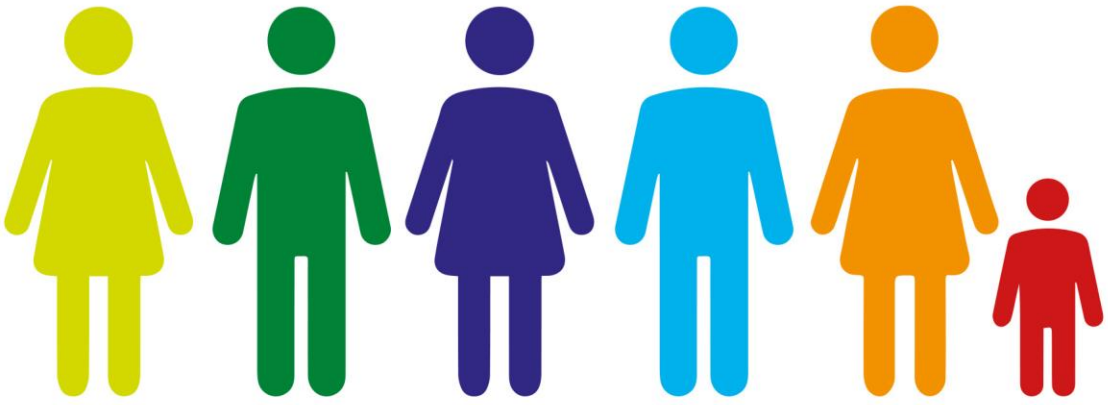
Monitoring mental health and suicide prevention reform

Fifth National Mental Health *and* Suicide Prevention Plan 2021

Progress Report 4



Australian Government
National Mental Health Commission

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- Australian Government Department of Health and Aged Care
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- Primary Health Networks
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- Australian Institute of Health and Welfare, and the Australian Bureau of Statistics, for providing data to report against the performance indicators.

Acknowledgement of Country

The Commission acknowledges the traditional custodians of the lands throughout Australia. We pay our respects to their clans, and to the elders, past present and emerging, and acknowledge their continuing connection to land, sea and community.

Acknowledgement of Lived Experience

We acknowledge the individual and collective contributions of those with a lived and living experience of mental ill-health and suicide, and those who love, have loved and care for them. Each person's journey is unique and a valued contribution to Australia's commitment to mental health suicide prevention systems reform.

About this report
This report can be downloaded from our website: www.mentalhealthcommission.gov.au

This publication is the fourth and final report in a series of annual Fifth Plan progress reports. A complete list of the Commission's publications is available on our website.

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A note on language

The term ‘consumers and carers’ has been used throughout the Fifth Plan final progress report to maintain consistency across the terminology used by the Fifth Plan and all subsequent progress reports. The Commission understands that people choose to describe themselves in a variety of ways in relation to mental health, services and systems, and so these terms are contested and evolving. The Commission respects and acknowledges the multiple ways in which people use different terminology.

Learn more about our work

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Cover graphic: The Contributing Life silhouette shown on the cover represents the diverse range of individuals within our communities. It supports the Contributing Life framework – a whole-of-person, whole-of-system, whole-of-life approach to mental health and wellbeing. Learn more about this approach on our website: mentalhealthcommission.gov.au/Lived-Experience/ Contributing-Lives,-Thriving-Communities

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Foreword

For many years, consumers and carers[1] have been calling for a national and coordinated approach to Australia's mental health and suicide prevention system.

For the first time, the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) committed governments to working together to integrate the planning and delivery of mental health and suicide prevention services. Its development brought together the knowledge of people with lived experience of mental illness, the mental health sector, including consumer and carer organisations, mental health and suicide prevention service providers, Aboriginal and Torres Strait Islander organisations, state and territory governments and a range of stakeholders. It was an important moment in the nation's mental health and suicide prevention response.

The Fifth Plan presented an ambitious vision for Australia's mental health and suicide prevention system and set the direction for future policy change from 2017 to 2022, with the intent that implementation would finish in 2022.

The mental health and suicide prevention sector has undergone significant change since the Fifth Plan was endorsed. In that time, we have had the:

- Productivity Commission Inquiry into Mental Health
- National Suicide Prevention Adviser's Final Advice
- announcement of a National Suicide Prevention Office
- House of Representatives Select Committee on Mental Health and Suicide Prevention's Inquiry into Mental Health and Suicide Prevention
- Royal Commission into Victoria's Mental Health System
- Royal Commission into Aged Care Quality and Safety
- establishment of a Royal Commission into Defence and Veteran Suicide.

There have been catastrophic bushfires, droughts, floods and the start of the COVID-19 pandemic. All of these have affected the mental health of Australians and required rapid policy and program responses—from government to community-based services. The COVID-19 pandemic has highlighted the importance of the work being done under the Fifth Plan, such as actions to strengthen the mental health workforce, expand digital services and resources, and invest in mental health research.

[1] The term 'consumers and carers' has been used throughout the Fifth Plan final progress report to maintain consistency across the terminology used by the Fifth Plan and all subsequent progress reports.
The Commission understands that people choose to describe themselves in a variety of ways in relation to mental health, services and systems, and so these terms are contested and evolving. The Commission respects and acknowledges the multiple ways in which people use different terminology.

In the 2021–22 Budget, the Australian Government announced $2.3 billion mental health and suicide prevention reform package in response to the recommendations from the Productivity Commission's Mental Health Inquiry final report and the National Suicide Prevention Adviser's Final Advice.

