

Monitoring mental health  
and suicide prevention reform

# Fifth National Mental Health and Suicide Prevention Plan, 2018

Progress Report



**Australian Government**  
**National Mental Health Commission**

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# Foreword

In August 2017, the COAG Health Council endorsed The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan). This plan builds on the foundations of previous reform efforts and establishes a national approach for collaborative government effort over the period of 2017–2022. Underpinned by eight priority areas, the Fifth Plan is aligned with the current aims and policy directions of the National Mental Health Policy that are well positioned for change in terms of need and opportunity.

The National Mental Health Commission (NMHC) has been tasked with monitoring and reporting the implementation of the Fifth Plan, and we are pleased to present our first report on the progress made since release of the Fifth Plan in August 2017.

This progress report is the first of a series that will be delivered over the life of the Fifth Plan, and the NMHC is encouraged by the progress currently being made against the actions of the implementation plan. Subsequent reports will use the baseline information of this year's report to provide a sense of how actions are progressing into the future. As the Fifth Plan approaches the later stages of its life and reforms begin to lead to change that will be visible for consumers and carers and the sector more broadly, we will report on these changes to ensure that there is genuine improvement for people living with a mental illness.

To gauge the progress of the implementation actions, the NMHC surveyed 51 relevant stakeholders, including Primary Health Networks (PHNs), Australian Government and state and territory departments of health, national and state mental health commissions, and relevant Australian Health Ministers' Advisory Council (AHMAC) sub-committees.

Implementation of the Fifth Plan would not be possible without the commitment and sustained effort of governments. The expertise and remit of AHMAC committee structures in particular, are critical enablers to its success.

Change and system reform takes time and persistence to achieve, but we are confident that through our combined and collaborative efforts, mental health and suicide prevention can be improved in Australia. We would like to offer our thanks to all parties involved – the Australian Government, state and territory governments, PHNs and AHMAC committees – for their continued efforts in implementing the Fifth Plan, and for their contributions to this report.



**Maureen Lewis**  
Interim CEO of the NMHC



**Lucy Brogden**  
Chair of the NMHC Advisory Board



# Executive Summary

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) builds on the foundation established by previous reform efforts and sets out a national approach for collaborative government effort over the period 2017 to 2022.

The Fifth Plan is underpinned by eight targeted priority areas, which align with the aims and policy directions of the National Mental Health Policy that are currently well positioned for change in terms of need and opportunity.

These priority areas are:

- **Priority Area 1:** Achieving integrated regional planning and service delivery.
- **Priority Area 2:** Effective suicide prevention.
- **Priority Area 3:** Coordinating treatment and supports for people with severe and complex mental illness.
- **Priority Area 4:** Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.
- **Priority Area 5:** Improving the physical health of people living with mental illness and reducing early mortality.
- **Priority Area 6:** Reducing stigma and discrimination.
- **Priority Area 7:** Making safety and quality central to mental health service delivery.
- **Priority Area 8:** Ensuring that the enablers of effective system performance and system improvement are in place.

The Fifth Plan includes actions that aim to achieve specific outcomes under each of the priority areas, set the direction for change and provide a foundation for longer-term system reform. These are outlined in the Fifth National Mental Health and Suicide Prevention Plan Implementation Plan (Implementation Plan). Governments also identified 24 indicators that will be used to measure progress of the mental health and suicide prevention sector over the life of the Fifth Plan.

## The National Mental Health Commission (NMHC) has been given responsibility for delivering an annual report, for presentation to Health Ministers, on the implementation progress of the Fifth Plan actions and performance against the identified indicators.

This report constitutes the first of the NMHC's annual reports against the Fifth Plan. It outlines the progress achieved against the Implementation Plan actions as at 30 June 2018, and presents a baseline for the available performance indicators which will allow change to be monitored in future reports.

### Implementation progress

To gauge the progress of the implementation actions, the NMHC surveyed 51 relevant stakeholders, including Primary Health Networks (PHNs), Australian Government and state and territory departments of health, national and state mental health commissions, and relevant Australian Health Ministers' Advisory Council (AHMAC) sub-committees.

Survey respondents were asked to self-report the progress of their contribution to each action, as at 30 June 2018. Specifically respondents were asked to:

- categorise their progress against each action using a four point scale: 'behind schedule', 'on track', 'ahead of schedule' or 'complete'
- provide free text descriptions of their key achievements, barriers, and enablers relating to their contribution to the Fifth Plan actions
- categorise the level of consumer and carer involvement in progressing their contribution using a seven point scale: 'inform', 'consult', 'involve', 'collaborate', 'empower', 'unsure what level of involvement has been used' and 'no involvement of consumers and/or carers'.

Using self-report measures means that there could potentially be a degree of variability between responses based on differing interpretations of progress. The NMHC will refine the guidance for respondents to ensure greater clarity of the progress categories and to clearly articulate the nature of survey responses from individual agencies and stakeholders in future progress reports.

The survey required stakeholders to rate the progress of their own contributions to actions. Therefore, in cases where multiple stakeholders are contributing to a single action, they may have rated their progress differently. In these cases, the rating of a single stakeholder may not necessarily reflect the overall progress of the action.

In adopting the free text approach to the collection of achievements, barriers, and enablers, the responses received have provided the NMHC with a wealth of material for reporting. Therefore, a small number of examples that best represent progress against the priority areas have been selectively included in the report. The NMHC will use the wider pool of response data to develop additional materials that showcase good practice and significant achievements across the mental health sector.

### Achievements

All governance arrangements that oversee the implementation of the Fifth Plan are well established.

Stakeholders reported diverse and significant achievements, many of which were consistent across priority areas. These included successfully engaging with consumers and carers to inform regional plans and stepped care planning (Priority Area 1) and the co-design of services with Aboriginal and Torres Strait Islander people for Aboriginal and Torres Strait Islander people (Priority Area 4).

The introduction of education and training to service providers (Priority Areas 4 and 5) and consumers (Priority Area 5) to improve care and support to people living with mental illness is significant, as is the introduction of new services specifically targeting young people (Priority Area 3), Aboriginal and Torres Strait Islander people (Priority Area 4), and the physical health of people living with mental illness (Priority Area 5).

Achievements were also reported in mental health care accessibility, with improvements made in general practice to better support patients living with mental illness (Priority Areas 3 and 5).

## Barriers

Funding and resources were commonly reported barriers across priority areas for PHNs, with many reporting that they lack the funding necessary to implement the Fifth Plan actions. This includes the funding and resources required to achieve integrated planning and delivery (Priority Area 1), coordinated treatment and supports (Priority Area 3), meaningful engagement with Aboriginal and Torres Strait Islander people (Priority Area 4), and to improve physical health for people living with mental illness (Priority Area 5).

Almost a quarter of PHNs surveyed, and a number of state and territory government health departments reported the availability of guidance from the Australian Government Department of Health as a barrier across a number of priority areas. These respondents reported that they are awaiting guidance on integrated regional planning and service delivery (Priority Area 1) before they can progress with this action. A small number of PHNs also noted that the lack of clarity in guidance materials regarding accountability in Aboriginal and Torres Strait Islander mental health and suicide prevention was a barrier to planning in this area (Priority Area 4).

The National Mental Health Service Planning Framework (NMHSPF) was reported as a barrier in three priority areas. Stakeholders noted that the NMHSPF does not currently capture rurality or Aboriginal and Torres Strait Islander status, and many jurisdictions are unable to utilise the NMHSPF as a result. The NMHSPF is currently being redeveloped to include these populations. In addition, a small number of PHNs and state and territory government health departments reported the training required to utilise the NMHSPF as a barrier due to the time and resources required to attend the sessions. These barriers have been reported as an impediment to progress in integrating regional planning and service delivery (Priority Area 1), effectively coordinating treatment and supports for people with severe and complex mental illness (Priority Area 3) and ensuring that enablers of effective system performance and improvement are in place (Priority Area 8).

Service integration was another common barrier identified by stakeholders across priority areas. This involves complexities for health care providers – integrating health systems, strategies and competing priorities into shared plans (Priority Area 1) and managing the transition between secondary and primary care (Priority Area 3) – as well as for consumers and carers, who must navigate a complex and fragmented health care system until service integration is achieved (Priority Area 5).

## Enablers

Stakeholder engagement, including consultation with consumers and carers was consistently reported as the key enabler to achieving success across the vast majority of priority areas (Priority Area 1, Priority Area 2, Priority Area 3, Priority Area 4, Priority Area 5, Priority Area 6, and Priority Area 8). This is particularly significant as the contributions of those with lived experience to policy, planning, service design, delivery and evaluation are central to the success of the Fifth Plan.

Stakeholders also reported the expertise and remit of AHMAC committee structures as critical enablers to achieving integrated regional planning and service delivery (Priority Area 1), suicide prevention (Priority Area 2), ensuring safety and quality are central to mental health service delivery (Priority Area 7) and ensuring that enablers of effective system performance and improvement are in place (Priority Area 8).

### **Consumer engagement**

Across the eight priority areas, stakeholders reported the level of engagement and participation with consumers and carers as largely focused on ‘consulting’, ‘informing’, ‘involving’ and ‘collaborating’. Some stakeholders also reported engagement and participation through ‘empowerment’, whilst a small number of stakeholders reported no involvement of consumers or carers at this stage of implementation.

### **Performance indicators**

The Fifth Plan identifies a set of 24 performance indicators, designed to collectively provide a picture of how Australia’s mental health system is performing. These indicators range from measures of the health status of the population to measures of the process of mental health care.

The Fifth Plan indicator set includes indicators which can currently be measured, along with indicators that require various amounts of development before they will be available for reporting. Under Action v of the Fifth Plan, the Mental Health Information Strategy Standing Committee (MHISSC) has responsibility for identifying data sources and developing methodologies for the 24 performance indicators identified in the Fifth Plan. The MHISSC has completed this work for 13 of the 24 indicators, and data on these indicators is included in this report.

This report outlines the scope and rationale of each of the 13 available indicators and provides selected high level analyses, including data on Aboriginal and Torres Strait Islander people where available. As this is the first of the NMHC’s annual reports against the Fifth Plan, the data presented establishes a baseline for each available indicator. In each subsequent annual report, where updated data is available, comparisons will be made between baseline data and contemporary data to identify emerging trends in the performance of the mental health sector.

The Fifth Plan establishes a national approach for collaborative government action to improve Australia’s mental health system over the period 2017 to 2022. This 2018 report, released just over a year since the Fifth Plan was endorsed by the Council of Australian Governments (COAG), is the first of the NMHC’s annual reports against the Fifth Plan and establishes the direction for future reporting.

Given the relative infancy of the implementation of the Fifth Plan, it is difficult to provide detailed commentary on progress to date. As the implementation of the Fifth Plan approaches completion, the NMHC will report on implementation progress in more detail to ensure that there is genuine improvement for people living with a mental illness in Australia.

# Introduction

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) was endorsed by the Council of Australian Governments (COAG) on 4 August 2017 and is the latest in a series of National Mental Health Plans, which set out national actions to achieve the intent of the National Mental Health Policy. The Fifth Plan builds on the foundation established by previous reform efforts and sets out a national approach for collaborative government effort over the period 2017 to 2022.

The Fifth Plan is underpinned by eight targeted priority areas, which align with the aims and policy directions of the National Mental Health Policy that are currently well positioned for change in terms of need and opportunity. The eight priority areas are:

- **Priority Area 1:** Achieving integrated regional planning and service delivery.
- **Priority Area 2:** Effective suicide prevention.
- **Priority Area 3:** Coordinating treatment and supports for people with severe and complex mental illness.
- **Priority Area 4:** Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.
- **Priority Area 5:** Improving the physical health of people living with mental illness and reducing early mortality.
- **Priority Area 6:** Reducing stigma and discrimination.
- **Priority Area 7:** Making safety and quality central to mental health service delivery.
- **Priority Area 8:** Ensuring that the enablers of effective system performance and system improvement are in place.

The Fifth Plan includes actions that aim to achieve specific outcomes under each of the priority areas, set the direction for change and provide a foundation for longer-term system reform. These actions have been committed to by governments and are detailed in The Fifth National Mental Health and Suicide Prevention Plan Implementation Plan (Implementation Plan). Governments also identified 24 indicators that will be used to measure performance of the mental health and suicide prevention sector over the life of the Fifth Plan.

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 are making a difference. To this end, the NMHC has been given responsibility for delivering an annual report, for presentation to health ministers, on the implementation progress of the Fifth Plan and performance against the identified indicators.

This report constitutes the first of the NMHC's annual reports against the Fifth Plan. It outlines the progress achieved against the Implementation Plan actions as at 30 June 2018, and presents a baseline for the available performance indicators.

# Implementation of the Fifth National Mental Health and Suicide Prevention Plan

## Introduction and Methodology

The Implementation Plan details roles, responsibilities and tangible actions under each of the eight priority areas. The NMHC has responsibility for monitoring and reporting progress against these actions annually.

To inform this monitoring and reporting, the NMHC undertook a survey using an online consultation tool which was distributed to stakeholders in April 2018. Relevant stakeholders were identified against each action description of the Implementation Plan. A total of 51 stakeholders were identified, including: 31 Primary Health Networks (PHNs), eight state and territory government health departments, the Australian Government Department of Health, national and state mental health commissions and the relevant Australian Health Ministers' Advisory Council (AHMAC) sub-committees. Of these 51 identified stakeholders, the NMHC received 47 survey responses. The North Coast PHN (NSW), Gold Coast PHN (Qld), Murray PHN (Vic) and Western NSW PHN did not respond. These stakeholders cited lack of time and resources as key barriers to their participation in the survey.

The Fifth Plan is still in the early stages of implementation. As such, survey questions were limited to progress against actions that are already due for completion or are in the process of implementation. Stakeholders were not asked to respond to actions with milestone commencement dates beyond June 2018. Additionally, stakeholders were only asked questions relating to actions they are responsible for and were asked to rate the progress of their contribution to the action, rather than the progress of the action as a whole.

Survey questions were designed to provide a mix of quantitative and qualitative measures of progress against actions within each Priority Area of the Fifth Plan. Survey respondents were asked to self-report their progress, as of 30 June 2018, using a four point scale:

- **Behind Schedule** – progress against this action has not met its anticipated timelines and/or less progress has been made than required at this stage to meet the milestone(s) in the Fifth Plan.
- **On Track** – progress against this action has met its anticipated timelines and/or sufficient progress has been made at this stage to meet the milestone(s) in the Fifth Plan.
- **Ahead of Schedule** – progress against this action exceeds its anticipated timelines and/or sufficient progress has been made at this stage to meet the milestone(s) in the Fifth Plan.
- **Complete** – this action is complete/no further progress is required against this action.

Stakeholders were asked to rate the progress of their own contribution to actions. Therefore in cases where multiple stakeholders have roles under a single action, it is possible for stakeholders to have different ratings. In these cases, the rating of a single stakeholder may not reflect the overall progress of the action.

The NMHC also sought free text descriptions of the key achievements, barriers, and enablers to each stakeholder's contribution to the progress of Fifth Plan actions. Key emerging themes from these responses have been compiled by the NMHC and are documented below.

Participation of consumers and carers is paramount to achieving the objectives of the Fifth Plan. As such, the final element of the survey asked stakeholders to rate the level of participation and engagement of consumers and carers in implementing actions under the Fifth Plan.

Respondents rated participation and engagement against the following seven levels of engagement:

- 1** No involvement of consumers and/or carers.
- 2** Inform – providing consumers and/or carers with information to assist their understanding of an issue.
- 3** Consult – seeking feedback from consumers and/or carers on issues, options or to inform decision making.
- 4** Involve – working directly with consumers and/or carers to ensure their concerns and aspirations are understood and considered.
- 5** Collaborate – partnering with consumers and/or carers in developing options and decision making.
- 6** Empower – placing final decision making in the hands of consumers and/or carers.
- 7** Unsure what level of involvement has been used.

