develop additional performance measures in response to consumer, carer and community priorities. These will build on investments already made in data collection and performance measurement development.
29. Governments will work to ensure that progress and reform are monitored in all parts of the mental health service system.
30. Governments will report annually on the progress of mental health reform and implementation of the Fifth Plan.

## Overview

Reporting on the progress of mental health reform is essential in order to know that the commitments in the Fifth Plan are being honoured, and that they are making a difference. An annual reporting process will be established that provides timely public reports on the implementation of the Fifth Plan. This reporting process will include a set of high level measures of service and system performance, and support the continued development of a richer set of measures relevant to all service sectors.

All services providing support to people living with mental health issues should use information to support clinical care, evidence-based decision making, service improvement, planning and research. Without accurate information, mental health service providers cannot learn and improve; and consumers, carers, staff and funders cannot have confidence in the mental health system. National reporting should ideally be based on information that has been collected and refined through local use. This requires long term planning and investment. The data required to monitor and improve mental health services is complex and sensitive, and is collected by a wide range of providers.

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**Action 27:** Governments will implement a set of national reform and system performance measures to monitor whether we are making a difference in mental health reform. .

Australian mental health services collect a wide range of information on activities and outcomes. A core set of national Key Performance Indicators was first developed in 2005 and refined during the Fourth National Mental Health Plan.<sup>83</sup> They have provided an important foundation for national reporting, and are also included in local reporting by many state and territory mental health services. However, new information is needed to monitor contemporary mental health reform initiatives and to identify what works and what does not within a complex, multi-layered health and welfare system.

A first requirement for national reporting is to identify a small number of key measures which are available for use to monitor the longer term outcomes of mental health reform. These include population level and system level measures targeted at monitoring the extent to which health and social services are changing in agreed directions. These measures should be enduring across the life of multiple Plans, rather than being limited to the specific actions of the Fifth Plan.

Work to identify available measures was carried out by the Mental Health Information Strategy Standing Committee (MHISSC), which brings governments, consumers and carers together with other mental health stakeholders involved in collecting or using mental health information. This work was guided by domains originally proposed by the NMHC.<sup>84</sup> The proposed indicators, detailed in Table 1, include indicators constructed from health service data collections and population surveys.

The majority of the proposed indicators relate to more than one of the priority areas in the Fifth Plan. For example, improved service integration (Priority Area 1), more coordinated care (Priority Area 2) and safer and more effective care (Priority Area 7) will all contribute to reduced rates of long term health conditions, and improved clinical and social outcomes for people with severe and complex mental illness. Indicators such as childhood vulnerability, rates of long term health conditions, clinical and social outcomes, access to care, and rates of coercive care will provide insight into the gaps in experience, care or outcome for priority groups such as Aboriginal and Torres Strait Islander people.

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<sup>83</sup> National Mental Health Performance Subcommittee (2013), Key Performance Indicators for Australian Public Mental Health Services, 3<sup>rd</sup> Edition. Canberra, Commonwealth of Australia.

<sup>84</sup> National Mental Health Commission (2013), National Targets and Indicators for Mental Health Reform. [ONLINE] Available at: [National Targets and Indicators for Mental Health Reform](#) [Accessed 5 October 2016].

**Table 1: Proposed national indicators of mental health system performance and reform (currently available indicators)**

DOMAIN	INDICATOR
<b>Healthy start to life</b>	1. Proportion of children developmentally vulnerable in the Australian Early Development Index (AEDI)
<b>Better physical health and living longer</b>	2. Rate of long term health conditions in people with mental illness
<b>Good mental health and well-being</b>	3. Prevalence of mental illness
	4. Proportion of adults with very high levels of psychological distress
<b>Meaningful and contributing life</b>	5. Rate of social/community/family participation in people with mental illness
	6. Proportion of people with mental illness in employment
	7. Proportion of carers of people with mental illness in employment
<b>Responsive and effective service systems</b>	8. Change in mental health consumers' clinical outcomes
	9. Population access to mental health care
	10. Rate of post discharge community care follow up
	11. Proportion of total mental health workforce accounted for by the mental health peer workforce
	12. Proportion of consumers with positive experiences of service
<b>Avoidable harm</b>	13. Rate of suicide
	14. Rate of seclusion in acute mental health units
	15. Rate of involuntary hospital treatment

**Action 28:** Governments will work to develop additional performance measures in response to consumer, carer and community priorities. These will build on investments already made in data collection and performance measure development.