As part of this package, the National Suicide Prevention Office was established to drive a whole-of-governments approach to suicide prevention by:

- enabling strategic national directions
- building government capabilities
- supporting cross-jurisdictional and cross-portfolio actions
- reporting on agreed outcomes.

The intergovernmental structures that support mental health reform have also changed. This includes the replacement of the Council of Australian Governments with the National Federation Reform Council and the dissolution of the Australian Health Minister's Advisory Council committees that were tasked with implementing the Fifth Plan. A new National Mental Health and Suicide Prevention Agreement has been established to enable collaboration on systemic, whole-of-governments reform to deliver comprehensive, coordinated, consumer-focused and compassionate mental health and suicide prevention systems.

At the National Mental Health Commission, it has been our role to monitor and report on the progress of implementing the Fifth Plan and the performance of the mental health system against the identified indicators. In light of the fundamental changes in the mental health reform landscape and associated intergovernmental structures, the work of monitoring and reporting on the progress of the Fifth Plan has come to a natural conclusion. This will be the final progress report.

Despite the unique challenges encountered over the Fifth Plan's life, 43 of its 65 actions and sub-actions have been implemented, and 15 are being finalised through business-as-usual activities or progressed under the mental health and suicide prevention reforms announced in the 2021–22 Budget.

For example, the 2021–22 Budget reforms, among other actions, capture whole-of-community approaches to suicide prevention (Action 5) and community mental health support needs of people who do not qualify to receive supports under the National Disability Insurance Scheme (Action 6).

As the final report in the series, this report includes a reflection on the performance of the Fifth Plan in making meaningful progress towards fulfilling its vision, and an overview of key learnings. These learnings will be instrumental in guiding future reform efforts and bringing us closer to achieving an integrated mental health system that meets the needs of all Australians.

Overall, our analysis shows that significant activity has been generated through the Fifth Plan, but it is not possible to adequately determine whether it was effective in achieving its intent based on the data available.

Despite the increased use of data and performance indicators in monitoring the Fifth Plan implementation, the Commission remains concerned by the lack of robust evidence of its impact and the implications this has for establishing effective accountability and for informing quality improvement to the system.

These findings highlight the urgent need for ongoing and increased regular collection and monitoring of in-depth and informative quantitative and qualitative data, including the perspectives of consumers and carers, closely aligned with the agreed objectives of future reforms, to help drive more robust processes that establish national accountability.

These findings also emphasise the need for clear and specific targets, along with a commitment to evaluation from the outset of development of future mental health and suicide prevention plans, supported by adequate resource allocation.

The Commission looks forward to continuing its work with all governments, the mental health and suicide prevention sectors and people with lived experience of mental ill health and suicide, to ensure that future reforms take into account the lessons learned from the Fifth Plan, so that Australians receive the benefits of person-centred, safe, high-quality, integrated and effective mental health and suicide prevention systems.

Professor Ngiare Brown
Chair

Executive summary

The Fifth Plan identified 8 priority areas and 32 actions (65 when including all sub-actions and governance, monitoring and reporting actions) designed to improve the transparency, accountability, efficiency and effectiveness of Australia's mental health and suicide prevention systems.

Although previous plans emphasised the need for better integration and coordination of care, for the first time, the Fifth Plan committed all governments to work together to integrate planning and service delivery at a regional level.

It was also the first plan to include suicide prevention as a priority area, committing to a systems-based approach to suicide prevention with strong national planning and collaboration that draws on existing strategic guidance to develop a consolidated national suicide prevention implementation strategy.

The Fifth Plan outlined how all governments would work together to integrate mental health care, physical health care and suicide prevention services in Australia. Ultimately, the Fifth Plan aimed to improve the lives of people living with a mental ill health and the impacts of suicide, and the lives of their families, carers and communities.

Although the impact of the Fifth Plan on long-term outcomes for consumers and carers may not be realised for some time, it has led to:

- activity designed to strengthen collaboration between jurisdictions
- the development of frameworks, strategies and guidelines to improve Australia's mental health and suicide prevention systems
- the suite of mental health and suicide prevention reforms announced in the 2021–22 Budget
- additional guidance for service planners to help target mental health and suicide prevention services where and when they are needed
- a stronger focus on improving the experience of consumers and carers engaging with the mental health and suicide prevention systems, including an emphasis on the safety and quality of services and culturally appropriate services for Aboriginal and Torres Strait Islander peoples.

In May 2020, the cessation of the Council of Australian Governments (COAG) was announced, to be replaced by a more streamlined intergovernmental structure. As a result of this change, the committees that were tasked with implementing the Fifth Plan have dissolved and their work in coordinating its implementation has come to an end.

The Australian Government and all states and territories signed a new National Mental Health and Suicide Prevention Agreement (National Agreement) in March 2022. The National Agreement aims to achieve systemic, whole-of-government reform to deliver comprehensive, coordinated, consumer-focused mental health and suicide prevention systems with joint accountability across all governments.

The National Agreement commits to continuing work under the Fifth Plan and responds to the recommendations of the Productivity Commission Inquiry into Mental Health, the National Suicide Prevention Adviser's Final Advice, and the House of Representatives Select Committee on Mental Health and Suicide Prevention final report.

As a result, this report is the fourth and final in the annual series of reports. It outlines the progress achieved against the Fifth Plan as at 31 December 2021, and presents the available performance indicators. Citations to the sources of all indicator data used in this report can be found in the accompanying Fifth Plan Performance Indicators Excel workbook.