The NMHC wishes to acknowledge the limitations of the methodology used in this process, particularly in the reliance on self-reporting. To ensure integrity of the results, close analysis was undertaken by the NMHC and feedback was sought from key stakeholders in the development of the current report.

Consumers and carers are not tasked with implementing the Fifth Plan and as such were not an identified stakeholder for the survey described in this report. However, the NMHC will continue to engage consumers and carers in its ongoing work to monitor the impacts of reforms under the Fifth Plan.

## Future Planning

For the 2018 report, the NMHC sought responses from each stakeholder involved in the implementation of the Fifth Plan via a direct approach, and not through the committee structures responsible for coordinating the plan actions. Given the relative infancy of the Fifth Plan, this approach provided the NMHC with the opportunity to independently engage with stakeholders. In order to improve data collection for future reports, the NMHC will work with the relevant AHMAC sub-committees to implement a more efficient survey process, with the aim of increased participation from stakeholders in future years.

Going forward, the NMHC will also establish and convene a technical advisory group with representatives from state and territory governments to provide advice for the development of the 2019 report.

# Fifth Plan Implementation Progress – Survey Results

## Governance

### Responsible stakeholders

The Mental Health Expert Reference Panel (MHERP), the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group, the Mental Health Principal Committee (MHPC), the Suicide Prevention Project Reference Group (SPPRG), the Australian Government Department of Health and the state and territory government health departments were all identified as responsible stakeholders.

The NMHC notes that the Reducing Stigma and Discrimination Working Group was established after the Implementation Plan was endorsed by COAG. This group is also contributing to these actions, but was not surveyed for this report. Future progress reports will include progress updates from this working group.

All governance arrangements to oversee the implementation of the Fifth Plan are now well established.

### **ACTION i**

Governments will establish a Mental Health Expert Advisory Group that will advise AHMAC, through MHPC, on the implementation of the Fifth Plan and analyse progress.

The Australian Government Department of Health, the MHERP and the MHPC reported their progress as 'on track'. All state and territory government health departments reported their progress as 'on track'.

### **ACTION ii**

Governments will establish a Suicide Prevention Subcommittee that will report to MHPC on priorities for planning and investment.

The Australian Government Department of Health, the SPPRG and the MHPC reported their progress as 'on track'. All state and territory government health departments reported their progress as 'on track'.

### **ACTION iii**

Governments will establish an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee that will report to MHPC on priorities for planning and investment.

The MHPC, the Australian Government Department of Health and the state and territory government health departments all reported their progress as 'on track' and have established the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group (the current name for the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee).

Additionally, the MHPC were tasked with leading the joint development of Terms of Reference and membership for the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group and establishing a meeting schedule. The MHPC have reported their progress as 'on track'.

#### **ACTION iv**

Governments will renew the National Mental Health Policy. This review will begin in 2018 and be completed during the life of the Plan. It will be completed with sufficient time to inform development of any future National Mental Health and Suicide Prevention Plans under this Strategy.

The MHERP and the Australian Government Department of Health reported their progress as 'on track'. The MHPC reported their progress as 'behind schedule'.

No comments regarding achievements, barriers or enablers were sought for the Governance actions.

#### **Measuring and Reporting Change**

Stakeholders responsible for measuring and reporting change relating to the implementation plan include the Mental Health Information Strategy Standing Committee (MHISSC), the MHPC, the NMHC, the Australian Government Department of Health, and the state and territory government health departments.

#### **ACTION v**

Governments will request the National Mental Health Commission (NMHC) delivers an annual report, for presentation to Health Ministers, on the implementation progress of the Fifth Plan and performance against identified indicators once the baselines have been established.

The MHISSC, the MHPC and the state and territory government health departments all reported their progress as 'on track'.

Action v was further broken down into components for contributing stakeholders to address:

- (a) The Commonwealth will negotiate this activity with NMHC.
- (b) The NMHC will consult with jurisdictions on agreed data and reporting processes.
- (c) The Commonwealth will contribute Commonwealth data and information to the NMHC to facilitate the NMHC monitoring and reporting role.
- (d) MHISSC to work with NMHC to identify data sources and indicator specifications for agreed indicators, and to advise on processes for coordinating data submissions to the agreed reporting authority (NMHC) where data are available.

The Australian Government Department of Health and the NMHC both reported their progress as 'on track'.

#### **ACTION vii**

Governments will develop a longer term strategy for information and indicator development.

The sole stakeholder coordinating this action, the MHISSC, reported their progress as 'on track'.

No comments regarding achievements, barriers or enablers were sought for the Measuring and Reporting Change actions.

## Priority Area 1: Achieving integrated regional planning and service delivery

For consumers and carers, a lack of integration and agreement on care pathways and service entry thresholds creates frustration and leads to poor treatment continuity, difficulty in maintaining treatment and poorer treatment outcomes. It also leads to a loss of faith in the treatment system.

In the context 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 and carers. Integration can be implemented at different levels, but integration at any level can deliver better experiences and outcomes for consumers and carers.

Stakeholders responsible for contributing to actions under this Priority Area include the Australian Government Department of Health, the MHERP, the MHISSC, the MHPC, the NMHC, PHNs and the state and territory government health departments.

As reported by stakeholders, the level of engagement and participation with consumers and carers was largely focused on 'involving', 'consulting' and 'collaborating'. Two stakeholders (a PHN and a state government health department) reported no involvement of consumers or carers at this stage of implementation. Two stakeholders, both PHNs, also reported engagement and participation through 'empowerment' to achieve integrated regional planning and service delivery.

### ACTION 1.1

The development and public release of joint regional mental health and suicide prevention plans.

The Australian Government Department of Health, the MHPC and the NMHC all reported their progress as 'on track'.

This action was further broken down into components for contributing stakeholders to address:

#### (a) Achieving integrated regional planning and service delivery.

The health departments of South Australia and Victoria reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

#### (b) The development of joint regional mental health and suicide prevention plans.

Of the PHNs surveyed, Western Queensland, Murrumbidgee (NSW) and the Australian Capital Territory reported their progress as 'ahead of schedule', with Adelaide, Tasmania and Northern Queensland PHNs reporting their progress as 'behind schedule'. The remaining 20 PHNs reported their progress as 'on track'.

The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

#### (c) The public release of joint regional mental health and suicide prevention plans.

Of the PHNs surveyed, Western Queensland reported their progress as 'complete' and Murrumbidgee PHN (NSW) reported their progress as 'ahead of schedule'. Adelaide, Nepean Blue Mountains, Tasmania, Western Sydney, Country SA, North Western Melbourne, Northern Queensland, and Western Victoria PHNs reported their progress as 'behind schedule'. The remaining 17 PHNs reported their progress as 'on track'.

The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### ACTION 1.2

Providing guidance for the development of joint regional mental health and suicide prevention plans.

The Australian Government Department of Health and the MHPC reported their progress as 'on track'. Of the state and territory government health departments, South Australia and Victoria reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### **ACTION 1.3**

Developing a plan for ongoing development, refinement and application of the National Mental Health Service Planning Framework (NMHSPF).

The Victorian Department of Health and Human Services reported their progress as 'complete' and the South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

This action was broken down into further components for the Australian Government Department of Health to address:

- (a) governments will agree on the process for the ongoing refinement, application and resourcing of the NMHSPF
- (b) the Commonwealth will manage contractual arrangements with an expert provider for ongoing development of the NMHSPF.

The Australian Government Department of Health reported their progress on these actions as 'complete'.

### **ACTION 1.4**

Developing and releasing planning tools based on the NMHSPF and an evidence-based stepped care model.

The Victorian Department of Health and Human Services reported their progress as 'complete'. All other state and territory health departments reported their progress as 'on track'.

This action was further broken down into components for the Australian Government Department of Health to address:

- (a) governments will agree on licensing arrangements/agreements
- (b) the Commonwealth will issue licences to authorised users of the NMHSPF
- (c) the Commonwealth will release the planning tools and support materials and lead the provision of training to be provided by the Commonwealth-contracted expert provider.

The Australian Government Department of Health reported their progress against these actions as 'on track'.

### **ACTION 1.5**

Making available key national data to inform regional level understanding of service gaps, duplication and areas of highest need.

The MHISSC reported their progress as 'on track'. The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

This action was further broken down into components for the Australian Government Department of Health to address:

- (a) governments will contribute to relevant data for the development of regional data
- (b) the Commonwealth will use existing funding arrangements with the AIHW to facilitate this action.

The Commonwealth Department of Health reported their progress against these actions as 'on track'.

## **ACTION 2**

Governments will work with PHNs and LHNs to implement integrated planning and service delivery at the regional level. This will include:

### **ACTION 2.1**

Utilising existing agreements between the Commonwealth and individual state and territory governments for regional governance and planning arrangements.

The Australian Government Department of Health and all state and territory departments of health reported their progress as 'on track'.

### **ACTION 2.2**

Engaging with the local community, including consumers and carers, community managed organisations, ACCHS, NDIS providers, the NDIA, private providers and social service agencies.

The Australian Government Department of Health and the MHERP both reported their progress as 'on track'. Of the PHNs surveyed, Western Queensland and Central Queensland, Wide Bay and Sunshine Coast PHNs reported their progress as 'complete', and Adelaide, Western Sydney, Northern Queensland and Western Victoria PHNs reported their progress as 'behind schedule'. The remaining 21 PHNs reported their progress as 'on track'.

This action was further broken down into components for the state and territory government health departments to address:

- (a) PHNs and LHNs will work collaboratively to engage regional stakeholders in the regional planning and service delivery process.
- (b) Governments will strengthen existing partnerships with stakeholders to engage with the local communities.

The South Australian Government Department for Health and Wellbeing reported their progress against both of these actions as 'behind schedule'. All other state and territory government health departments reported their progress as 'on track'.

## **ACTION 2.3**

Undertaking joint regional mental health needs assessment to identify gaps, duplication and inefficiencies to make better use of existing resources and improve sustainability.

This action was further broken down into components for the contributing stakeholders to address:

- (a) PHNs and LHNs will work towards data sharing to map regional service provision and identify areas of duplication, inefficiency and service gaps.

The MHPC reported their progress as 'on track'. Of the PHNs surveyed, Tasmania, Western Sydney, Western Queensland, and Central Queensland, Wide Bay and Sunshine Coast PHNs reported their progress as 'ahead of schedule', and Adelaide, North Western Melbourne, and Northern Queensland reporting their progress as 'behind schedule'. The remaining 20 PHNs reported their progress as 'on track'.

The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

- (b) PHNs and LHNs will utilise the NMHSPF and other planning tools to facilitate regional needs assessment and planning.

The MHPC reported their progress as 'on track'. Of the PHNs surveyed, Central Queensland, Wide Bay and Sunshine Coast PHN reported their progress as 'complete', Western Queensland PHN reported their progress as 'ahead of schedule' and Adelaide, North Western Melbourne, Northern Queensland and South Eastern Melbourne PHNs reported their progress as 'behind schedule'. The remaining PHNs all reported their progress as 'on track'.

The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### **ACTION 2.5**

Developing joint, single regional mental health and suicide prevention plans and commissioning services according to those plans.

The MHPC reported their progress as 'on track'.

This action was further broken down into components for the contributing stakeholders to address:

- (a) PHNs and LHNs will jointly develop comprehensive regional mental health and suicide prevention plans.
- (b) PHNs and LHNs will use these plans to progressively guide service development and commissioning.

Of the PHNs surveyed, Western Queensland PHN reported their progress against these actions as 'ahead of schedule'. The Adelaide, Nepean Blue Mountains, Western Sydney, Northern Territory, Northern QLD, and Country SA PHNs reported their progress as 'behind schedule'. The remaining PHNs reported their progress against both of these actions as 'on track', with the exception of Hunter, New England and Central Coast PHN who reported their progress against part (a) jointly developing comprehensive prevention plans as 'on track', but their progress against part (b) using plans to progressively guide service development and commissioning as 'behind schedule'.

The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### **ACTION 2.6**

Identifying and harnessing opportunities for digital mental health to improve integration.

The MHPC reported their progress as 'on track'. Of the PHNs surveyed, Western Queensland, Perth South, Perth North and Country WA PHNs reported their progress as 'ahead of schedule', and Adelaide, Nepean Blue Mountains, Northern Territory, Country SA, and Hunter, New England and Central Coast PHNs reported their progress as 'behind schedule'. The remaining PHNs all reported their progress as 'on track'.

The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### **ACTION 2.7**

Developing region-wide multi-agency agreements, shared care pathways, triage protocols and information-sharing protocols to improve integration and assist consumers and carers to navigate the system.

The MHERP and the MHPC reported their progress as 'on track'. Of the PHNs surveyed, Adelaide, Nepean Blue Mountains, Country SA, Western Victoria, and South Eastern Melbourne PHNs reported their progress as 'behind schedule'. The remaining PHNs all reported their progress as 'on track'.

The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

## **ACTION 2.8**

Developing shared clinical governance mechanisms to allow for agreed care pathways, referral mechanism, quality processes and review of adverse events.

The MHPC reported their progress as 'on track'. Of the PHNs surveyed, Adelaide, Nepean Blue Mountains, Western Sydney, Country SA, Northern Queensland, Central Queensland, Wide Bay and Sunshine Coast, Western Victoria, and South Eastern Melbourne PHNs reported their progress as 'behind schedule'. The remaining PHNs all reported their progress as 'on track'.

The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### **Priority Area 1: Achievements**

The establishment of data sharing protocols and agreements were reported by multiple PHNs (South Eastern NSW, North Sydney, Western Sydney, Western Queensland, Country WA, Perth South and Perth North PHNs) as significant milestones to progressing integrated regional planning and service delivery. These data sharing agreements facilitate the sharing of pertinent data to inform needs assessment and service planning.

A number of PHNs also reported completion of regional service mapping (South Eastern Melbourne, Country SA, Western Victoria, and Gippsland PHNs) and needs assessments (Country SA PHN, Northern Sydney PHN, Northern Territory PHN, Gippsland PHN, Western Victoria PHN, Hunter, New England and Central Coast PHN, and South Eastern Melbourne PHN) to identify priority areas for service enhancement.

Consumer engagement and consultation was also reported as an achievement for PHNs, particularly in relation to the development of regional plans, stepped care planning, and specific populations such as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) people, the Culturally and Linguistically Diverse (CALD) community and young people.

### **Priority Area 1: Barriers**

Given the complexities involved with integrating planning and services at a regional level, a number of barriers were reported by PHNs and state and territory government health departments. PHNs noted that shared plans will be difficult to establish due to the diversity across health care systems and health care strategies, and the competing priorities of numerous stakeholder groups. This is further compounded by the diverse and disparate consumer types across jurisdictions and in regional areas.

Funding and resources were also reported as significant barriers to achieving integrated planning and delivery, with multiple PHNs noting a lack of dedicated funding to implement the Fifth Plan. Coordinating approaches across regions and negotiating resource contributions from stakeholders has been more time-consuming and labour intensive than anticipated for PHNs.

A number of PHNs and state and territory government health departments reported the changing timeframes and scope for regional plans, and the availability of guidance from the Australian Government Department of Health as critical barriers to progress.

A recurring barrier reported by PHNs was the difficulty in accessing region-specific data from national datasets and the paucity of region-specific data on vulnerable populations such as LGBTIQ people, young people and people with a refugee background. The challenge of synthesising data sets from different systems, across stakeholders with different platforms, and in some cases, a number of custodians, was also reported as a significant barrier.

As the NMHSPF is not applicable to regional areas or Aboriginal and Torres Strait Islander people in its current format, regional planning using this tool cannot commence. The NMHC notes that work is currently in progress to redevelop the NMHSPF to include these populations. PHNs also reported NMHSPF training sessions as inconvenient and where travel from remote areas is required, expensive to access.