Performance measures need to be continually updated to ensure that national performance monitoring is effective. This requires a long term view because it involves many steps, including developing new measures, implementing them in services, making changes to data collection systems, collating the data and analysing them to create nationally consistent indicators.

The Fifth Plan will build on investments made during the Fourth National Mental Health Plan, and support the progressive rollout of several important new measures including

the YES, CES and Living in the Community (LCQ) questionnaires. Together these provide the measurement tools required to measure consumer experience, carer experience, and consumer perspectives on work, study, social activities, housing and broader wellbeing.

The Fifth Plan aims to improve integration between public and private services, to improve the continuity and coordination of mental health care for Australians, to improve physical health care and to improve care following suicide attempts. Measuring change for many of these issues will require different approaches to existing information collections, improved quality of current datasets, or better linkage between different datasets. These approaches are necessary and feasible, but require careful planning and testing, and may require new resources and investment.

Table 2 shows examples of current mental health priority areas for which developments in information collections, more sophisticated analysis or linkage may generate additional indicators for inclusion in national reporting.

**Table 2: Additional national indicators of mental health system performance and reform to be addressed during the Fifth Plan**

DOMAIN	POTENTIAL INDICATOR
Healthy start to life	16. Rate of access to early childhood support programmes
Better physical health and living longer	17. Mortality gap for people with a mental illness (using linked data)
Good mental health and well-being	18. Proportion of people with mental illness reporting connectedness and meaning in life (from LCQ)
Meaningful and contributing life	19. Proportion of mental health consumers in suitable housing (from LCQ)
Responsive and effective service systems	20. Proportion of consumers and carers with positive experiences of service (from YES)
	21. Proportion of carers with positive experiences of service (from CES)
Avoidable harm	22. Rate of follow-up after suicide attempt/self-harm (using linked data)
	23. Rate of involuntary hospital treatment (through better quality inpatient and community data)

The Fifth Plan outlines actions that will help to guide the development of new measures and indicators. All governments have agreed to develop a national mental health safety and quality framework to guide delivery of the full range of health and support services required by people living with mental health issues (see Action 21). A contemporary statement of national mental health information development priorities will also be developed (see Action 24). This will provide the long term blueprint for mental health information developments to ensure that all providers measure outcomes that matter to consumers, carers and the community.

There are many priority areas where better performance measurement is required, including wellbeing and recovery for individuals, the recovery focus of services, personal functioning and social outcomes, access to physical health care, and the safe use of psychiatric medications. Other priority areas will be addressed as they emerge during the course of the Fifth Plan.

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**Action 29:** Governments will work to ensure that progress and reform are monitored in all parts of the mental health service system.

Australia's mental health service system involves an increasingly complex mix of services and providers, including primary care services, Aboriginal Medical Services, non-government and community managed organisations, state and territory specialised mental health services, private hospitals, private office-based practice supported through the Medicare Benefits Scheme (MBS), headspace and other Commonwealth funded services. The Fifth Plan aims to improve regional integration and coordination between these services.

Currently, the most detailed data for national reporting is available from population surveys and from state and territory specialised mental health services. The immediately available indicators listed in Table 1 are mainly confined to these services.

There are obvious opportunities to begin to include community managed and Commonwealth government funded services within national reporting.

- There is increasing scope for data linkage between Commonwealth and state and territory providers. While technically complex and requiring rigorous privacy safeguards, such linkage would allow reporting on issues such as the integration of primary care and specialised care, rates of access to physical health care, and the important role of GPs and private office based practitioners in follow-up care after hospitalisation or suicide attempts.
- Recent Commonwealth initiatives, such as the establishment of headspace and PHNs, have created new national data collections. These collections are a valuable resource which will facilitate the reporting of the activity of these services against national quality and safety frameworks.
- Work has been completed on the development of a version of the YES questionnaire which is suitable for use in community managed organisations, and a short form that could be adapted for use in some primary care or office based practice settings. Roll out of the YES in these components of the mental health sector would provide valuable insights into the quality of the mental health care being provided to consumers.

It is vital that all services within mental health system work as one to understand and improve the quality, safety and effectiveness of the care and support provided to people living with mental health issues. All components of the mental health service system must work towards improving transparency and accountability to ensure that consistent, comparable information about the care being provided is available to consumers, carers, staff, providers and the community. Supporting the gradual expansion of reporting to include all components of the mental health sector is an important commitment of the Fifth Plan.

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**Action 30:** Governments will report annually on the progress of mental health reform and implementation of the Fifth Plan.