Implementation progress

Of the 65 Fifth Plan actions and sub-actions, 43 have been completed and 15 are being finalised through business-as-usual activities or progressed under the mental health and suicide prevention reforms announced in the 2021–22 Budget.

A single rating cannot be reported for Actions 14 and 27, as they are being implemented separately by each jurisdiction. The remaining 5 actions have been closed, as they were superseded by the announcement of the National Agreement.

Of the 65 actions and sub-actions, 58 were designed to address the 8 priority areas under the Fifth Plan, and the remaining 7 focused on governance, monitoring and reporting.

All actions under Priority Areas 1 and 4 are complete or closed. Most actions under the other 6 priority areas are complete or well progressed. Of the actions reported as not completed, several were close to finalisation at the conclusion of the reporting period. These include the development of the:

- *National Safety and Quality Health Services Standards User Guide for Acute and Community Mental Health Services*
- National Safety and Quality Health Services Standards for Community Managed Organisations (Action 22)
- National Digital Mental Health Framework (Action 32).

A small subset of actions depends on the finalisation of other activities before they can be completed. This includes developing a Workforce Development Program that will guide strategies to address future workforce supply requirements and retention of skilled staff (Action 31), which is contingent on the National Mental Health Workforce Strategy being completed.

Some actions were interrupted by COVID-19 and the cessation of COAG. This includes the start of regular national reporting on the physical health of people living with mental illness (Action 17), which still requires work by the committee formerly known as the Mental Health Information Strategy Standing Committee.

Some actions are being addressed through other mental health reform initiatives, including work to reduce stigma and discrimination in the health workforce (Action 19).

Some actions have moved to ongoing administrative activities, such as implementing monitoring of consumer and carer experiences of care across the specialised and primary care mental health service sectors (Action 23) and ensuring service delivery systems monitor the safety and quality of their services (Action 25).

Status updates are discussed in detail in Appendix A.

Some of the outputs of completed actions include:

- guidance material to support planning and delivery of regional mental health and suicide prevention services for Aboriginal and Torres Strait Islander peoples
- the establishment of Gayaa Dhuwi (Proud Spirit) as a national Aboriginal and Torres Strait Islander leadership body in mental health, social and emotional wellbeing and suicide prevention
- the Indigenous Mental Health and Suicide Prevention Clearinghouse for best-practice services and programs
- safety and quality standards for mental health service providers and guidance for consumers and carers
- the Being Equally Well Roadmap, which provides guidance and resources for practitioners and aims to reduce the life expectancy gap for people living with severe and complex mental illness
- the third edition of the National Mental Health and Suicide Prevention Information Priorities.

The Commission has also released the National Lived Experience (Peer) Workforce Development Guidelines and the National Mental Health Research Strategy. Work is also progressing on the National Stigma and Discrimination Reduction Strategy and the National Mental Health Workforce Strategy.

The National Mutual Recognition Interjurisdictional Project Steering Committee continues its efforts to improve the consistency of mental health legislation across jurisdictions, led by Queensland Health.

Reporting on the Your Experience of Service survey will continue through the business-as-usual activities of the Australian Institute of Health and Welfare, with New South Wales, Victoria and Queensland participating so far.

Performance against identified indicators

As the final progress report on the Fifth Plan, this report presents the indicators over the life of the Fifth Plan. In considering the performance indicator (PI) data, it is important to recognise that the data can only present a partial picture of progress.

Conclusions about the Fifth Plan's effectiveness are not possible on the basis of this data alone. This is because:

- the performance indicators cannot provide information about why a measure of health, wellbeing or system performance has or has not changed over time, or what is needed to achieve the desired changes
- the performance indicators identified in the Fifth Plan are not closely aligned with the actions of the Fifth Plan, so they cannot be used to determine whether the Fifth Plan actions have been effective in achieving their intent
- for several data sources, insufficient data is available to establish trends over time
- each performance indicator has specific caveats that limit the conclusions that can be drawn from the data available—for example, reliance on self-report, issues with sample representativeness and gaps in data for specific population groups
- many of the indicators represent broad long-term outcomes, influenced by multiple risk and protective factors, including various personal characteristics and socio-cultural factors such as

economic conditions and stigma relating to mental illness and suicide; change in these indicators will likely require significant long-term investment and collaborative effort before the impact of incremental improvements become evident in the data.

Although the performance indicators do not provide a picture of why change is occurring, they do enable broad understanding of the extent to which change is or is not occurring in the mental health and suicide prevention systems, and so may point to priority areas for future reforms.

Reporting has begun for 18 of the 24 performance indicators, but further work is required to enable reporting on the remaining 6.

At the national level, some aspects of the mental health and wellbeing of Australians have been stagnant, and some are deteriorating slightly. Of note, the proportion of children who are developmentally vulnerable[2] (PI 1) has not reduced, and the proportion of Aboriginal or Torres Strait Islander children who are developmentally vulnerable continues to be significantly higher, at more than double that of non-Indigenous children in 2018 and 2021.

Like previous years, the proportion of children who were developmentally vulnerable in 2021 increased as distance from metropolitan centres increased—almost half (46.2%) of children in very remote areas met the criteria for developmentally vulnerable in one or more Australian Early Development Census domains.

In addition, long-term physical health conditions continue to disproportionately impact people with mental ill health, with 50.6% of people with mental illness having a long-term physical health condition in 2020–21 compared with 33.6% of people without mental illness (PI 2).