## Priority Area 1: Enablers

Engagement with consumers and stakeholders was reported as an enabler to progress by a number of PHNs, with many reporting consumer consultation as critical to planning, governance, and the development of frameworks. A number of PHNs also reported the willingness of consumers and stakeholders to consult and collaborate as crucial for driving change to improve mental health programs and services. This includes utilising existing formal arrangements with service providers, committees, alliances and collaborative structures to leverage work in integrated planning and delivery.

A number of state and territory government health departments reported committee structures such as the National Mental Health Service Planning Framework Steering Committee,

and the MHERP working groups as integral for coordinating approaches and information sharing. With representatives from the Australian Government Department of Health, state and territory governments, non-government organisations, peak bodies and consumer and carer representatives, these committees provide a platform for jurisdictional representatives to engage directly with the Australian Government and other key stakeholders on issues relevant to the Fifth Plan and joint planning activities.

A number of state and territory government health departments also reported the NMHSPF as a reliable tool for enabling joint planning activities within regions.

## Priority Area 2: Suicide prevention

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. Suicide prevention is a complex area of policy with interconnected responsibilities—government agencies, service providers and the community-managed sector all have a role in reducing suicide rates through effective suicide prevention responses.

Stakeholders responsible for coordinating these actions include the MHPC and the SPPRG.

As reported by stakeholders, the level of engagement and participation with consumers and carers was largely focused on ‘collaborating’.

### **ACTION 3**

Governments will establish a new Suicide Prevention Subcommittee of MHPC to set future directions for planning and investment.

The MHPC reported their progress as ‘on track’.

### **ACTION 4**

Governments will, through the Suicide Prevention Subcommittee of MHPC, develop a National Suicide Prevention Implementation Strategy that operationalises the 11 elements above taking into account existing strategies, plans and activities.

The MHPC and the SPPRG both reported their progress as ‘on track’.

## Priority Area 2: Achievements

No significant or common achievements were identified across stakeholder groups at this point in time.

## Priority Area 2: Barriers

No significant or common barriers were identified across stakeholder groups at this point in time.

## Priority Area 2: Enablers

Enablers of note included the commitment and expertise of the members of the established groups, with both reporting that the willingness of members to collaborate and work together to draft an effective and meaningful strategy is the key enabler at this stage in the process. The inclusion of members with lived experience on the SPPRG was also highlighted as a critical enabler to ensuring that National Suicide Prevention Implementation Strategy is designed to support the cohort it is intended to support.

### **Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness**

The needs of people with severe mental illness are not homogenous. Some people have episodic illness. Others have more persistent illness that can reduce their ability to function, experience full physical health or manage the day-to-day aspects of their lives. Some people can be supported through time-limited clinical services in the primary care setting, while others require hospital-based services or some form of community support.

Despite ongoing efforts by governments and service providers, many people with severe and complex mental illness still do not receive the supports they need.<sup>1</sup>

Stakeholders responsible for contributing to Priority Area 3 actions include the Australian Government Department of Health, the PHNs, and the state and territory government health departments.

As reported by stakeholders, the level of engagement and participation with consumers and carers was largely focused on ‘consulting’, ‘informing’ and ‘involving’. Three stakeholders (one PHN and two state government health departments) reported no involvement of consumers or carers at this stage of implementation. Two PHNs also reported engagement and participation through ‘empowerment’ to coordinate treatment and supports for people with severe and complex mental illness.

#### **ACTION 6**

**Governments will negotiate agreements that prioritise coordinated treatment and supports for people with severe and complex mental illness.**

The Australian Government Department of Health reported their progress as ‘on track’. The Western Australia Department of Health reported their progress as ‘ahead of schedule’. All other states and territory health departments reported their progress as ‘on track’.

#### **ACTION 7**

**Governments will require PHNs and LHNs to prioritise coordinated treatment and supports for people with severe and complex mental illness at the regional level and reflect this in regional planning and service delivery.**

Of the PHNs surveyed, Western Queensland and Hunter, New England and Central Coast PHNs reported their progress as ‘ahead of schedule’ and Adelaide, Nepean Blue Mountains, and Northern Territory PHNs reported their progress as ‘behind schedule’. The Western Australian and South Australian health departments reported their progress as ‘behind schedule’. All other state and territory health departments reported their progress as ‘on track’.

Action 7 was further broken down into three components for the Australian Government Department of Health to address:

- (a) directing PHNs to plan and commission services for people with severe and complex mental illness through PHN funding agreements
- (b) using joint guidance material on regional plans to outline their expectations of PHNs and LHNs for coordinated treatment and supports for people with severe and complex mental illness

The Australian Government Department of Health reported their progress against these actions as ‘on track’.

#### **ACTION 9**

**Governments will develop, implement and monitor national guidelines to improve coordination of treatment and supports for people with severe and complex mental illness.**

The Australian Government Department of Health reported their progress against these actions as ‘on track’.

### Priority Area 3: Achievements

A number of common achievements were reported across stakeholder groups for Priority Area 3. For three state and territory government health departments (Qld, NSW and Vic), a bilateral agreement with the Australian Government Department of Health for the National Psychosocial Support Measure have been successfully negotiated. The NMHC notes that all states and territories have executed this agreement with the Australian Government since Fifth Plan reporting commenced. This agreement enables the state government health departments to provide non-clinical support for people with severe mental illness who are not more appropriately supported by the National Disability Insurance Scheme (NDIS).

Achievements reported by PHNs were diverse. Eleven PHNs have commissioned, or are in the process of commissioning, a review and redesign of mental nursing services in their region. These services build upon and replace the 'Mental Health Nurse Incentive Program'. By redesigning these services, PHNs have increased service access, encompassed a broader scope, and increased flexibility in delivering mental health nurse-led services to people living with severe or complex mental illness.

Support for young people living with severe or complex mental illness was another area where PHNs reported achievements. This included the following:

- commissioning services for young people with or at risk of severe or complex mental illness (North Western Melbourne PHN, Country WA PHN and Tasmania PHN)
  - commissioning trauma informed clinics for youth (Northern Queensland PHN)
  - commissioning dialectical behaviour therapy clinics for youth (Northern Queensland PHN)
  - co-locating mental health nurses with headspace (South Western Sydney PHN)
  - collaborating with Local Health Networks (LHNs) to design and implement a model of care with headspace services (Adelaide PHN),
  - introducing suicide prevention positions in two headspace centres (Northern Queensland PHN)
- targeting hard-to-reach young people to provide evidence-based and focused psychological interventions (Murrumbidgee PHN)
  - co-designing and procuring Youth Complex Services with a young consumer at each stage of the process (Hunter, New England and Central Coast PHN).

A number of PHNs also reported making improvements to support and access to referral services for general practitioners (GPs). These improvements include the development of an online appointment system for GPs to quickly access psychiatric appointments for their patients (Adelaide PHN), the co-design of an integrated general practice setting to provide coordinated care for people living with persistent mental illness (South Western Sydney PHN), and the co-commission of a telephone psychiatry support line for GPs (South Eastern NSW PHN and Northern Sydney PHN) – allowing clinicians to consult directly with psychiatrists on the treatment and management plans of patients living with severe or complex mental illness.

### Priority Area 3: Barriers

The transition to the NDIS was a barrier reported by multiple state and territory government health departments, with regard to coordinating treatment and supports. Respondents noted that the transition increased complexity for LHNs and PHNs in coordinating care in partnership with a rapidly growing range of NDIS providers, and that the transition of funding to the NDIS is likely to affect the ability to maintain existing community-based psychosocial support services. The perceived delay by the Australian Government Department of Health and the National Disability Insurance Agency (NDIA) in acknowledging that the NDIS has not properly accounted for mental illness as a psychosocial disability was also reported as a barrier to achieving coordinated treatment for people with severe and complex mental illness.

Two state government health departments noted that joint guidance material on regional mental health and suicide prevention plans is yet to be distributed by the Australian Government Department of Health. As a consequence, these governments have been unable to commence facilitating agreements between PHNs and LHNs for coordinated treatment and supports for people living with severe and complex mental illness. The NMHC notes that this action is due for completion in mid-2018.

As with the state and territory government health departments, the transition to the NDIS was reported as a barrier for a number of PHNs. Respondents noted that the impact of the NDIS was unknown in a number of regions, including the effect the NDIS would have on the capacity of community mental health service providers, and the cessation of some support services. The national delays in transitioning people to the scheme were also reported to be a significant barrier to the coordination of treatment and supports.

A common barrier identified by PHNs was the NMHSPF, with respondents noting that rurality and Aboriginal and Torres Strait Islander status are not captured in the NMHSPF. The training required to use the NMHSPF was also reported as a barrier, given the time and resources required to access the training sessions. Resistance to change was reported as a barrier by four PHNs who commented that providers were unhappy with service redesign and that the time taken to establish a new service and to gain the trust of referring providers and client groups was significant.

The transition between secondary and primary care was reported by six PHNs as a barrier to coordinating treatment and supports for people with severe and complex mental illness. Respondents noted that the inconsistency of shared care protocols between primary and secondary care, and the absence of defined clinical pathways, complicated the effective provision of support services. This also included the lack of a community-based mental health strategy to assist with the provision of these services in some regions.

The final common barrier identified across PHNs was the lack of dedicated funding to drive the coordination of treatment and supports. PHNs reported that funding uncertainty and variability were significant barriers, as well as the lack of flexibility in funding activities that focus on integration and psychosocial support. PHNs also reported the need for more clarity around the timeframe and focus of Australian Government funding for psychosocial supports.

### **Priority Area 3: Enablers**

A number of PHNs reported that consultation with consumers and carers and engagement with experienced service providers (including GPs and Aboriginal Community Controlled Health Services (ACCHS)) were significant enablers to progress. PHNs also reported the shared commitment between stakeholders to provide consumers with coordinated treatment and support as an enabler to driving change and progressing actions. Existing service and joint planning agreements, committee structures, and collaborations were reported by many PHNs as critical enablers for success.

Stepped care guidelines were reported by multiple PHNs as enabling alignment with the needs of the people in their region and assisting with the reform process.

State and territory governments reported their strong partnerships with PHNs and LHNs as significant enablers for supporting the establishment of arrangements for coordinated treatment and supports for people living with severe and complex mental illness.

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

Aboriginal and Torres Strait Islander people have consistently higher rates of psychological distress, mental illness and suicide than non-Indigenous Australians, and face multiple barriers when accessing appropriate services and supports. These barriers include the cost of health services, the cultural competence of the service, remoteness and availability of transport and the attitudes of staff. Racism continues to have a significant impact on Aboriginal and Torres Strait Islander peoples' decisions about when and why they seek health services and their acceptance of and adherence to treatment.<sup>2</sup>

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 a culturally capable model of health care. This approach needs an appropriate balance of clinical and culturally informed mental health system responses, including access to traditional and cultural healing.

Stakeholders responsible for contributing to the Fifth Plan actions include the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group, the Australian Government Department of Health, MHISSC, MHPC, PHNs and state and territory government health departments.

As reported by stakeholders, the level of engagement and participation with consumers and carers was largely focused on 'involving' and 'consulting'. Three stakeholders (one AHMAC sub-committee and two PHNs) reported no involvement of consumers or carers at this stage of implementation. Six stakeholders (five PHNs and one state government health department) also reported engagement and participation through 'empowerment' to improve mental health and suicide prevention for Aboriginal and Torres Strait Islander people.

### ACTION 10

Governments will work with PHNs and LHNs to implement planning and service delivery for Aboriginal and Torres Strait Islander peoples at the regional level.

The MHPC reported their progress as 'on track'.

This action was further broken down into specific actions for contributing stakeholders to address:

(a) **Engaging Aboriginal and Torres Strait Islanders communities in the co-design of all aspects of regional planning and service delivery.**

Of the PHNs surveyed, Western Queensland PHN reported their progress as 'complete', Western Sydney PHN reported their progress as 'ahead of schedule', and Adelaide PHN, Hunter, New England and Central Coast PHN, and South Eastern Melbourne PHN reported their progress as 'behind schedule'. The remaining 22 PHNs reported their progress as 'on track'. The South Australian and Victorian health departments reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

(b) **Collaborating with service providers regionally to improve referral pathways between GPs, ACCHS, social and emotional wellbeing services, alcohol and other drug services, and mental health services.**

Of the PHNs, Western Queensland PHN reported their progress as 'ahead of schedule' and Adelaide PHN reported their progress as 'behind schedule'. The remaining 25 PHNs reported their progress as 'on track'. The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory departments reported their progress as 'on track'.

(c) **Ensuring that there is strong presence of Aboriginal and Torres Strait Islander leadership on local mental health service and related area service governance structures.**

Of the PHNs, Western Queensland PHN reported their progress as 'ahead of schedule', with Tasmania PHN, North Western Melbourne PHN, Central Queensland, Wide Bay and Sunshine Coast PHN, Western Victoria PHN and Hunter, New England and Central Coast PHN reporting their progress as 'behind schedule'. The remaining 21 PHNs, as well as all state and territory government health departments reported their progress as 'on track'.

#### **ACTION 11**

Governments will establish an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention subcommittee of MHPC that will set future directions for planning and investment.

The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group and the MHPC both reported their progress as 'on track'.

#### **ACTION 12**

Governments will improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with ACCHS and other service providers by:

##### **ACTION 12.1**

Developing and distributing a compendium of resources.

The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group and the MHPC both reported their progress as 'on track'.

##### **ACTION 12.2**

Increasing knowledge of social and emotional wellbeing concepts, improving the cultural competence and capability of mainstream providers, and promoting the use of culturally appropriate assessment and care planning tools and guidelines.

The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group and the MHPC both reported their progress as 'on track'.

#### **ACTION 12.3**

Recognising and promoting the importance of Aboriginal and Torres Strait Islander leadership and supporting implementation of the Gayaa Dhuwi (Proud Spirit) declaration.

The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group and the MHPC both reported their progress as 'on track'.

#### **ACTION 12.4**

Training all staff delivering mental health services to Aboriginal and Torres Strait Islander peoples in trauma-informed care.

The Australian Government Department of Health, the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group and the MHPC, all reported their progress as 'on track'. The Queensland Department of Health reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

#### **ACTION 13**

Governments will strengthen the evidence base needed to improve mental health services and outcomes for Aboriginal and Torres Strait Islander peoples through:

##### **ACTION 13.1**

Establishing a clearinghouse of resources, tools and program evaluations for all settings to support the development of culturally safe models of service delivery.

The Australian Government Department of Health, the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group, and the MHPC all reported their progress as 'on track'.

##### **ACTION 13.2**

Ensuring that all mental health services work to improve the quality of identification of Indigenous people in their information systems through the use of appropriate standards and business processes.

The MHISSC reported their progress as 'on track'.

### **ACTION 13.3**

Ensuring future investments are properly evaluated to inform what works.

The Australian Government Department of Health and the MHPC reported their progress as 'on track'. The Queensland Department of Health reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### **ACTION 13.4**

Reviewing existing datasets across all settings for improved data collection on the mental health and wellbeing of, and the prevalence of mental illness in, Aboriginal and Torres Strait Islander peoples.

The MHISSC reported their progress as 'on track'.

### **ACTION 13.5**

Utilising available health services data and enhancing those collections to improve services for Aboriginal and Torres Strait Islander peoples.

The Australian Government Department of Health and the MHISSC reported their progress as 'on track'.

## **Priority Area 4: Achievements**

Multiple achievements were reported by PHNs as they work towards improving mental health and suicide prevention for Aboriginal and Torres Strait Islander people. A number of new services and programs that are specifically tailored to Aboriginal and Torres Strait Islander communities have been commissioned (and in some cases, already introduced) to provide culturally appropriate service access for mental health, suicide prevention and young people with severe mental illness. These services range from community-based peer support programs (Hunter, New England and Central Coast PHN) to suicide after-care programs in major hospitals (Central and Eastern Sydney PHN), to integrated social and emotional health and wellbeing services across Aboriginal Medical Services (Brisbane North PHN), and an Aboriginal Mental Health and Suicide Prevention service (Northern Sydney PHN).