The success of National Mental Health Plans depends as much on their implementation as the specific directions and actions that they outline. Monitoring and reporting on implementation is an essential part of this process, as it enables all parties to keep track of progress against commitments made, as well as build accountability by informing the community about progress.

A new national annual report will be established to provide a progressive overview of progress against agreed actions in the Fifth Plan, as well as the progress of national mental health reform. Updated each year, the report will serve as the principal vehicle for evaluating the implementation of the Fifth Plan and key measures of longer term mental health reform outcomes.

## WORKING TOGETHER TO ACHIEVE CHANGE

It will take a collective effort, underpinned by strong leadership and collaboration, to support the aims of the Fifth Plan and enable longer term system reform. This includes all levels of government, organisations, professional bodies and service providers within and beyond the mental health and suicide prevention systems, schools, universities and other educational institutions, the media, workplaces, consumers and carers, and each of us as individuals.

Governments will provide a key leadership role across the actions identified in the Fifth Plan. There will be a need for better collaboration and coordination across governments and government agencies, and a commitment to driving change beyond the mental health service system. Local governments will be an important partner in fostering local ownership of activities within their local community to promote mental health and wellbeing and prevent suicide.

Governments will need to consider existing investments in mental health and suicide prevention when implementing the actions identified in the Fifth Plan. This may include examining the effectiveness of existing investments, opportunities to harness or leverage off existing investments, whether existing investments should be rebalanced, and opportunities to address areas of duplication and inefficiency.

Organisations, professional bodies and service providers within and beyond the mental health and suicide prevention environments will have an important role in implementing and supporting change. In particular, PHNs and LHNs will be instrumental in leading and enabling a number of changes at the regional level, in partnership with their local communities and taking into account local circumstances. Efforts will need to look beyond the mental health service system in order to holistically meet the needs of people living with mental health issues and improve their outcomes. It will also be important to harness innovations and reflect on lessons learned.

Workplaces will have a role in promoting mental health and wellbeing, including efforts to reduce stigma and discrimination and opportunities to improve participation in the workforce for people living with mental health issues. Workforce skills, supply and distribution are fundamental to service delivery. Consideration will therefore need to be given to workforce composition and development.

People living with mental health issues will have a central role in leading their recovery, including shaping the way in which services are planned and delivered to meet their needs. Their carers will have an important supporting role, including involvement in service planning and delivery.

As individuals, we all have a fundamental role to play in promoting and contributing to mental health and wellbeing by creating socially inclusive communities that break down stigma and discrimination and support recovery. Individual efforts can be supported by broader efforts, across the spectrum of health, social services, education, employment, workplaces and the media.

It is through a collective effort that we can achieve better mental health and wellbeing for everyone.

## GLOSSARY

For the purpose of the Fifth Plan, the key terms below have the following meanings:

**Adverse health outcome** An outcome that has the potential to negatively affect a person's state of health.

**Adverse social and economic outcome** An outcome that has the potential to negatively affect a person's social and economic opportunities. This may include a person's employment, education and housing opportunities.

**Australian Commission on Safety and Quality in Health Care (ACSQHC)** The agency that leads and coordinates national improvements in safety and quality in health care across Australia.

**Burden of disease** A measure used to assess and compare the relative impact of different diseases and injuries on populations.

**Care navigator** A person who works collaboratively with consumers and carers to assist them in finding the most appropriate treatment, care or supports.

**Carer** A person who cares for or otherwise supports a person living with mental health issues. A carer has a close relationship with the person living with mental health issues and may be a family member, friend, neighbour, member of a broader community or staff member.

**Carer Experience of Service (CES) survey** Gathers information from carers about their experiences of care, and aims to help mental health services and carers to work together to build better services.

**Community supports** Non-clinical services in the community that assist people living with mental health issues to live meaningful and contributing lives and support them in their recovery. These may include services that relate to daily living skills, self-care and self-management, physical health, social connectedness, housing, education and employment.

**Comorbidity** The presence of one or more diseases or disorders in a person, in addition to a primary disease or disorder.

**Consumer** A person living with mental health issues who uses, has used or may use a mental health service.

**Contributing life** The National Mental Health Commission outlines that a fulfilling life is one where people living with mental health issues can expect the same rights, opportunities and health as the wider community. It is a life enriched with close connections to family and friends, supported by good health, wellbeing and health care. It means having a safe, stable and secure home and having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering.

**Diagnostic overshadowing** Misattribution of a person's physical health symptoms to their mental illness, resulting in inadequate diagnosis and treatment.