National suicide rates for the Australian population did not improve over the reporting period. In 2020, the national suicide rate was 12.1 per 100,000 population, down from a post-2006 high of 13.2. However, when looking over the previous 10 years, the suicide rate for Aboriginal and Torres Strait Islander peoples increased from 22.2 per 100,000 population in 2011–15 to 25.6 per 100,000 population in 2016–20, compared with 11.5 and 12.4 per 100,000 population, respectively, for non-Indigenous Australians.

These findings highlight the importance of continued efforts and investments nationally and across communities to prevent escalation into suicidal crisis, as well as equity-driven and targeted suicide prevention strategies to prioritise population groups disproportionally affected by suicide.

Although some indicators have not shown improvement, multiple indicators suggest that certain aspects of the performance of the mental health system are improving, including progress on consideration of key safety and consumer rights.

For example, during 2020–21, there were 7.3 seclusion events per 1,000 bed days in acute specialised mental health hospital services (PI 22). This is a decrease from a rate of 8.1 the previous year, and from 15.6 in 2008–09 when national data reporting started.

[2] This is the percentage of children who meet the criteria for developmentally vulnerable in one or more Australian Early Development Census domains. The domains are physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge.

We have also seen encouraging changes in workforce composition. The rate of full-time equivalent (FTE) lived experience (consumer) workers increased from 44.3 per 10,000 mental health care provider FTE staff in 2015–16 to 70.4 in 2019–20, an average annual increase of 12.3%.

Data suggests that the processes for transitioning people from hospital to community care are becoming more streamlined, with the rate of community mental health care following hospital discharge (PI 16) increasing from 53.6% in 2010–11 to 75.1% in 2019–20.

The largest average annual increase (3.2%) in post-discharge community mental health care between 2015–16 to 2019–20 was for remote and very remote areas, which now have rates of post-discharge community mental health care that are comparable to that in major cities, inner regional and outer regional locations.

We have also seen encouraging signs that people are using subsidised mental health services, with data showing national improvements in Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care. These results reinforce the value of an equitable, public health model for these services. However, available data also suggests that the system is struggling to meet the demand (PI 15), and this may be further challenged by the levels of psychological distress in the population (PI 7).

The extent to which community care is preventing readmissions to acute care (PI 17) and inpatient care is promoting positive outcomes for consumers have also emerged as particular challenges requiring ongoing attention. Results are discussed in further detail in the performance indicators section of the report.

Overall, during the life of the Fifth Plan, the 18 reported indicators show national improvements in:

- population access to Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care
- the number of seclusion events (confinement of a consumer or patient) within public acute admitted-patient specialised mental health service units
- employment of consumer and carer workers
- post-hospital discharge community mental health care access
- rates of daily smoking among people with mental illness.

Sustained improvements have not been seen in:

- population access to public and private clinical mental health care
- the proportion of mental health-related hospitalisations that are followed by readmission within 28 days of discharge
- the proportion of consumers who experienced no significant change or significant deterioration of clinical symptoms following inpatient mental health care
- alcohol consumption, illicit drug use and misuse of pharmaceuticals
- the proportion of children who are developmentally vulnerable
- the proportion of adults with very high levels of psychological distress
- suicide rates.

Review of the Fifth Plan

Although we have seen advances in the mental health and suicide prevention policy space over the Fifth Plan's life, available data indicates there is a clear need for further progress in achieving this ambitious and long-term vision for Australia's mental health and suicide prevention systems.

Stakeholders reported encountering several challenges during implementation of the Fifth Plan, including a lack of funding and resources occasionally acting as a barrier to delivery. Some stakeholders also had difficulties clarifying the roles, responsibilities and expectations involved in implementing this reform over the Fifth Plan's life.

Stakeholders said that engagement with consumers and stakeholders was a key enabler to progress, with many reporting consumer consultation as being critical to planning, governance and the development of frameworks.

Although there was intent to undertake an evaluation of the Fifth Plan (Action vi), this work was delayed by resourcing and capacity issues, and the action was subsequently closed following the dissolution of COAG. Without an independent evaluation of the Fifth Plan, conclusions around its performance in achieving its objectives are difficult to make. This is a significant shortcoming in terms of informing continuous improvement and applying learnings to future reforms.

In considering the barriers in implementing the Fifth Plan, future mental health and suicide prevention plans should prioritise:

- ensuring all actions for future reform are specific, measurable and time-bound
- ensuring expectations, roles and capabilities of stakeholders are clearly defined from the outset
- ensuring appropriate mechanisms are built into implementation plans that appropriately support and resource stakeholders to implement actions
- a commitment to evaluation, reflected by adequate resource allocation for high-quality evaluation and planning, including identifying key evaluation goals and questions, defining key roles and responsibilities, and establishing a data collection and analysis plan.

Recognising that not all Fifth Plan actions have been completed, there should be concerted action to ensure commitments made in the Fifth Plan are honoured and implemented. Actions yet to be fully achieved should be prioritised moving forward to ensure they lead to tangible improvements to the mental health and wellbeing of carers and consumers.

In terms of measuring change, recognising the broad nature of the performance indicators and the length of time between data collection, a key priority should be sustained monitoring and reporting of the Fifth Plan performance indicators over the next decade to determine whether predicted changes are occurring across the set of indicators.

Although it will not be possible to link improvements or deteriorations with the Fifth Plan's implementation, this data will still be important in understanding what areas should be prioritised in future reform efforts.