State and territory government health departments also reported the implementation of programs to support Aboriginal and Torres Strait Islander peoples' mental health in early intervention (NSW) and family wellbeing (WA).

Co-designing services with Aboriginal and Torres Strait Islander stakeholders was also reported as an achievement for a number of PHNs. This involved engaging directly with Aboriginal and Torres Strait Islander service providers, community members and elders, as well as ACCHSs in the region to develop support services for mental health, suicide prevention and psychosocial support.

State and territory health departments also reported their involvement and engagement with Aboriginal and Torres Strait Islander people through advisory groups and Project Reference Groups as key achievements.

A significant achievement for both PHNs and state and territory governments was the introduction of dedicated positions for Aboriginal and Torres Strait Islander people in mental health services, as well as clinical positions in mental health to support Aboriginal and Torres Strait Islander people. These resources include a 'grow local' program to increase the mental health workforce capacity in local regions (Country WA PHN), introducing a mental health clinician on site at an Aboriginal and Torres Strait Islander college (Northern Queensland PHN), and funding Aboriginal and Torres Strait Islander traineeship positions in the state budget (Victorian Department of Health and Human Services). The Western Australian State Government Health Department also reported that the Western Australia Mental Health Commission have engaged suicide prevention officers to integrate social and emotional wellbeing activities into Aboriginal communities.

A number of respondents reported the provision of education and/or cultural training and other resources for GPs and other health care providers as critical tools for improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Achievements in this area include:

- The development of an Aboriginal module under the evidence-based Connecting with People training program – a trauma informed approached for use with mainstream providers as well as Aboriginal health services and communities (South Australian Government Department for Health and Wellbeing).

- Development of the Aboriginal Mental Health Clinical Practice Guideline and Pathways – a culturally appropriate guide for working with Aboriginal and Torres Strait Islander mental health consumers, to support mainstream clinicians to provide culturally competent practices to Aboriginal and Torres Strait Islander people (South Australian Government Department for Health and Wellbeing).
- Commissioning the Aboriginal Health Council of Western Australia to develop Cultural Competence Training for GPs in Mental Health (Perth North PHN, Perth South PHN and Country WA PHN) and the provision of cultural competence training for GPs and other primary health service providers (Tasmania PHN).
- The provision of Aboriginal and Torres Strait Islander focused workshops on suicide awareness and training (Western Victoria PHN).
- A national forum and workshop to explore suicide prevention strategies, interventions, and follow-up care with a focus on integrating cultural and professional expertise (Country SA PHN).

#### Priority Area 4: Barriers

A number of PHNs as well as the Queensland Department of Health reported funding as a barrier to improving Aboriginal and Torres Strait Islander mental health and suicide prevention. The specific funding barriers presented varied between stakeholders, and included challenges integrating social and emotional health services with multiple funding sources, funding restrictions due to siloed approaches to health and wellbeing issues, and the inconsistent level of resources and support for mainstream organisations to have a well-developed, inclusive approach for Aboriginal and Torres Strait Islander people. The Queensland Department of Health also noted that the lack of funding and support from the Australian Government to implement these Fifth Plan actions was a barrier to progress.

The lack of clarity around roles, responsibilities and guidance materials was reported as a barrier for a number of PHNs, particularly in relation to implementation and accountability. The NMHC notes that guidance for PHNs and LHNs on joint regional plans is due to be developed by governments by mid-2018. This guidance will outline the expectations regarding integrated planning and service delivery for Aboriginal and Torres Strait Islander people including expectations for involvement of ACCHSs and Aboriginal and Torres Strait Islander communities, engagement of Aboriginal and Torres Strait Islander helpers and peer workers, operationalising the cultural respect framework within regional mental health service systems, and governance structures and mechanisms being inclusive of the Aboriginal and Torres Strait Islander perspective.

PHNs also reported the lack of a suitable workforce to provide mental health and suicide prevention support as a barrier to progression, with many noting that the provision of cultural safety as key to achieving the best outcomes for Aboriginal and Torres Strait Islander people. The insufficient pool of appropriate professionals – as well as the low retention rates for the Aboriginal and Torres Strait Islander mental health and suicide prevention workforce – are significant barriers to the provision of services to the Aboriginal and Torres Strait Islander communities.

Another critical barrier reported by PHNs is the time and resources required to genuinely consult and engage with Aboriginal and Torres Strait Islander people. In order to develop meaningful relationships based on mutual trust, prolonged periods of ongoing engagement are necessary. Failing to develop and maintain these strong ties with communities are barriers to improving mental health and suicide prevention. The Western Australia Department of Health reported that without robust community consultation, the implementation of new funding and introduction of new specialist roles in the Western Australia region can cause confusion and animosity within communities and for stakeholders.

The lack of data on Aboriginal and Torres Strait Islander health was reported as a significant barrier by many PHNs. The stigma and discrimination associated with identifying as an Aboriginal or Torres Strait Islander person means that Indigenous status is often not captured when people access health services. This is further compounded by incomplete census data on the Aboriginal and Torres Strait Islander population, due to underreporting. This lack of data can result in services for Aboriginal and Torres Strait Islander populations not being appropriately designed or adequately funded, as the extent and needs of the population are not well defined.

#### **Priority Area 4: Enablers**

Despite many PHNs reporting the time and resources required to engage with Aboriginal and Torres Strait Islander people as a barrier, PHNs acknowledged that engagement with these communities is a critical enabler to improving mental health and suicide prevention. Engagement through collaboration and partnerships with Indigenous organisations, committees, councils and forums, and direct consultation with local communities and elders frequently resulted in strong relationships and enabled a greater understanding of approaches that are culturally appropriate. Specifically, a number of PHNs reported their strong relationships with local ACCHSs as crucial enablers, with many reporting the development of partnerships for joint service planning.

State and territory government health departments also reported engagement as a critical enabler, as it allowed for the provision of direct advice on social and emotional wellbeing, and mental health and suicide prevention services from Aboriginal and Torres Strait Islander peoples.

A small number of PHNs reported dedicated funding for Aboriginal and Torres Strait Islander health, mental health and drug and alcohol initiatives as enablers to progress. Funding flexibility to enable demonstration of new initiatives as a result of consultation with Aboriginal and Torres Strait Islander communities was also reported as an enabler.

Resources have also been made available to implement several Fifth Plan actions under the Queensland Department of Health's Connecting Care to Recovery 2016-2021 plan and the South Australian Government Department for Health and Wellbeing's Closing the Gap and the South Australian Suicide Prevention Plan 2017-2022.

## Priority Area 5: Improving the physical health of people living with mental illness and reducing early mortality

People living with mental illness have poorer physical health than other Australians, as their physical health needs are often overshadowed by their mental health condition. Ensuring that people living with mental illness receive better screening for physical illness, and that interventions are provided early as part of a person-centred treatment and care plan, will be critical to improving the long-term physical and mental health outcomes for people living with mental illness and people with a chronic or debilitating illness who may be at higher risk of a mental illness. 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.

Stakeholders responsible for contributing to these actions include the Australian Government Department of Health, the MHPC, the MHISSC, the NMHC, PHNs, state and territory government health departments and the state mental health commissions.

As reported by stakeholders, the level of engagement and participation with consumers and carers was largely focused on 'informing' and 'consulting'. Three stakeholders (one state government health department and two PHNs) reported no involvement of consumers or carers at this stage of implementation. Five stakeholders (three PHNs, one state government health department and a state government mental health commission) also reported engagement and participation through 'empowerment' to improve the physical health of people living with mental illness.

### ACTION 14

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Governments commit to the elements of Equally Well – The National Consensus Statement for improving the physical health of people living with mental illness in Australia.

The Australian Government Department of Health, NMHC and state mental health commissions all reported their progress as 'on track'. The New South Wales Ministry of Health reported their progress as 'ahead of schedule' and the Tasmanian Department of Health and Human Services and the South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### ACTION 15

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Governments will develop or update guidelines and other resources for use by health services and health professionals to improve the physical health of people living with mental illness.

The Australian Government Department of Health and the MHPC reported their progress as 'on track'. The South Australian Government Department for Health and Wellbeing and the Tasmanian Department of Health and Human Services reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### ACTION 16

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Governments will work with PHNs and LHNs to build into local treatment planning and clinical governance the treatment of physical illness in people living with mental illness by:

### **ACTION 16.1**

Including it as part of joint service planning activity between PHNs and LHNs.

The Australian Government Department of Health and the MHPC reported their progress as 'on track'.

Of the PHNs surveyed, Western Queensland PHN reported their progress as 'ahead of schedule' with Adelaide PHN, Nepean Blue Mountains PHN, Northern Territory PHN, North Western Melbourne PHN, Northern Queensland PHN, and Central Queensland, Wide Bay and Sunshine Coast PHN reporting their progress as 'behind schedule'. All other PHNs reported their progress as 'on track'.

This action was further broken into down components for the state and territory government health departments to address:

- (a) **Governments will use joint guidance material on regional plans to outline their expectations of PHNs and LHNs for the inclusion of mechanisms to support the physical health of people living with mental illness in joint service planning activity.**

The Western Australian, South Australian, and Victorian health departments reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.
- (b) **PHNs and LHNs will jointly release regional plans that include mechanism to support the physical health needs of people living with mental illness.**

The Western Australia Department of Health and the South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### **ACTION 16.2**

Including it as part of joint clinical governance activity.

The Australian Government Department of Health and the MHPC reported their progress as 'on track'.

The Tasmanian, Western Australian, Victorian and South Australian state government health departments reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### **ACTION 17**

Governments will commence regular national reporting on the physical health of people living with mental illness.

The Australian Government Department of Health and the MHSSC reported their progress as 'on track'.

The South Australian Government Department for Health and Wellbeing reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

This action was further broken down into components for the MHSSC to address:

- (a) **Identify mechanism for reporting on the physical health of Australians with mental illness.**
- (b) **Develop one or more nationally-consistent performance indicators on the physical health of Australians with mental illness.**
- (c) **Identify strategies for ongoing analysis and reporting of the mortality gap for Australians with mental illness.**

The MHSSC reported their progress against these actions as 'on track'.

## Priority Area 5: Achievements

Following the launch of the Equally Well Consensus Statement, the NMHC has confirmed pledges of support from 73 organisations for the National Consensus Statement. This includes all state and territory government health departments, 15 PHNs and five professional colleges and associations. The consensus statement articulates a national vision to improve the quality of life of people living with mental illness by providing equity of access to quality health care, with the ultimate aim of bridging the life expectancy gap between people living with mental illness and the general population.

Multiple PHNs (Northern Sydney PHN, Central and Eastern Sydney PHN, Perth South PHN, Perth North PHN and Country WA PHN) report introducing education and training to GPs about the management of physical health issues for people living with mental illness. The Queensland Department of Health also reported the provision of physical health training and educational events to clinicians employed by Queensland Health.

Increased and improved access to health providers for people living with mental illness was also reported as a significant achievement for multiple PHNs. This improved access includes the implementation of primary mental health clinical care coordinators to support improved access to metabolic monitoring in primary care for individuals living with mental illness (Adelaide PHN), a GP mental health shared care program to improve mental and physical health outcomes (Country SA PHN), a trial of telehealth services to assist people with a chronic physical condition to manage mental health problems and conditions (Country WA PHN), and the introduction of shared care nurses into general practices to assess and support patients living with mental illness and chronic disease (Western Queensland PHN and Central and Eastern Sydney PHN).

The phased implementation of a Mental Health Stepped Care Model, to link consumers back to their GP, will ensure physical health, mental health, and other social support needs are addressed holistically (Eastern Melbourne PHN). Similarly, the Western Australian Mental Health Commission has also provided an individualised community-based support program for people living with a severe mental illness, which supports a holistic person-centred approach to physical and mental health wellbeing.

A number of recently commissioned and implemented programs and initiatives were also reported as achievements by PHNs and state and territory government health departments. These include a healthy living workgroup to improve the impact of health conditions on mental health (Darling Downs and West Moreton PHN), a peer-led initiative aimed at improving the physical health of people living with mental illness (South Eastern NSW PHN), the development of Health Care Home which allows GPs to support patients with chronic disease (Western Sydney PHN), a smoking cessation program for people living with mental illness (Gippsland PHN), and the launch of My Medicines and Me – a collaborative tool for consumers to understand, track and communicate side-effects of medications to their health care professional (Western Australia Department of Health).

## Priority Area 5: Barriers

Funding was reported as a barrier by a number of PHNs, particularly in relation to the lack of a clear funding mechanism to address physical health issues. PHNs also reported limitations of existing funding structures and segmented funding arrangements as barriers to improving physical health for people living with mental illness, through programs and initiatives.

The reluctance of GPs to provide support to patients living with mental illness was reported as a barrier, with multiple PHNs noting that GPs need to be empowered to care for patients with complex needs through the provision of education and training. A number of these PHNs reported the implementation of GP education and training as achievements, with the aim of overcoming this barrier in future.

The fragmentation of services and the transition between primary and secondary care were reported as significant barriers by a number of PHNs, with many noting that improved transition mechanisms between services are required to progress this priority area. The Western Australia Department of Health, the Western Australian Mental Health Commission and the Queensland Mental Health Commission also reported limited formal arrangements to support the integration of community mental health support services and primary health care service, and the lack of a coordinated, integrated approach as cumbersome and complex for consumers to navigate.

## Priority Area 5: Enablers

My Health Record was reported by a number of PHNs as an enabler to improving communication and transition between services for people living with complex health needs. The centralisation of personal health data enables consumers to operate within a system that considers all of their health needs, which is critical for improving the physical health of people living with mental illness.

PHNs also reported the level of engagement with GPs as a crucial enabler to improving physical health. This includes involving GPs in model designs, and working closely with medical practices to improve working relationships and communications between services.

The willingness and ability to develop more integrated services was reported as an enabler by a number of PHNs. This includes developing Collaborative Care Plans for patients engaged with multiple service providers, integrating funded programs and internal portfolios, and participating in networks to share best practice. Furthermore, the Queensland Mental Health Commission reported that service providers in the region were collaborating and consulting with consumers to develop, deliver, and review numerous health promotion, prevention and early intervention programs. Partnerships across government, NGOs and the private sector were also found to be enabling the integration of service delivery.

## Priority Area 6: Reducing stigma and discrimination

Reducing stigma and discrimination is critical to improving the wellbeing of people living with mental illness 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 illness still experience significant stigma. A sustained, collective effort is needed to dispel the myths associated with mental illness, change ingrained negative attitudes and behaviours and, ultimately, support social inclusion and recovery.

Stakeholders responsible for contributing to these actions include the Australian Government Department of Health, the MHERP, the MHPC and the NMHC.

A dedicated Reducing Stigma and Discrimination Working Group has also been established since implementation of the Fifth Plan commenced. This group is also contributing to these actions but was not surveyed for this report. Future progress reports will include progress updates from this working group.

As reported by stakeholders, the level of engagement and participation with consumers and carers was largely focused on 'consulting' and 'collaborating'.

### **ACTION 18**

Governments will take action to reduce the stigma and discrimination experienced by people with mental illness that is poorly understood in the community.

This action item was further broken down into components for stakeholders to address:

- (a) **The Commonwealth Department of Health will engage an expert provider to undertake a review of existing initiatives and evidence to inform the approach to implementation of this action.**  
The Australian Government Department of Health have reported their progress as 'complete'.
- (b) **The Commonwealth government and the MHPC will lead targeted consultations on options for a nationally coordinated approach to stigma and discrimination reduction.**  
The Australian Government Department of Health and the MHPC have both reported their progress as 'on track'.
- (c) **The MHPC will propose the direction to AHMAC for collaborative future government action.**  
The MHPC have reported their progress as 'on track'.

## **ACTION 19**

Governments will reduce stigma and discrimination in the health workforce by:

- **Action 19.1:** developing and implementing training programs that build awareness and knowledge about the impact of stigma and discrimination
- **Action 19.2:** responding proactively and providing leadership when stigma or discrimination is seen
- **Action 19.3:** empowering consumers and carers to speak about the impacts of stigma and discrimination.