**Disability-Adjusted Life Years (DALY)** Estimates the years of life lost due to premature death and the years of healthy life lost due to disability from disease or injury.

**Discrimination (mental illness)** Unfair treatment of a person or group of people on the basis of a particular characteristic. Discrimination happens when people act on stigmatising views about people living with mental health issues.

**Early intervention** The early identification of risk factors and provision of timely treatment, care or support for people experiencing early signs and symptoms of mental illness. It aims to prevent the incidence, severity and impact of mental illness.

**Gayaa Dhuwi (Proud Spirit) Declaration** A declaration on Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander people.

**Governments** Commonwealth, state and territory governments.

**Lived experience** People with lived experience are people who identify either as someone who is living with (or has lived with) mental health issues or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental health issues. People with lived experience are sometimes referred to as consumers and carers.

**Living in the Community Questionnaire (LCQ)** Gathers information from consumers about aspects of social inclusion and recovery by exploring aspects of their life in the community such as social activities, participation in employment or study, living situation and physical health care.

**Living Is For Everyone (LIFE) Framework** Australia's national suicide prevention framework.

**Local Hospital Networks (LHNs)** Entities established by states and territories governments to manage single or small groups of public hospital services, including managing budgets and being directly responsible for performance. Most, but not all, LHNs are responsible for managing public hospital services in a defined geographical area. At the discretion of states and territories, LHNs may also manage other health services such as community based health services. LHNs may have different names in some jurisdictions. For example, they are referred to as Local Health Districts in New South Wales, Health and Hospital Services in Queensland, Local Health Services in South Australia, and the Tasmanian Health Service in Tasmania.

**Mental disorder** See mental illness.

**Mental health** The World Health Organization defines mental health as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.

**Mental health issue** See mental illness.

**Mental Health Drug and Alcohol Principal Committee (MHDAPC)** A principal committee of the Australian Health Ministers' Advisory Council. The role of MHDAPC is to support integration and provide an opportunity to progress the work of the both the

mental health and drug and alcohol sectors, as well as enabling the development and implementation of specific and related national initiatives and projects.

**Mental Health Information Strategy Standing Committee (MHISSC)** Provides advice to the Mental health Drug and Alcohol Principal Committee and is a national collaborative forum for the development and implementation of national initiatives in mental health information.

**Mental health service system** Comprises all services that have a primary function of providing treatment, care or support to people living with mental health issues and/or their carers.

**Mental illness** A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders, and schizophrenia.

**National Disability Insurance Agency (NDIA)** The agency responsible for implementing the National Disability Insurance Scheme.

**National Disability Insurance Scheme (NDIS)** Provides eligible participants with permanent and significant disability with the reasonable and necessary supports they need to enjoy an ordinary life. The NDIS also connects people with disability and their carers, including people who are not NDIS participants and their carers, to supports in their community.

**National Mental Health Service Planning Framework** A framework to guide evidence-based decision making about the mix and level of mental health services and workforce needed to meet local circumstances.

**National Mental Health Strategy** A framework to guide mental health reform. It includes the National Mental health Policy, the Mental Health Statement of Rights and Responsibilities, and four successive National Mental Health Plans.

**National Safety and Quality Health Service Standards** Standards developed by the Australian Commission on Safety and Quality in Health Care to improve the safety and quality of health service provision across a wide variety of health care services.

**National Standards for Mental Health Services** Standards that assist in the development and implementation of appropriate practices and guide continuous quality improvement across the broad range of mental health services.

**Non-fatal burden** A measure of healthy years lost due to ill health. Non-fatal burden is assessed when calculating the total burden of disease experienced by a population.

**Indicator** A quantitative measure that is used to assess the extent to which a given objective has been achieved.

**Person-centred** Treatment, care and support that places the person at the centre of their own care and considers the needs of the person's carers.

**Prevention (mental illness)** Action taken to prevent the development of mental illness, including action to reduce promote mental health and wellbeing and action to reduce the risk factors for mental illness.

**Prevention (suicide)** Action taken to reduce the incidence suicide.

**Primary Health Networks (PHNs)** Entities established by the Commonwealth to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

**Primary care** Generally the first point of contact for people living with mental health issues and their carers. Primary care providers include general practitioners, nurses, allied health professionals, pharmacists and Aboriginal health workers.

**Productivity** The efficiency with which inputs (such as labour) are converted into outputs (such as goods and services). Growth in productivity can lead to improvements in living standards.