As well as ongoing monitoring of these broad outcomes, a focus on monitoring more short- and medium-term outcomes for incremental policy, service and system changes should be adopted to make it clearer that reform is making a meaningful change and to help drive continuous improvement.

Selecting these outcomes should be informed by considerations of scientific soundness and usefulness for decision-making. Given the importance of social determinants and the effects of mental ill health on a person's functioning, effort should be made to move from purely clinical and health-focused indicators to include indicators that focus on factors such as wellbeing, employment, physical health and income, and capture how integration drives improved outcomes for consumers and carers.

In addition to committing to monitoring and measuring key outcomes, agreement on a set of specific targets and timeframes should be a priority to promote accountability and drive change. Targets should reflect realistic and achievable aspirations and be co-designed with consumers and carers to ensure they are relevant and fit for purpose.

Noting current data gaps and the impact this has on drawing conclusions about the effectiveness of policies and initiatives, agencies should work together to improve how data is collected, recorded and disseminated to address these gaps and increase the availability of reliable data. This should be supported by a strong evaluation culture to improve transparency and accountability. Priorities for data development should include outcomes identified by mental health consumers and carers to ensure they are relevant and fit for purpose.

Finally, it is critical to regularly collect and monitor more in-depth and robust quantitative and qualitative data on the perspectives of consumers and carers in the formal evaluation of future Mental Health and Suicide Prevention Plans. Efforts should also be made to ensure responses represent the full breadth of the consumer and carer population to more broadly assess whether the reform is successfully achieving its objectives. Large and representative samples that include priority populations will help answer critical questions such as what specific interventions or service improvements are generating an impact, for whom and under what circumstances.

Introduction

The Fifth Plan was endorsed by the Council of Australian Governments (COAG) Health Council in August 2017. Responsibility for implementing the Fifth Plan was assigned to the Australian Health Ministers' Advisory Council (AHMAC), and the Mental Health Principal Committee (MHPC) and its subordinate committees, with the intent that implementation would finish in 2022.

Building on the foundations of the previous 4 National Mental Health Plans, the Fifth Plan established a cross-jurisdictional framework for collaborative government effort for 2017 to 2022. Like its predecessors, the Fifth Plan prioritised specific areas of action to achieve the vision of the National Mental Health Policy, which was first endorsed in 1992 and later updated in 2008.

The vision of the 2008 National Mental Health Policy is for a mental health system that:

- enables recovery
- prevents and detects mental illness early
- ensures that Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

The Fifth Plan committed Australian governments to achieving outcomes in 8 priority areas that align with this vision, specifically:

- **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.

Previous National Mental Health Plans prioritised specific areas of action consistent with the need and opportunity identified at that time. Priority areas of previous National Plans are listed in Table 1. Of note, the Fifth Plan was developed at a time of considerable change in Australia's social policy landscape.

Key changes included:

- the establishment of the National Disability Insurance Scheme

- both Australian Government and state and territory governments devolving identified service delivery responsibilities to regional entities—the Primary Health Networks (PHNs) and Local Health Networks (LHNs)
- the establishment of several state government Mental Health Commissions focused on a whole-of-government approach to promoting mental health and suicide prevention.

Like its predecessors, the Fifth Plan emphasised the need for safety and quality in mental health service delivery, and for coordinating treatment and supports for people with severe and complex mental illness. However, the Fifth Plan was the first plan to specifically commit to achieving integrated regional planning and service delivery (Priority Area 1).

Although previous National Mental Health Plans have aimed to strengthen integration, each has had a different focus and actions. In the Fifth Plan, integration is about building relationships between organisations with similar aims, to improve the outcomes and experiences of consumers and carers. The Fifth Plan recognises that PHNs and LHNs provide the core architecture to support integration at the regional level. This represents a fundamental change in the role of a National Mental Health Plan as one that sets an enabling environment for regional action instead of dictating change from the top.

The Fifth Plan was the first to:

- identify suicide prevention as a priority area, committing to coordinated actions by both levels of government to address this critical issue (Priority Area 2)
- specifically outline an agreed set of actions to address social and emotional wellbeing, mental illness and suicide among Aboriginal and Torres Strait Islander peoples as a priority (Priority Area 4)
- elevate the importance of addressing the physical health needs of people who live with mental illness (Priority Area 5)
- elevate the importance of reducing the stigma and discrimination that accompanies mental illness (Priority Area 6).

On 29 May 2020, the COAG arrangements ceased, to be replaced by a more streamlined intergovernmental structure. This has resulted in changes that affect the coordinating of the Fifth Plan as a discrete reform.

Under the new intergovernmental arrangements, the COAG Health Council and AHMAC have been replaced with the Health Ministers Meeting and Health Chief Executives Forum, respectively. However, an equivalent of the MHPC and its subordinate committees has not yet been established, and the original implementation and reporting framework for the Fifth Plan is no longer in place.

The Fifth Plan has been superseded by the National Mental Health and Suicide Prevention Agreement. The Australian Government and state and territory governments have committed to this National Agreement, which enables collaboration on systemic, whole-of-governments reform to deliver comprehensive, coordinated, consumer-focused and compassionate mental health and suicide prevention systems.

As a consequence, this report will be the final annual Fifth Plan progress report prepared by the National Mental Health Commission.

This report is comprised of 3 sections:

- The first section outlines the progress achieved against the Fifth Plan actions since it began and up to 31 December 2021.
- The second section outlines the most recent data available for each of the Fifth Plan performance indicators.
- The third section provides a reflection on the effectiveness and appropriateness of the Fifth Plan in achieving its objectives since it began in 2017, to help inform the way forward for future mental health reform.