The MHERP and the MHPC have reported their progress against all three actions as 'on track'.

## **ACTION 20**

Governments will ensure that the Peer Workforce Development Guidelines to be developed in Priority Area 8 create role delineations for peers workers and identify effective anti-stigma interventions with the health workforce.

The MHPC and the NMHC have reported that their progress is 'on track'.

## **Priority Area 6: Achievements**

No significant or consistent achievements were identified in responses across stakeholder groups.

## **Priority Area 6: Barriers**

The NMHC noted the need to provide clarification to PHNs regarding the differences between two sets of guidelines currently in development. The NMHC will commence work on the Fifth Plan Peer Workforce Development Guidelines upon finalisation of the Peer Workforce Guidance for PHNs in mid-2018 to reduce confusion between the two pieces of work. Engagement with PHNs will be ongoing.

## **Priority Area 6: Enablers**

As reported by stakeholders, current enablers to reducing stigma and discrimination include the direct engagement with consumer and carer representatives as well as the Mental Health Reform Stakeholder Group. National targeted consultations will also inform the development of the Fifth Plan Peer Workforce Development Guidelines as lead by the NMHC.

## Priority Area 7: Making safety and quality central to mental health service delivery

Safety and quality have been integral to mental health reform over the past three decades and the subject of significant collaboration between governments. A safe health system minimises or avoids potential or actual harm to consumers. A quality health system provides the right care to consumers, improves health outcomes for consumers, and optimises value. When combined, the concepts of safety and quality promote a focus on the things that are right, as well as looking at what goes wrong, in healthcare.

Stakeholders responsible for contributing to these actions include the Australian Government Department of Health, the MHISSC, the MHPC, the NMHC, the Safety and Quality Partnership Standing Committee (SQPSC) and the state and territory government health departments.

As reported by stakeholders, the level of engagement and participation with consumers and carers was largely focused on 'involving', 'informing' and 'collaborating'. Two state government health departments, also reported engagement and participation through 'empowerment' to ensure safety and quality are central to mental health service delivery.

### **ACTION 21.1**

Identifying new and emerging national safety and quality priorities, and updating the 2005 statement of National Safety Priorities in Mental Health.

The SQPSC has reported their progress as 'on track'

### **ACTION 21.3**

A guide for consumers and carers that outlines how they can participate in all aspect of what is undertaken within a mental health service.

The SQPSC and the NMHC have both reported their progress as 'on track'.

### **ACTION 21.5**

Coverage of all relevant service delivery sectors.

The SQPSC has reported their progress as 'on track'.

### **ACTION 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.

The MHISSC has reported their progress as 'on track'.

### **ACTION 24**

Governments will develop an updated statement on National Mental Health Information Priorities for information developments over the next ten years.

The MHISSC has reported their progress as 'on track'.

### **ACTION 25**

Governments will ensure service delivery systems monitor the safety and quality of their services and make information on service quality performance publicly available.

The SQPSC has reported their progress as 'on track'

### **ACTION 26**

Governments will improve consistency across jurisdictions in mental health legislation.

The SQPSC and the MHPC have both reported their progress as 'on track'.

## **ACTION 27**

**Governments will make accessible the WHO Quality Rights guidance and training tools.**

SQPSC has reported their progress as 'on track'. The NMHC notes that due to the high cost of implementation, MHPC did not support the initial proposal to fund the World Health Organization (WHO) Quality Rights training to reinforce the human rights principles underpinning the Australian mental health system. In response to this, implementation for Action 27 was subsequently referred back to SQPSC for further development of the approach.

This action was further broken down into components for the governments to address:

- (a) All governments will take steps to ensure the WHO Quality Rights guidance and training tools pertaining to mental health are accessible to promote awareness of consumer rights.
- (b) The Commonwealth and states/territories will request their funded organisations utilise the guidance and training tools.

The Australian Government Department of Health has reported their progress as 'on track'. The South Australian Government Department for Health and Wellbeing and the Queensland Department of Health, reported their progress as 'behind schedule'. All other remaining states and territory health departments reported their progress as 'on track'.

## **Priority Area 7: Achievements**

Achievements at this stage of implementation centre on the establishment of, and participation in, committees and groups designed to ensure that safety and quality are central to mental health service delivery. State and territory governments also report working closely with Australian Government departments to ensure integrated regional planning, as well as developing guidance in collaboration on safety and quality in mental health services and experience of care reports.

## **Priority Area 7: Barriers**

No significant or consistent barriers were identified across stakeholder groups at this point in time.

## **Priority Area 7: Enablers**

Enablers reported by stakeholders include the expertise of members on the MHISSC and the SQPSC as key contributors to the development of performance indicators to inform a guide for consumer and carers.

## Priority Area 8: Ensuring that the enablers of effective system performance and system improvement are in place

The mental health system is complex and currently undergoing a period of reform. As the system transitions, it is important that whole-of-system enablers are prioritised to support continuous improvement and ensure services are best placed to respond to changing needs. Targeted and collective action is needed to support these enablers, ensuring a responsive and effective mental health system both now and into the future. This includes enhanced efforts in research, workforce development, adaptation to new information technology and improved data systems.

Stakeholders responsible for contributing to these actions include the Australian Government Department of Health, the MHISSC, the MHPC, the NMHC and the state and territory government departments of health.

As reported by stakeholders, the level of engagement and participation with consumers and carers was largely focused on 'informing', 'consulting' and 'collaborating'. One state government health department reported no involvement of consumers or carers at this stage of implementation.

### **ACTION 28**

Governments will request the National Mental Health Commission to work in collaboration with National Health and Medical Research Council (NHMRC), consumers and carers, states and territories, research funding bodies and prominent researchers to develop a research strategy to drive better treatment outcomes across the mental health sector.

The MHPC and the NMHC have both reported their progress as 'on track'.

### **ACTION 29**

Governments will develop Peer Workforce Development Guidelines.

The MHPC and the NMHC have both reported their progress as 'on track'.

### **ACTION 30**

Governments will monitor the growth of the national peer workforce through the development of national mental health peer workforce data including data collection and public reporting.

The MHISSC has reported their progress as 'on track'.

### **ACTION 31**

Governments will use the outputs from the NMHSPF to develop a Workforce Development Program

The Australian Government Department of Health and the MHPC have both reported their progress as 'on track'.

### **ACTION 32**

Governments will develop a National Digital Mental Health Framework in collaboration with the National Digital Health Agency.

The Australian Government Department of Health and the MHPC have both reported their progress as 'on track'.

The Queensland, South Australian and Western Australian health departments reported their progress as 'behind schedule'. All other state and territory health departments reported their progress as 'on track'.

### **Priority Area 8: Achievements**

The implementation of actions within this priority area is not scheduled to commence until mid-2018, and as a result, few achievements were reported. Of these achievements, most were context specific and commonalities/consistencies were not identified. However, it is worth noting that despite the relative infancy of the Fifth Plan, the majority of stakeholders appear to be well positioned to progress these actions. A number of stakeholders reported existing infrastructure to monitor effective system performance, existing performance report functions, and system wide data reviews. Some state and territory government health departments are also currently engaged with the Australian Government to progress a National Digital Mental Health Framework, as well as Peer Workforce Guidelines.

### **Priority Area 8: Barriers**

A number of stakeholders noted that the ongoing redevelopment of the NMHSPF is a barrier, as it doesn't currently include rural or Aboriginal and Torres Strait Islander populations in its current state. Until the redevelopment is complete, many jurisdictions are unable to utilise the framework fully.

### **Priority Area 8: Enablers**

Enablers reported by the MHISSC and the MHPC include the expertise of their members and the role of the NMHC as the driver of this work. The NMHC reported its strong relationships with jurisdictions, the NHMRC and the Australian Government Department of Health, as well as its history engaging with consumers and carers as enablers to ensuring effective system performance and improvement are in place.

Enablers reported by the state and territory government health departments were focused on effective engagement and communication between all stakeholders, including consumers, to implement these actions.

# The Fifth National Mental Health and Suicide Prevention Plan: Indicator Data Summary

The Fifth Plan identifies a set of 24 performance indicators, designed to collectively provide a picture of how Australia's mental health system is performing. These indicators range from measures of the health status of the population to measures of the process of mental health care. Wherever possible, the indicators provide both a national view and a more detailed view for community groups or mental health services, and allow performance to be reported for different age groups, for men and women, and for Aboriginal and Torres Strait Islander people.

The Fifth Plan indicator set includes indicators which can currently be measured, along with indicators that require various amounts of development before they will be available for reporting. Under Action v of the Fifth Plan, the Mental Health Information Strategy Standing Committee (MHISSC) has responsibility for identifying data sources and developing methodologies for the 24 performance indicators identified in the Fifth Plan. MHISSC has completed this work for 13 of the 24 indicators, and data on these indicators is included in this report. Development of appropriate methodology is underway on the 8 additional indicators with available data – including indicators on physical health, involuntary treatment, and consumers' experience of service.

It is anticipated that most of these indicators will be available for reporting in 2019. The timeline for completion of the remaining indicators is difficult to gauge, as they cannot be constructed from established data collections. MHISSC is investigating solutions for these indicators and they will be included in the NMHC's future reporting as they become available (see Appendix A for additional information).

The following section outlines the scope and rationale of each of the 13 available indicators and provides selected high level analyses, including data on Aboriginal and Torres Strait Islander people where available. As per Action v of the Fifth Plan, this report establishes a baseline for each indicator, against which future reporting will measure performance. Additional data and disaggregations for each indicator will be made available in an associated Excel workbook.

# Performance indicator 2

## Long-term conditions in people with mental illness

### What does this indicator measure?

This indicator measures the percentage of people with a mental illness who have another long-term health condition.

‘Another long-term health condition’ is defined as any of the following conditions:

- Asthma
- Arthritis
- Cancer
- Diseases of the circulatory system
- Diabetes mellitus
- Back problems
- Chronic obstructive pulmonary disease (COPD) (Bronchitis, emphysema).

This indicator can be disaggregated by age, sex, socio-economic status, remoteness and state and territory.

### Why is this important?

Equality in health is a basic human right for all Australians. However, it is well known that people living in our community with mental illness have poorer physical health than those without mental illness.<sup>3</sup>

Numerous studies have highlighted that people living with mental illness are more likely to die early. Most of the causes of early death relate to physical illnesses such as cardiovascular disease, diabetes and cancer.<sup>4</sup>

Monitoring the proportion of people with mental illness who have comorbid physical health conditions over time is essential to shed light on whether there has been any progress in improving the physical health of Australians with a mental illness.

### Caveats

Self-report data is used to collect experience of both mental and physical health conditions.

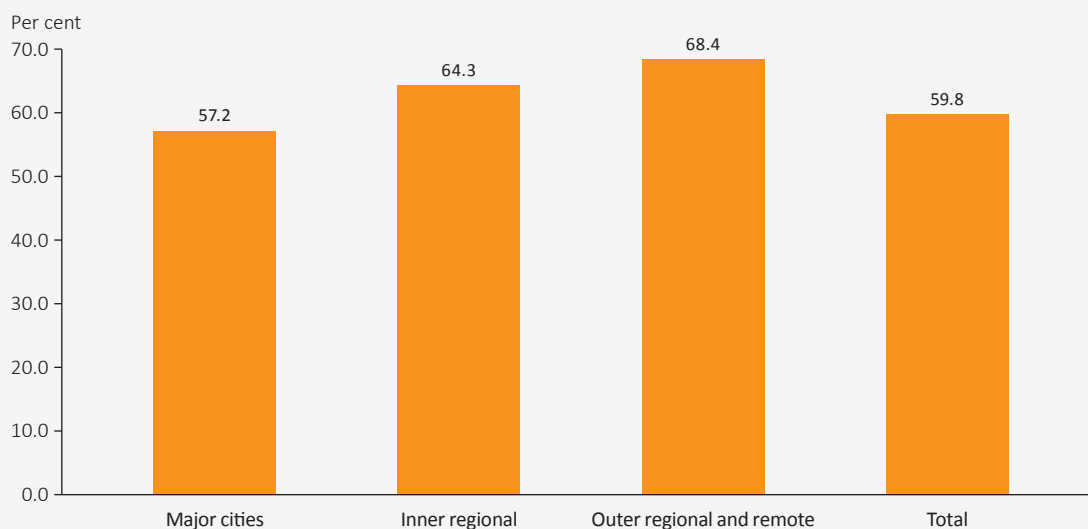
All ages are in scope for this indicator.

Due to historical limitations of the data collection, equivalent data for Aboriginal and Torres Strait Islander people is not currently available. However, due to recent developments this disaggregation may become available for reporting during the life of the Fifth Plan.

### Data Summary

In 2014–15 59.8% of people with a mental illness also had a long-term physical health condition. The proportion of people with a mental illness who also reported having a long-term physical health condition increased as remoteness increased (see Figure PI 2).

**Figure PI 2: Proportion of people with a mental illness with a long-term physical health condition, by remoteness, 2014–15**



Source: ABS National Health Survey, 2014–15.

# Performance indicator 3

## Tobacco and other drug use in adolescents and adults with mental illness

### What does this indicator measure?

This indicator measures the percentage of adolescents and adults with mental illness who report the use of licit and illicit drugs.

Illicit drugs are defined as illegal drugs, drugs and volatile substances used illicitly, and pharmaceuticals used for non-medical purposes. Alcohol and tobacco use, although most often licit, are also included in this indicator.

This indicator can be disaggregated by age, sex, state and territory, Indigenous status, and drug type.

### Why is this important?

There is a strong association between illicit drug use and mental illness; however it can be difficult to isolate to what degree drug use causes mental illness, and to what degree mental illness gives rise to drug use, often in the context of self-medication.<sup>5</sup>

Both licit and illicit drug use contributes to poorer health outcomes and decreased life expectancy for people with mental illness in Australia. Monitoring the rate of drug use provides an indicator of the effectiveness of prevention and drug use reduction programs.

People with mental illness have higher rates of tobacco use than other Australians.<sup>6</sup> In Australia, lung cancer is responsible for a reduction in life expectancy of 6 years. Tobacco use is responsible for 80% of lung cancer burden.<sup>7</sup>

### Caveats

This data includes people aged 14 and over.

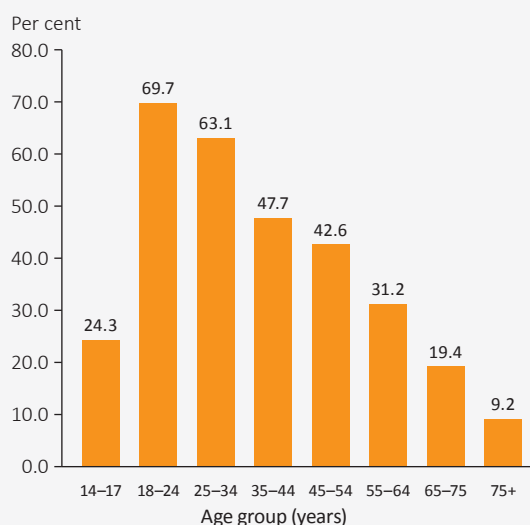
Data on pharmaceuticals that are used appropriately for their medical purpose are not included in this indicator.

Experience of mental illness is self-reported and relates to the person having been diagnosed or treated for a mental illness in the previous 12 months.