**Promotion (mental illness)** Action taken to promote mental health and wellbeing.

**Psychosocial disability** The disability experience of people with impairments and participation restrictions related to mental illness. These impairments and restrictions can include reduced ability to function, think clearly, experience full physical health, and manage the social and emotional aspects of their lives.

**Recovery** The National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers outlines that there is no single description or definition of recovery, because recovery is different for everyone. It notes that central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination. Some characteristics of recovery commonly cited are that it is a unique and personal journey; a normal human process; an ongoing experience and not the same as an end point or cure; a journey rarely taken alone; and nonlinear, with it being frequently interspersed with both achievement and setbacks. It defines personal recovery as being able to create and live a meaningful and contributing life in a community of choice, with or without the presence of mental health issues.

**Regional level** The level between the macro level of governments and micro level of service delivery. The regional level is where practical, targeted and locally appropriate action can be taken and strong community collaborations and partnerships can be formed. A region is not necessarily confined to the boundaries of a specific Primary Health Network or Local Hospital Network.

**Secondary care** Care provided by medical specialists. Secondary care providers can include psychiatrists and psychologists.

**Self-stigma (mental illness)** Stigmatising views that people living with mental health issues hold about themselves. Self-stigma occurs when people living with mental health issues accept the negative opinions or judgements held by others about people living with mental health issues.

**Severe mental illness** Is characterised by a severe level of clinical symptoms and often some degree of disruption to social, personal, family and occupational functioning. Severe mental illness is often described as comprising three sub-categories:

- Severe and episodic mental illness – refers to people who have discrete episodes of illness interspersed with periods of minimal symptoms and disability or even remission. This group comprises about two thirds of all adults who have a severe mental illness.

- Severe and persistent mental illness – refers to people with a severe mental illness where symptoms and/or associated disability continue at moderate to high levels without remission over long periods (years rather than months). This group represents about one third of all adults who have a severe mental illness.
- Severe and persistent illness with complex multiagency needs – refers to people with severe and persistent illness who are the most severe and disabled, who require the most intensive clinical care (assertive clinical treatment in the community often supplemented by hospitalisation), along with regular non-clinical support from multiple agencies to assist the person in managing their day to day living roles (e.g. personal and housing support). This group is relatively small (approx. 0.4% of adult population, 60,000 people) and is the group targeted for Tier 3 packages under the NDIS.

**Severe and complex mental illness** Is not directly aligned to any one of the above sub-categories of severe mental illness. Rather, it is broader and may include episodic or chronic (persistent) conditions, not confined to specific diagnostic categories. While incorporating severely disabled people (i.e. people with severe and persistent illness with complex multiagency needs), it also includes people who have complexities that are not disability-related. For example, people who have a severe mental illness comorbid with a chronic physical illness; people who may have no functional impairment arising from their mental illness, but whose illness is impacted adversely by complex social factors; people with multiple recurrent acute episodes that require frequent hospital care; people who present a high suicide risk; or people who have a need for coordinated assistance across a range of health and disability support agencies.

**Social and emotional wellbeing** Refers to the Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental health and other factors such as the social, spiritual and cultural wellbeing of people and the broader community.

**Social inclusion** Is the opportunity for people to participate in society through employment and access to services; connect with family, friends, personal interests and the local community; deal with personal crises; and have their voices heard.

**Social stigma (mental illness)** Individual and collective stigmatising attitudes and beliefs about people living with mental health issues. Social stigma reinforces self-stigma and structural stigma.

**Specialised mental health services** Include services provided by psychiatric hospitals, psychiatric units or wards in hospitals, community mental health care services, and residential mental health services.

**Stepped care** An evidence-based staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to a person's needs. Within a stepped care approach, a person is supported to transition up to higher intensity services or transition down to lower intensity services as their needs change.

**Stigma** A negative opinion or judgment that excludes, rejects, shames or devalues a person or group of people on the basis of a particular characteristic. Stigma against people living with mental health issues involves perceptions or representations of them as violent, unpredictable, dangerous, prone to criminality, incompetent, undeserving or weak in character. Stigma may include self-stigma, social stigma and structural stigma.

**Structural stigma (mental illness)** The policies and practices of social institutions that restrict opportunities for people living with mental health issues. Structural stigma reinforces self-stigma and social stigma.

**Wrap around care** Individualised and integrated services provided through a single coordinated process to comprehensively meet a person's needs.

**Your Experience of Service (YES) survey** Gathers information from consumers about their experiences of care, and aims to help mental health services and consumers to work together to build better services.