Table 1: Priority areas of National Mental Health Plans

	Priority areas/themes
First Plan (1993–1998)	Consumer rights The relationship between mental health services and the general health sector Linking mental health services with other sectors Service mix Promotion and prevention Primary care services Carers and non-governmental organisations Mental health workforce Legislation Research and evaluation Standards Monitoring and accountability
Second Plan (1998–2003)	Promotion and prevention Partnerships in service reform and delivery The quality and effectiveness of service delivery
Third Plan (2003–2008)	Promoting mental health and prevention of mental health problems and mental illness Improving service responsiveness Strengthening quality Fostering research, innovation and sustainability
Fourth Plan (2009–2014)	Social inclusion and recovery Prevention and early intervention Service access, coordination and continuity of care Quality improvement and innovation Accountability—measuring and reporting progress
Fifth Plan (2017–2022)	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

Implementation progress of Fifth Plan actions

As of 31 December 2021, 43 of the 65 actions and sub-actions have been completed. A further 5 actions were superseded by the announcement of the National Mental Health and Suicide Prevention Agreement (National Agreement).

A single rating cannot be reported for Actions 14 and 27, as they are being implemented separately by each jurisdiction. The remaining 15 actions are being finalised through business-as-usual activities or will be achieved through the mental health and suicide prevention reforms announced in the 2021–22 Budget.

Of the 4 'Governance' actions, 3 have been completed. The review of the National Mental Health Policy under Action iv has been overtaken by the reforms announced in the 2021–22 Budget and the National Agreement.

The 'Measuring and reporting on change' actions have been partially completed. The Australian Institute of Health and Welfare's (AIHW) has published the third edition of *National Mental Health and Suicide Prevention Information Priorities*. The Australian Government committed to commissioning an independent evaluation of the Fifth Plan informed by targeted consultation with governments, consumers and carers and the mental health sector (Action vi). The development of an evaluation plan was delayed in 2018–19 by resourcing and capacity issues, then again in 2019–20 by the COVID-19 pandemic and review of the former Council of Australian Governments (COAG) councils and ministerial forums. Action vi was subsequently closed when the COAG governance bodies ceased.

Despite some delays due to various barriers, almost all actions under Priority Area 1: 'Achieving integrated regional planning and service delivery' have now been completed. This includes the development and release of regional mental health and suicide prevention plans by Primary Health Networks (PHNs) and the development of the National Mental Health Service Planning Framework and guidance material to support PHNs and Local Hospital Networks (LHNs) with regional planning.

Although most actions under Priority Area 2: 'Suicide prevention' have been completed, the National Suicide Prevention Project Reference Group was dissolved when COAG ceased.

Before this, the National Suicide Prevention Strategy for Australia's Health System: 2020–2023 was endorsed by the (now former) COAG Health Council and the Mental Health Principal Committee (MHPC). The strategy commits all governments to working collaboratively on a journey towards zero suicides in Australia, and forms the foundations for national suicide prevention reform initiatives taking place in the health system in each jurisdiction, focusing primarily on health interventions and selected community-based activities.

The National Agreement will continue action on suicide prevention, providing a platform to ensure different portfolios and jurisdictions work together to build better mental health and suicide prevention systems for Australians. The Australian Government Department of Health and Aged Care leads this work in collaboration with states and territories.

Under the National Agreement, whole-of-community approaches to suicide prevention (Action 5) will continue. The agreement outlines joint responsibility for the Australian Government, and state and territory governments to collaborate at a regional level to determine community needs and plan the

response to those needs. This includes providing suicide prevention programs that reflect and respond to local needs and circumstances.

The National Suicide Prevention Office will develop a National Suicide Prevention Strategy that will complement work being done as part of the National Agreement, with the aim of broadening suicide prevention activities across whole of governments.

Actions under Priority Area 3: 'Coordinating treatment and supports for people with severe and complex mental illness' are largely complete, but have been superseded by the National Agreement:

The National Guidelines to Improve the coordination and treatment of people with severe and complex mental illness were completed in late 2020 and have been endorsed by all Australian governments.

Reforms announced in the 2021–22 Budget and the National Agreement will continue to support the needs of people with severe and complex mental illness, including those who do not qualify to receive supports under the National Disability Insurance Scheme (NDIS) (Action 6). For example, as part of the 2021–22 Budget, the Australian Government committed $171.3 million over 2 years to continue Australian Government psychosocial support services for people with severe mental illness who are not yet accepted or supported through the NDIS.

All actions under Priority Area 4: 'Improving Aboriginal and Torres Strait Islander mental health and suicide prevention' have been completed:

Gayaa Dhuwi (Proud Spirit) has been established as a national Aboriginal and Torres Strait Islander leadership body in mental health, social and emotional wellbeing and suicide prevention. The Australian Government continues to partner with Gayaa Dhuwi to finalise the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, which will recommend key government investment to improve mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention established a clearinghouse for best-practice services and programs. PHNs and LHNs have been supported with guidance on integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples and additional funding to support commissioning of enhanced Aboriginal and Torres Strait Islander mental health services.