### Data Summary

In 2016, 24.1% of adolescents and adults with a mental illness reported smoking tobacco daily and the rate of Aboriginal and Torres Strait Islander people who smoked daily was almost double the non-Indigenous rate (44.0% and 22.8% respectively). In 2016, 8.8% of adolescents and adults with a mental illness misused pharmaceuticals. Similar rates of misuse were observed in males and females (9.7% and 8.2% respectively). Illicit drugs were used by 22.6% of adolescents and adults with a mental illness, with marijuana/cannabis being the most commonly used drug (19.4% of adolescents and adults with a mental illness). Aboriginal and Torres Strait Islander people with a mental illness used illicit drugs at a higher rate than non-Indigenous people with a mental illness (32.8% and 22.2% respectively). In the past year, 44.3% of adolescents and adults with a mental illness consumed five or more standard alcoholic drinks on a single occasion. The rate at which adolescents and adults with a mental illness consumed five or more standard alcoholic drinks on a single occasion varied by age group, ranging from 69.7% in 18-24 year olds, to 9.2% in people aged 75 and over (see Figure PI 3).

**Figure PI 3: Percentage of adolescents and adults with a mental illness who consumed 5 or more standard drinks on a single occasion at least once in the past year, by age group, 2016**



Source: National Drug Strategy Household Survey (unpublished analysis).

# Performance indicator 6

## Prevalence of mental illness

### What does this indicator measure?

This indicator measures the percentage of people who experienced mental illness in the previous 12 months.

‘Mental illness’ is defined for this indicator as a clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional or social abilities.

This indicator can be disaggregated by age, sex, socio-economic status and mental illness type.

### Why is this important?

Differences in prevalence of mental illness across the age span and between sexes impact local population needs and service delivery profiles. As such, data on the prevalence of mental illness in Australia is important for policy development and to tailor planning of services. Prevalence rates also provide a global indication of the mental health of Australians.

### Caveats

Data for different components of this indicator are sourced from three different surveys. Data cannot be compared between surveys.

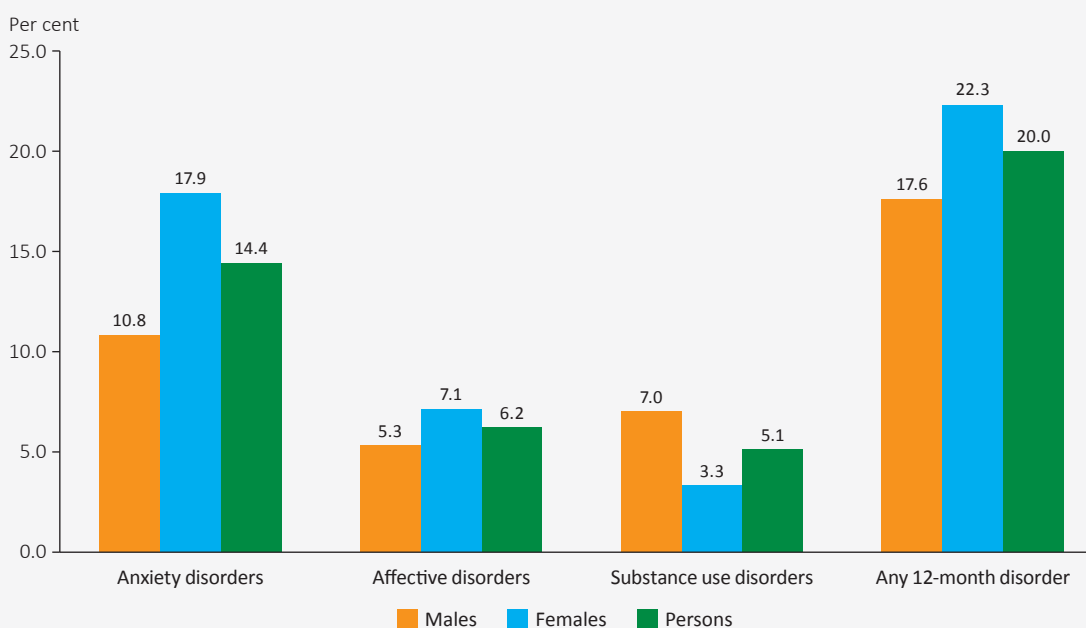
Data for people experiencing psychotic illness only includes people who are in contact with services.

Equivalent data are not available for Aboriginal and Torres Strait Islander people. The surveys that provide the data source for this indicator did not contain a large enough sample of Aboriginal and Torres Strait Islander people to produce a reliable national estimate. A comparable survey of Aboriginal and Torres Strait Islander people’s mental health is not currently available.

### Data Summary

In 2007, 20.0% of Australians (17.6% of males and 22.3% of females) aged 16-85 experienced a mental illness. A larger proportion of females experienced anxiety disorders and affective disorders, while a larger proportion of males experienced substance use disorders (see Figure PI 6).

**Figure PI 6: Prevalence of mental illness, by disorder type and sex, 2007**



Source: ABS National Survey of Mental Health and Wellbeing, 2007.

# Performance indicator 7

## Adults with very high levels of psychological distress

### What does this indicator measure?

This indicator measures the percentage of adults with very high levels of psychological distress. Psychological distress is derived from the Kessler Psychological Distress Scale.

This indicator can be disaggregated by remoteness; socio-economic disadvantage categories; age; sex; disability status; and by state and territory by sex. Data for combined high/very high levels of psychological distress are available by Indigenous status.

### Why is this important?

Psychological distress provides a proxy measure of the overall mental health and wellbeing of the population. Very high levels of psychological distress may signify a need for professional help and provide an estimate of the need for mental health services.

### Caveats

Data includes people aged 18 and over.

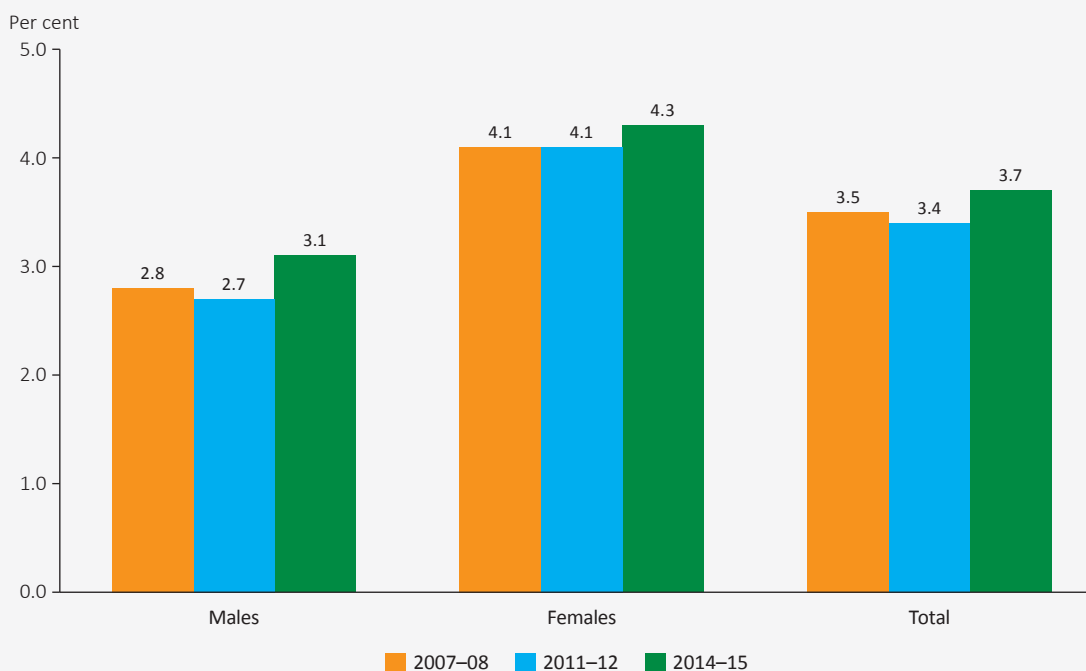
Data are age standardised to the 2001 Estimated Resident Population.

### Data Summary

Between 2007–08 and 2011–12 the proportion of males and females that experienced very high levels of psychological distress remained consistent, however both groups experienced a small increase between 2011–12 and 2014–15 (see Figure PI 7).

In 2014–15 the proportion of Aboriginal and Torres Strait Islander people with high/very high levels of psychological distress was more than 2.5 times the proportion of non-indigenous people with high/very high psychological distress.

**Figure PI 7: Proportion of adults with very high levels of psychological distress 2007–08 to 2014–15**



Sources: ABS (unpublished analysis) National Health Survey, 2014–15; Australian Health Survey, 2011–13 (2011–12 NHS component); National Health Survey, 2007–08, Cat. no. 4364.0.

# Performance indicator 10

## Adults with mental illness in employment, education and training

### What does this indicator measure?

This indicator measures the percentage of adults with a mental illness who are in employment, education or training.

‘In employment’ includes people who are employed to work full-time (usually 35 hours per week) or part-time (from one to less than 35 hours per week).

‘In education and training’ includes people who indicated they are currently studying for a qualification and people aged 15-19 who indicated they are attending secondary school.

This indicator can be disaggregated by age, sex, state and territory, socio-economic status and remoteness. Data for Aboriginal and Torres Strait Islander people are also available.

### Why is this important?

All governments are committed to ensuring a contributing life for people with a mental illness. This includes an individual’s ability to support their own livelihood and contribute to the greater community through employment options.

A range of evidence highlights that people with mental illness are over-represented in national unemployment statistics and that untreated mental illness is a major contributor to lost economic productivity.

An increasing body of evidence is accumulating that employment rates for people affected by mental illness can be improved substantially, leading to better health outcomes.

### Caveats

Experience of mental illness is collected by self-report.

Respondents reporting current study were required to be enrolled and currently participating in the course. People who had enrolled but not commenced, and people undertaking hobby or recreational courses are not included.

Data are limited to people aged 15–64.

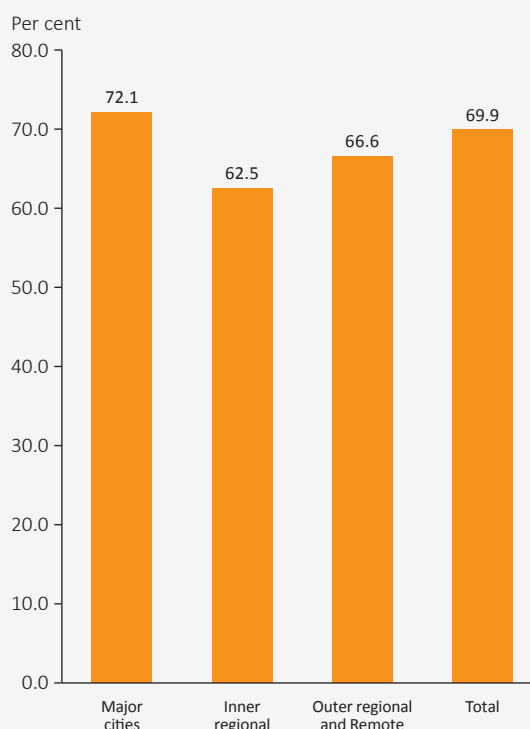
Data for Aboriginal and Torres Strait Islander people and non-indigenous people are not directly comparable.

### Data Summary

In 2014–15, 69.9% of Australians aged 15–64 with a mental illness were in employment, education or training. The proportion of people with a mental illness in employment, education or training varied depending on the remoteness of their usual residence (see Figure PI 10).

In 2014–15, 52.2% of Aboriginal and Torres Strait Islander people with a mental illness were in employment, education or training. A similar proportion of Aboriginal and Torres Strait Islander males and females were in employment, education or training (51.9% of males and 52.9% of females).

**Figure PI 10: Proportion of people with mental illness in employment, education or training, by remoteness, 2014–15**



Source: ABS National Health Survey, 2014–15.

# Performance indicator 14

## Change in mental health consumers' clinical outcomes

### What does this indicator measure?

The proportion of mental health-related episodes of care where:

- significant improvement
- significant deterioration
- no significant change

was identified between baseline and follow-up of completed outcome measures.

This indicator can be disaggregated by service setting and age group.

### Why is this important?

State/territory specialised mental health services aim to reduce symptoms and improve functioning. The effectiveness of services can be compared using routinely collected measures. This will assist in service benchmarking and quality improvement.

The implementation of routine mental health outcome measurement in Australia provides the opportunity to monitor the effectiveness of mental health services across jurisdictions.

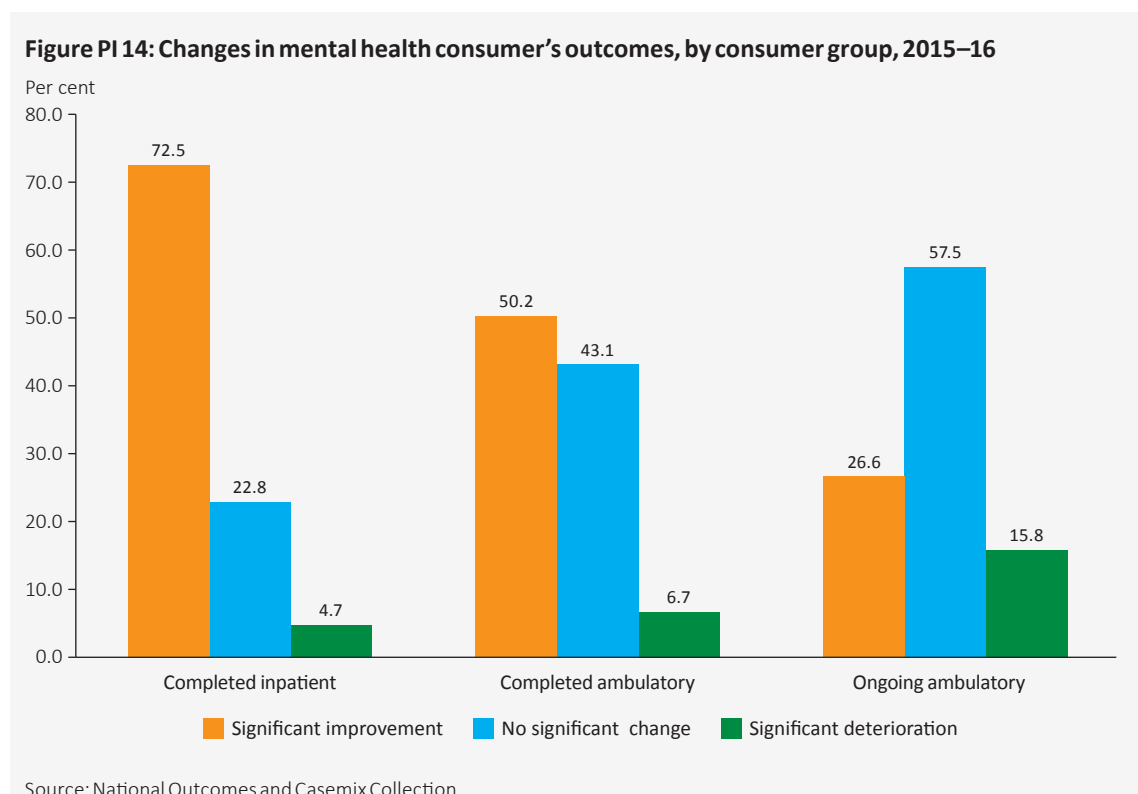
### Caveats

This data relates specifically to state and territory specialised mental health services, which are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability.

Due to historical limitations of the data collection, data cannot currently be disaggregated for Aboriginal and Torres Strait Islander people. However, due to recent developments this disaggregation may become available for reporting during the life of the Fifth Plan.

### Data Summary

In 2015–16, significant improvement was observed in 72.5% of completed inpatient episodes of care, 50.2% of completed ambulatory episodes of care, and 26.6% of ongoing ambulatory care (see Figure PI 14).



# Performance indicator 15

## Population access to clinical mental health care

### What does this indicator measure?

This indicator measures the percentage of the population receiving clinical mental health services.

This indicator can be disaggregated by economic disadvantage groups, remoteness, Indigenous status and, for some data, profession type of service provider.

### Why is this important?

The issue of unmet need has become prominent since the National Survey of Mental Health and Wellbeing<sup>8</sup> indicated that a majority of people affected by a mental disorder do not receive treatment.

The implication for performance indicators is that a measure is required to monitor population treatment rates and assess these against what is known about the distribution of mental disorders in the community.

Access issues figure prominently in concerns expressed by consumers and carers about the mental health care they receive. More recently, these concerns have been echoed in the wider community.

Most jurisdictions have organised their mental health services to serve defined catchment populations, allowing comparisons of relative population coverage to be made between organisations.

### Caveats

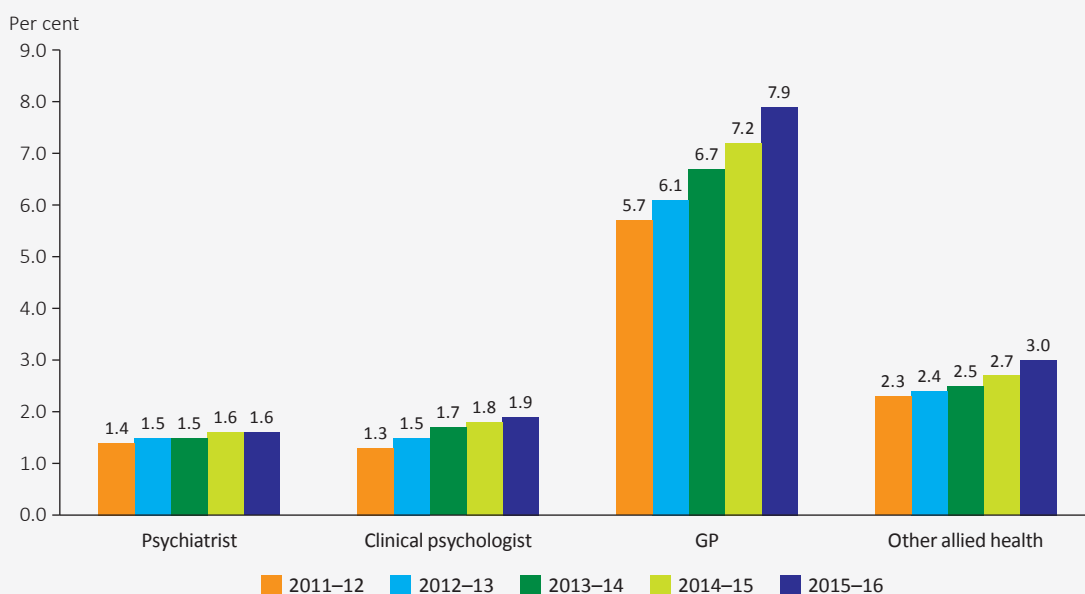
This indicator is calculated separately for public, private, and combined Medicare Benefits Scheme (MBS) and Department of Veterans' Affairs (DVA) data.

### Data Summary

From 2011–12 to 2015–16 the proportion of people accessing MBS and DVA-subsidised clinical mental health care increased for all service provider types. A higher proportion of the population accessed clinical mental health care via GPs, compared to other provider types (see Figure PI 15).

From 2011–12 to 2015–16, the proportion of Aboriginal and Torres Strait Islander people accessing public clinical mental health care services increased from 4.3% to 5.3%. In the same period, the proportion of non-Indigenous people accessing public clinical mental health care services increased from 1.5% to 1.6%.

**Figure PI 15: Proportion of population accessing MBS and DVA-subsidised clinical mental health care services, by Service Provider Type, 2011–12 to 2015–16**



Source: State and territory governments (unpublished analysis); Department of Health MBS Statistics (unpublished analysis); Department of Veterans' Affairs Treatment Account System data (unpublished analysis).

# Performance indicator 16

## Post-discharge community mental health care

### What does this indicator measure?

This indicator measures the percentage of separations from state/territory public acute admitted patient mental health care service units for which a community mental health service contact, in which the consumer participated, was recorded in the seven days following that separation.

This indicator can be disaggregated by age, sex, economic disadvantage groups, remoteness, and Indigenous status.

### Why is this important?

A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital readmission.

Consumers leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with community services and supports, are less likely to need early readmission.

Research indicates that consumers have increased vulnerability immediately following discharge, including higher risk for suicide.

### Caveats

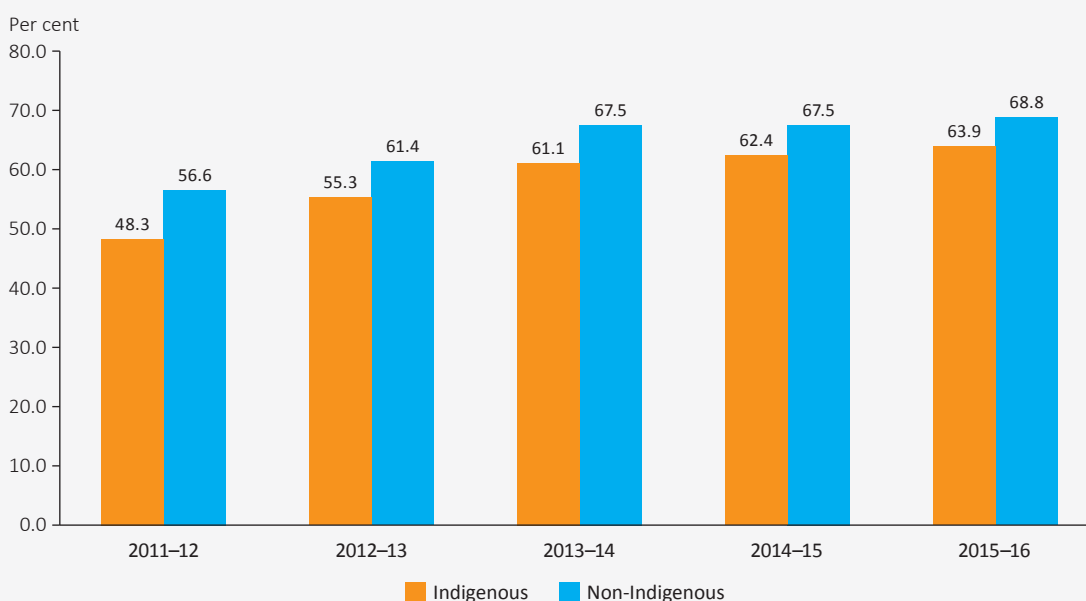
For this indicator, only direct contact with the consumer constitutes a 'post-discharge follow up'. A growing body of evidence suggests that for some cohorts (e.g. children and adolescents), follow-up with carers represents best practice.

This measure does not consider variations in intensity or frequency of service contacts following separation from hospital.

### Data Summary

Nationally, from 2011–12 to 2015–16 the percentage of separations from state/territory public acute admitted patient mental health care service units, involving Indigenous people, for which a community mental health service contact occurred within 7 days increased from 48.3% to 63.9%, and the percentage involving non-indigenous people increased from 56.6% to 68.8%. In this time period, the disparity between the rate of community mental health service follow-up for Indigenous people compared to non-indigenous people decreased from 8.3 percentage points in 2011–12 to 4.9 percentage points in 2015–16 (see Figure PI 16).

**Figure PI 16: Post-discharge community mental health care, 2011–12 to 2015–16**



Source: State and territory governments (unpublished analysis).

# Performance indicator 17

## Mental health readmissions to hospital

### What does this indicator measure?

This indicator measures the percentage of in-scope overnight separations from state/territory acute admitted patient mental health care service units that are followed by readmission to the same or to another public sector acute admitted patient mental health care service unit within 28 days of separation.

This indicator can be disaggregated by age, sex, socio-economic disadvantage group, remoteness and Indigenous status.

### Why is this important?

Readmissions to an acute admitted patient mental health care service unit following a recent discharge may indicate that inpatient treatment was incomplete or ineffective, or that follow-up care was inadequate to maintain the person's treatment out of hospital. In this sense, rapid readmissions may point to deficiencies in the functioning of the overall care system.

Avoidable rapid readmissions place pressure on finite beds and may reduce access to care for other consumers in need.

International literature identifies one month as an appropriate defined time period for the measurement of unplanned readmissions following separation from an acute admitted patient mental health care service unit.

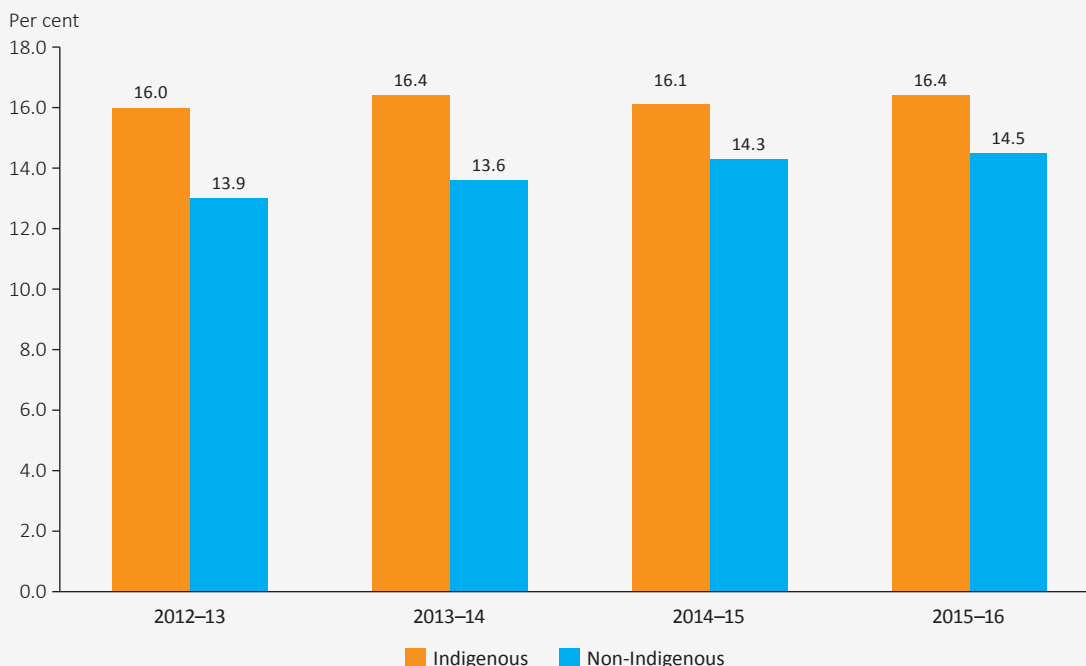
### Caveats

Due to data limitations no distinction is made between planned and unplanned readmissions.

### Data Summary

Nationally, from 2012–13 to 2015–16 separations involving Indigenous people had a consistent percentage of readmission within 28 days (see Figure PI 17). The percentage of separations for Indigenous people that were associated with a readmission within 28 days was consistently higher than separations for non-Indigenous people over this time period.

**Figure PI 17: Mental health readmissions to hospital, 2012–13 to 2015–16**



Source: State and territory governments (unpublished analysis).

# Performance indicator 18

## Mental health consumer and carer workers

### What does this indicator measure?

This indicator measures the proportion of staff employed in state and territory administered specialised mental health services who are mental health consumer workers and/or mental health carer workers.

‘Mental health consumer workers’ are persons employed (or engaged via contract) on a part-time or full-time paid basis, where the person is specifically employed for the expertise developed from their lived experience of mental illness.

‘Mental health carer workers’ are persons employed (or engaged via contract) on a part-time or full-time paid basis, where the person is specifically employed for the expertise developed from their experience as a mental health carer.

This indicator can be disaggregated by state and territory. Data is available separately for consumers and carers respectively.

### Why is this important?

Consumer and carer involvement in the planning and delivery of mental health services is considered essential to adequately represent the views of consumers and carers, advocate on their behalf, and promote the development of consumer responsive services.

There are a range of roles for consumers and carers within mental health services, and models adopted by jurisdictions differ in their approach, including advisory roles on committees, working within clinical teams and directly with consumers and carers.

### Caveats

The data are presented as the number of full-time equivalent (FTE) consumer and carer staff per 10,000 mental health care provider FTE.

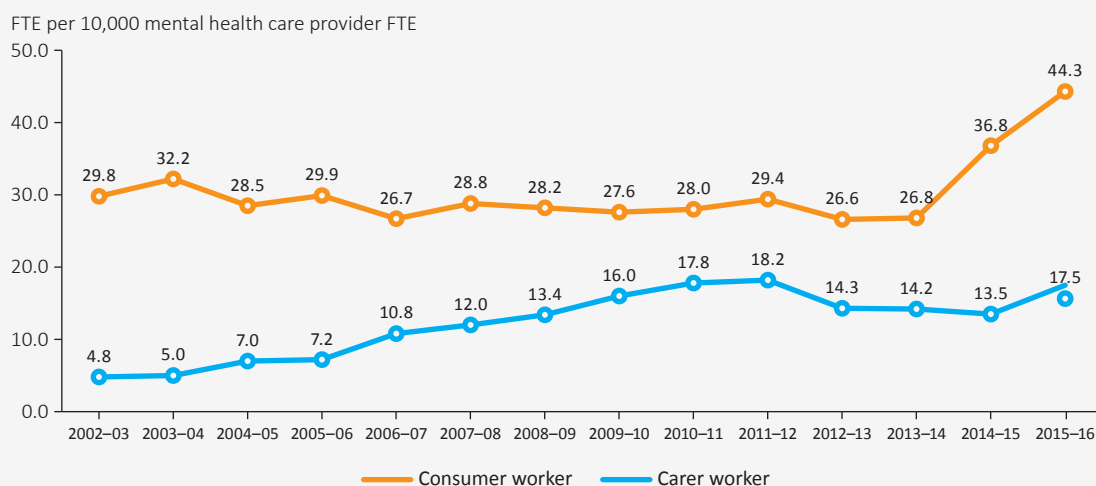
Consumer and carer workers employed in the community managed sector are not included in this data.

The source data collection does not include the Indigenous status of staff in mental health services. As a result data are not able to be disaggregated for Aboriginal and Torres Strait Islander consumer and carer workers.

### Data Summary

At the national level, the rate of consumer workers has increased from 29.8 FTE per 10,000 FTE mental health care providers in 2002–03, to 44.3 FTE in 2015–16. With the largest increase occurring between 2013–14 and 2015–16 (see Figure PI 18). Nationally, the rate of carer workers has increased from 4.8 FTE per 10,000 FTE mental health care providers in 2002–03, to 17.5 FTE in 2015–16.

**Figure PI 18: Mental health consumer and carer worker FTE staff, per 10,000 mental health care provider FTE, by staffing category, 2002–03 to 2015–16**



Sources: Australian Government Department of Health, National Survey of Mental Health Services Database (1998–99 to 2004–05); National Mental Health Establishments Database.

# Performance indicator 19

## Suicide rate

### What does this indicator measure?

This indicator measures the number of suicides per 100,000 Australians.

This indicator can be disaggregated by age, sex, state and territory and Indigenous status.

### Why is this important?

Suicide is a leading cause of death among the general population, and people with mental illness are at even greater risk.

Suicide is a complex problem that requires a whole of government response. All governments are committed to working together to achieve a decrease in the rate of suicide.

Numerous factors, including age, gender, other health problems, social or geographic isolation and drug or alcohol problems, can influence an individual's risk of suicide. This complex interaction of biological, psychological and social factors can influence the outcomes of programs intended to reduce suicide rates.