Almost all actions under Priority Area 5: 'Improving the physical health of people living with mental illness and reducing early mortality' have been completed:

- The Australian Government has committed funding to the Equally Well Program to support improvements to the physical health of those living with a mental illness. Cross-jurisdictional commitment to the Equally Well Consensus Statement is part of National Agreement negotiations.
- The Being Equally Well Roadmap has been launched, providing guidance and resources for health practitioners. It proposes developing tools for effective, proactive and quality shared care between general practice and mental health services.
- Further work is required under the new mental health reforms to finalise mechanisms for nationally consistent reporting on the physical health of Australians with mental illness. The Australian Government has provided funding through the 2021–22 Budget for Charles Sturt University to undertake a data linkage project, designed to monitor progress in reducing the life expectancy gap between people living with a mental illness and the general population.

Actions under Priority Area 6: 'Reducing stigma and discrimination' are well progressed and will be finalised under the new mental health reforms and through business-as-usual activities:

In December 2020, all state and territory governments tasked the Commission with leading the development of the National Stigma and Discrimination Reduction Strategy. This strategy will recommend actions to reduce self, public and structural stigma and discrimination across various settings, including the health and mental health systems.

The 2021–22 Budget included funding for initiatives to reduce stigma associated with seeking mental health care among health practitioners and to improve the awareness and skillset of the health workforce to appropriately respond to Aboriginal and Torres Strait Islander mental health issues.

Work is progressing on a 10-year National Mental Health Workforce Strategy.

The National Mental Health Commission has released the National Lived Experience (Peer) Workforce Development Guidelines under Action 29 of the Fifth Plan. The guidelines aim to strengthen understanding and collaboration across the mental health sector and beyond, contributing to more effective services and better outcomes for people accessing services, their families, supporters and communities.

Most actions under Priority Area 7: 'Making safety and quality central to mental health service delivery' are complete or progressing through business-as-usual activities:

- The Australian Commission on Safety and Quality in Health Care (ACSQHC) has developed a *National Safety and Quality Health Services Standards User Guide for Acute and Community Mental Health Services*.
- The ACSQHC has developed the National Safety and Quality Health Standards for Community Managed Organisations.
- The Commission has published the *Mental Health Safety and Quality Engagement Guide* for consumers and carers, to strengthen their role in safety and quality initiatives within mental health services.
- In late 2020, the AIHW published the Third Edition National Mental Health and Suicide Prevention Information Priorities to set a vision for national mental health information in Australia for the coming decade.
- All Australian governments have taken steps to make the World Health Organization Quality Rights guidance and training tools relevant to mental health accessible to consumers, carers, community-managed organisations and other health services, with several jurisdictions reporting that this action has been 'completed'.
- The AIHW now reports on the Your Experience of Service survey instrument, with 3 states participating so far.
- Supported by the National Mutual Recognition Interjurisdictional Project Steering Committee, Queensland Health is leading efforts to improve consistency across jurisdictions in mental health legislation, by developing a national legislative framework for the mutual recognition of civil mental health orders. A model Bill has been provided to the New South Wales Parliamentary Counsel's Office for drafting on behalf of the National Parliamentary Counsels' Committee.

Some actions under Priority Area 8: 'Ensuring that the enablers of effective system performance and system improvement are in place' have been completed, and others are progressing through business-

as-usual activities. The National Mental Health Research Strategy was released in early 2022, in consultation with the mental health research sector. The Workforce Development Program is contingent on the strategy being developed under Priority Area 6. The National Digital Mental Health Framework has been publicly released.

The status of all Fifth Plan actions is outlined in Appendix A. Due to the dissolution of the COAG governance bodies that formerly contributed to Fifth Plan reporting, the reporting framework used in previous years could not be implemented, as an equivalent of the MHPC and its subordinate committees has not yet been implemented.

Status updates were informed by the Australian Government Department of Health and Aged Care, state and territory departments of health, state mental health commissions and the Commission.

To supplement the status updates, PHNs, governments and state mental health commissions were invited to submit a case study to highlight an initiative implemented under the Fifth Plan. Case studies submitted by stakeholders are included in Appendix B. Case studies covered various recently introduced initiatives, including new projects, programs and services to support mental health, and new strategies, plans and frameworks that align with one or more priorities of the Fifth Plan.

Examples of achievements include:

- projects to consolidate and promote existing initiatives and resources to help grow mental health lived experience voices and leadership, including establishing a central repository of mental health consumer and care leadership-related knowledge and initiatives, and the co-designing a Mental Health Lived Experience Governance Framework and Toolkit to guide priority organisations and jurisdictions when engaging with people with lived experience
- suicide prevention programs, including Mateship Matters, The Way Back Support Service and the Pharmacy Project, which is helping community pharmacists to play a meaningful role in suicide prevention by building their confidence and skills to respond to people in distress and at risk of suicide
- strategic plans for mental health and wellbeing, including the Western Australian Foundational Plan for Mental Health, Alcohol and Other Drug Services, and Suicide Prevention, and Planning for Wellbeing—a joint regional plan for mental health, suicide prevention and alcohol and other drugs by Brisbane North PHN and Metro North Health.