### Caveats

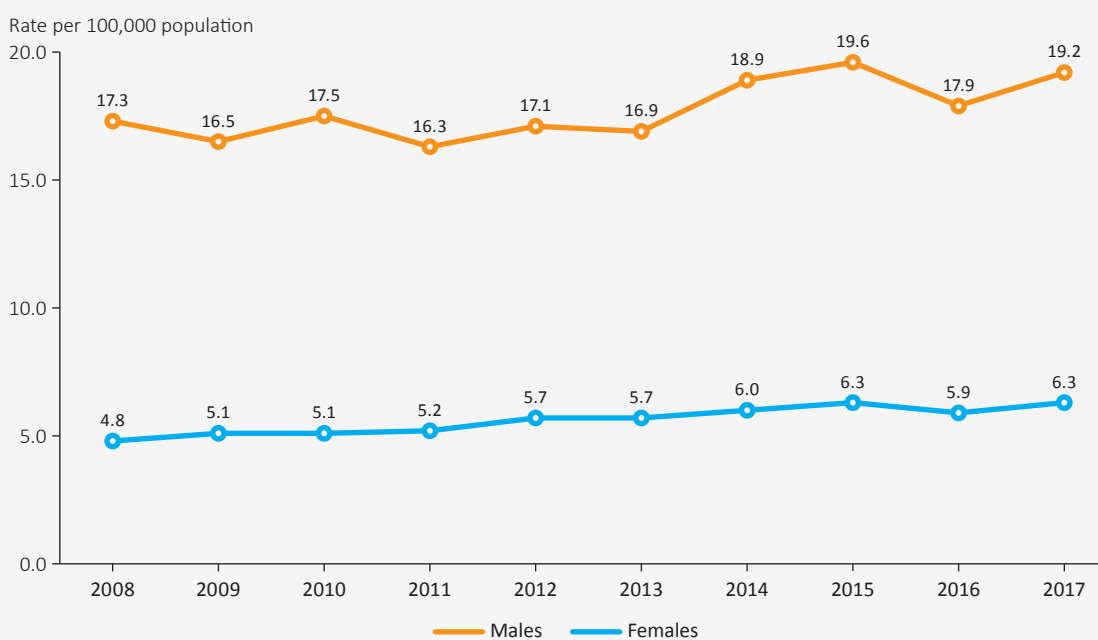
Due to the process of suicide death investigation and registration, data are deemed preliminary when first published, revised when published the following year and final when published after a second year. This may result in minor changes in published time series data.

### Data Summary

Between 2008 and 2017 the national suicide rate for males ranged from 16.3 to 19.6 per 100,000 population, and females ranged from 4.8 to 6.3 per 100,000 population (see Figure PI 19).

For the period 2013–17, the national suicide rate for Aboriginal and Torres Strait Islander people was about double the non-indigenous rate (24.9 and 12.0 per 100,000 population respectively).

**Figure PI 19: Suicide rate by sex, 2008 to 2017**



Source: ABS Causes of Death, 2017.

# Performance indicator 22

## Seclusion rate

### What does this indicator measure?

This indicator measures the number of seclusion events per 1,000 patient days within public acute admitted patient specialised mental health service units.

Seclusion is defined as the confinement of the consumer/patient at any time of the day or night alone in a room or area from which free exit is prevented.

This indicator can be disaggregated by state and territory, remoteness of the hospital and target population.

### Why is this important?

High levels of seclusion are widely regarded as inappropriate treatment, and may point to inadequacies in the functioning of the overall system and risks to the safety of consumers receiving mental health care.

The reduction, and where possible, elimination of seclusion in mental health services has been identified as a priority in the publication National safety priorities in mental health: a national plan for reducing harm.<sup>9</sup> The use of seclusion in public sector mental health service organisations is regulated under legislation and/or policy of each jurisdiction.

### Caveats

Data relates to seclusion in state and territory public acute admitted patient mental health service units only. Seclusion that occurred in other mental health settings is not in-scope.

The source data collection does not include the demographic information of consumers/patients. As a result data cannot be disaggregated for Aboriginal and Torres Strait Islander people.

### Data Summary

The rate of seclusion in public sector acute mental health hospital services (all populations) was 15.6 per 1,000 patient days in 2008–09 and decreased to 7.4 per 1,000 patient days in 2016–17. Across service target populations, in 2016–17 the highest rate of seclusion was in forensic services, 14.7 per 1,000 patient days, up from 10.8 per 1,000 patient days in 2008–09 (see Table PI 22).

**Table PI 22: Seclusion rate, per 1,000 patient days, in public sector acute mental health hospital services, by target population, 2008–09 to 2016–17**

Target population	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
General	17.1	15.4	13.1	11.6	10.3	9.6	9.1	9.2	8.0
Child and adolescents	17.0	11.4	16.6	18.1	14.5	9.6	12.0	10.3	11.1
Older person	4.0	3.2	1.3	0.7	0.8	0.6	0.4	0.5	0.6
Forensic	10.8	12.0	8.7	10.7	13.6	7.7	7.1	9.2	14.7
Mixed*	15.1	13.3	12.3	10.3	10.0	..	..	..	..
All	15.6	13.9	12.1	10.6	9.8	8.2	7.9	8.1	7.4

.. Not applicable

\*Target population could be correctly identified for all service units from 2013–14, removing the need for a mixed category. Service units previously reported in the mixed category are now reported in either the general, child and adolescent, older person or forensic categories.

Source: State and territory governments (unpublished analysis).

# Performance indicator 24

## Experience of discrimination in adults with mental illness

### What does this indicator measure?

This indicator measures the percentage of adults with a mental illness who report the experience of discrimination.

This indicator can be disaggregated by age, sex, state and territory, socio-economic status and remoteness. Data for Aboriginal and Torres Strait Islander people are also available.

### Why is this important?

International evidence shows strong associations between poverty, disadvantage, deprivation, exclusion and mental illness. Discrimination in people with mental illness can increase feelings of isolation and create barriers to seeking help.

A person's right to full inclusion and to a meaningful life of their choosing, free of stigma and discrimination is key to recovery-oriented care.

### Caveats

Experience of mental illness is collected by self-report.

Data for Aboriginal and Torres Strait Islander people and non-Indigenous people are not comparable. Due to data limitations, data for Aboriginal and Torres Strait Islander people include only their experience of discrimination related to their Aboriginal and Torres Strait Islander status.

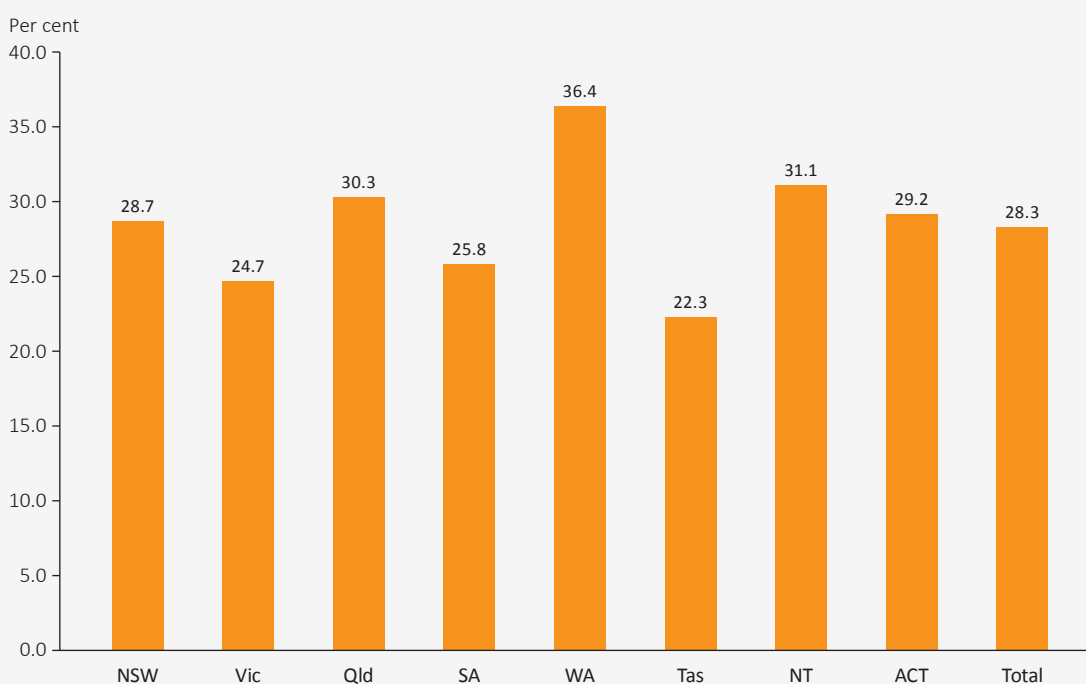
Data include people aged 18 years and older.

### Data Summary

In 2014, 28.3% of people with a mental illness reporting having experienced discrimination. There was variation between jurisdictions, ranging from 22.3% of Tasmanians with a mental illness experiencing discrimination, to 36.4% of people in Western Australia (see Figure PI 24).

In 2014–15, 44.5% of Aboriginal and Torres Strait Islander people with a mental illness experienced discrimination due to their Aboriginal and Torres Strait Islander status, with similar rates of discrimination reported by males and females (44.4% and 43.9% respectively).

**Figure PI 24: Proportion of adults with mental illness who experience discrimination, state or territory, 2014**



Source: ABS General Social Survey, 2014.

# Appendices

# Appendix A

## Fifth National Mental Health and Suicide Prevention Plan Performance Indicators

Domain	Related Fifth Plan priority area(s)	Indicator number and name	Current reporting status
Healthy start to life	N/A	PI 1: Children who are developmentally vulnerable	Requires further development
Better physical health and living longer	Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Improving the physical health of people living with mental illness and reducing early mortality.	PI 2: Long-term health conditions in people with mental illness	Included in the 2018 report
	Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Improving the physical health of people living with mental illness and reducing early mortality.	PI 3: Tobacco and other drug use in adolescents and adults with mental illness	Included in the 2018 report
	Improving the physical health of people living with mental illness and reducing early mortality.	PI 4: Avoidable hospitalisations for physical illness in people with mental illness	Requires further development
	Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Improving the physical health of people living with mental illness and reducing early mortality. Making safety and quality central to mental health service delivery.	PI 5: Mortality gap for people with mental illness	Requires further development
Good mental health and wellbeing	Achieving integrated regional planning and service delivery. Effective suicide prevention. Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Improving the physical health of people living with mental illness and reducing early mortality. Reducing stigma and discrimination. Making safety and quality central to mental health service delivery. Ensuring that the enablers of effective system performance and system improvement are in place.	PI 6: Prevalence of mental illness	Included in the 2018 report
	Achieving integrated regional planning and service delivery.	PI 7: Adults with very high levels of psychological distress	Included in the 2018 report
	Coordinating treatment and supports for people with severe and complex mental illness. Reducing stigma and discrimination.	PI 8: Connectedness and meaning in life	Requires further development
Meaningful and contributing life	Achieving integrated regional planning and service delivery. Coordinating treatment and supports for people with severe and complex mental illness.	PI 9: Social participation in adults with mental illness	Requires further development
	Coordinating treatment and supports for people with severe and complex mental illness.	PI 10: Adults with mental illness in employment, education or training	Included in the 2018 report
	Coordinating treatment and supports for people with severe and complex mental illness.	PI 11: Carers of people with mental illness in employment	Requires further development
	Reducing stigma and discrimination. Ensuring that the enablers of effective system performance and system improvement are in place.	PI 12: Proportion of mental health consumers in suitable housing	Requires further development

Domain	Related Fifth Plan priority area(s)	Indicator number and name	Current reporting status
Effective support, care and treatment	Achieving integrated regional planning and service delivery. Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Reducing stigma and discrimination. Making safety and quality central to mental health service delivery.	PI 13: Experience of service for mental health consumers	Requires further development
	Achieving integrated regional planning and service delivery. Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Making safety and quality central to mental health service delivery.	PI 14: Change in mental health consumers' clinical outcomes	Included in the 2018 report
	Achieving integrated regional planning and service delivery. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.	PI 15: Population access to clinical mental health care	Included in the 2018 report
	Achieving integrated regional planning and service delivery. Effective suicide prevention. Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Making safety and quality central to mental health service delivery.	PI 16: Post-discharge community mental health care	Included in the 2018 report
	Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.	PI 17: Mental health readmissions to hospital	Included in the 2018 report
	Ensuring that the enablers of effective system performance and system improvement are in place.	PI 18: Mental health consumer and carer workers	Included in the 2018 report
Less avoidable harm	Achieving integrated regional planning and service delivery. Effective suicide prevention. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.	PI 19: Suicide rate	Included in the 2018 report
	Effective suicide prevention.	PI 20: Suicide of people in inpatient mental health units	Requires further development
	Achieving integrated regional planning and service delivery. Effective suicide prevention. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Making safety and quality central to mental health service delivery.	PI 21: Rates of follow-up after suicide attempt/self-harm	Requires further development
	Coordinating treatment and supports for people with severe and complex mental illness. Making safety and quality central to mental health service delivery.	PI 22: Seclusion rate	Included in the 2018 report
	Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.	PI 23: Rate of involuntary hospital treatment	Requires further development
Stigma and discrimination	Reducing stigma and discrimination.	PI 24: Experience of discrimination in adults with mental illness	Included in the 2018 report

Note: the names of some indicators have changed since their inclusion in the Fifth Plan, however their intent remains unchanged.

# Appendix B

## Glossary

### **Ambulatory mental health care**

Ambulatory mental health care is mental health care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics. The term is also used to refer to care provided to patients of community-based (non-hospital) health care services.

### **Another long-term health condition**

Another long-term health condition is defined as any of the following conditions:

- Asthma
- Arthritis
- Cancer
- Diseases of the circulatory system
- Diabetes mellitus
- Back problems
- Chronic obstructive pulmonary disease (COPD) (Bronchitis, emphysema).

### **Community mental health care**

Community mental health care refers to government-funded and -operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics.

### **Illicit drugs**

Illicit drugs are defined as illegal drugs, drugs and volatile substances used illicitly, and pharmaceuticals used for non-medical purposes.

### **Mental health carer workers**

Mental health carer workers are persons employed (or engaged via contract) on a part-time or full-time paid basis, where the person is specifically employed for the expertise developed from their experience as a mental health carer.

### **Mental health consumer workers**

Mental health consumer workers are persons employed (or engaged via contract) on a part-time or full-time paid basis, where the person is specifically employed for the expertise developed from their lived experience of mental illness.

### **Overnight separations**

Overnight separations are separations when a patient undergoes a hospital's formal admission process, completes an episode of care, is in hospital for more than one day and 'separates' from the hospital.

### **Psychological distress**

This question is sourced from the Kessler psychological distress scale. The scale consists of questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms a person may have experienced in the four weeks prior to interview.

### **Residential mental health care services**

A residential mental health service is a specialised mental health service that:

- employs mental health trained staff onsite
- provides rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment
- encourages the residents to take responsibility for their daily living activities.

These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ onsite mental health trained staff for some part of the day.

### **Seclusion**

Seclusion is defined as the confinement of the consumer/patient at any time of the day or night alone in a room or area from which free exit is prevented.

### **Separation**

Separation is the term used to refer to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).

### **Specialised mental health services**

Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. This includes admitted patient mental health care services, ambulatory mental health care services and residential mental health care services.

# Appendix C

## Acronyms

<b>ACCHS</b>	Aboriginal Community Controlled Health Service	<b>NDIA</b>	National Disability Insurance Agency
<b>AHMAC</b>	Australian Health Ministers' Advisory Council	<b>NDIS</b>	National Disability Insurance Scheme
<b>AIHW</b>	Australian Institute of Health and Welfare	<b>NGOs</b>	Non-government organisations
<b>CALD</b>	Culturally and Linguistically Diverse	<b>NMHC</b>	National Mental Health Commission
<b>COAG</b>	Council of Australian Governments	<b>NHMRC</b>	National Health and Medical Research Council
<b>FTE</b>	full-time equivalent	<b>NMHSPF</b>	National Mental Health Service Planning Framework
<b>GPs</b>	General Practitioners	<b>PHNs</b>	Primary Health Networks
<b>LGBTIQ</b>	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer	<b>PI</b>	Performance Indicator
<b>LHNs</b>	Local Health Networks	<b>SPPRG</b>	Suicide Prevention Project Reference Group
<b>MHERP</b>	Mental Health Expert Reference Panel	<b>SQPSC</b>	Safety and Quality Partnership Standing Committee
<b>MHISSC</b>	Mental Health Information Strategy Standing Committee	<b>WHO</b>	World Health Organization
<b>MHPC</b>	Mental Health Principal Committee		

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**Australian Government**  
**National Mental Health Commission**