Figure 1: Status overview of Fifth Plan actions

Action	Status
Governance	
i	Completed
ii	Completed
iii	Completed
iv	Closed
Measuring and reporting on change	
v	Progressing through business-as-usual activities
vi	Closed
vii	Completed

Action	Status
Priority Area 1: Achieving integrated regional planning and service delivery	
1.1	Completed
1.2	Completed
1.3	Completed
1.4	Completed
1.5	Completed
2.1	Closed
2.2	Completed
2.3	Completed
2.4	Completed
2.5	Completed
2.6	Completed
2.7	Completed
2.8	Completed
Priority Area 2: Suicide Prevention	
3	Completed
4	Completed
5	Progressing through other reforms

Action	Status
Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness	
6	Completed
7	Completed
8	Closed
9	Progressing through business-as-usual activities
Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention	
10	Completed
11	Completed
12.1	Completed
12.2	Completed
12.3	Completed
12.4	Completed
13.1	Completed
13.2	Completed
13.3	Completed

Action	Status
Priority Area 5: Improving the physical health of people living with mental illness and reducing early mortality	
14	National status rating not possible, as states and territories are implementing action independently
15	Completed
16.1	Completed
16.2	Completed
16.3	Completed
17	Progressing through other reforms
Priority Area 6: Reducing stigma and discrimination	
18	Progressing through other reforms
19.1	Progressing through other reforms
19.2	Progressing through other reforms
19.3	Progressing through other reforms
20	Completed and moved to ongoing administrative activities

Action	Status
Priority Area 7: Making safety and quality central to mental health service delivery	
21.1	Closed
21.2	Completed
21.3	Completed
21.4	Progressing through business-as-usual activities
21.5	Completed
22	Progressing through business-as-usual activities
23	Progressing through business-as-usual activities
24	Completed
25	Progressing through business-as-usual activities
26	Progressing through business-as-usual activities
27	National status rating not possible, as states and territories are implementing action independently
Priority 8: Ensuring that the enablers of effective system performance and system improvement are in place	
28	Completed
29	Completed
30	Completed
31	Progressing through business-as-usual activities
32	Progressing through business-as-usual activities

Performance against the identified indicators

The Fifth Plan identified 24 performance indicators (PIs) designed to collectively measure the mental health and wellbeing of Australians, and the performance of the mental health system throughout the life of the Fifth Plan and beyond.

With this long-term monitoring in mind, the performance indicators include broad measures of the mental health status of the population and the process of mental health care, rather than measures that closely align with the priority areas or actions under the Fifth Plan. As such, they cannot be used to determine whether the Fifth Plan's actions have been effective in achieving its specific objectives.

Appendix C outlines the 24 performance indicators.

Where trend data is available, performance indicators can point towards improvements in health, wellbeing or system performance. However, the performance indicators cannot provide information about why a measure of health, wellbeing or system performance has or has not changed over time, or what is needed to achieve the desired changes. This is because of the broad nature of the performance indicators and the fact that they are influenced by an array of environmental and socio-cultural factors. As a result, even if changes over time are detected, it is very difficult to determine whether the Fifth Plan has had its intended impact on these outcomes or whether the change is the result of other contributing factors.

Further information about the limitations of the performance indicators is provided in the review section of this report.

The 24 Fifth Plan performance indicators are listed in **Error! Reference source not found.**, grouped by reporting purpose and reporting status. For several data sources, not enough data is available to establish trends over time.

A total of 9 performance indicators are measured every 3 or more years. Given the Fifth Plan's life was for 5 years, many of these indicators only have 1 or 2 datasets available to assess change over the time the Fifth Plan was being implemented.

Each performance indicator also has specific caveats that limit the conclusions that can be drawn from the data available. Examples include reliance on self-report, issues with sample representativeness, and gaps in data for specific population groups. Detailed information on the performance indicators, collection schedules and specific caveats is provided at Appendix C.

Table 2: Performance indicators, by reporting purpose and reporting status

Performance indicator purpose and status	Performance indicators
Reported performance indicators	
Performance indicators that monitor the health and wellbeing of Australians	• PI 1: Children who are developmentally vulnerable • PI 2: Long-term health conditions in people with mental illness • PI 3: Tobacco and other drug use in adolescents and adults with mental illness • PI 6: Prevalence of mental illness

Performance indicator purpose and status	Performance indicators
Reported performance indicators	
	• PI 7: Adults with very high levels of psychological distress • PI 9: Social participation in adults with mental illness • PI 10: Adults with mental illness in employment, education or training • PI 11: Adult carers of people with mental illness in employment • PI 19: Suicide rate • PI 24: Experience of discrimination in adults with mental illness.
Performance indicators that monitor the performance of the mental health system	• PI 13: Mental health consumer experience of service • PI 14: Change in mental health consumers' clinical outcomes • PI 15: Population access to clinical mental health care • PI 16: Post-discharge community mental health care • PI 17: Mental health readmissions to hospital • PI 18: Mental health consumer and carer workers • PI 22: Seclusion rate • PI 23: Involuntary hospital treatment
Not-yet-reported performance indicators	
Performance indicators that aim to monitor the health and wellbeing of Australians	• PI 4: Avoidable hospitalisations for physical illness in people with mental illness • PI 5: Mortality gap for people with mental illness • PI 8: Connectedness and meaning in life
Performance indicators that aim to monitor the performance of the mental health system	• PI 12: Proportion of mental health consumers in suitable housing • PI 20: Suicide of people in inpatient mental health units • PI 21: Rates of follow-up after suicide attempt/self-harm

Under Action v of the Fifth Plan, the former Mental Health Information Strategy Standing Committee (MHISSC) was responsible for identifying data sources and indicator specifications for the 24 performance indicators. The MHISSC completed work on 18 of the 24 indicators, and this report includes data on these indicators.

The remaining indicators cannot be constructed from established data collections. The MHISSC was investigating solutions for these indicators before COAG ceased. Under the new National Mental Health and Suicide Prevention Agreement (National Agreement), shared work will continue between the Australian Government and state and territory governments to develop priority indicators. Priority data and indicators identified in the National Agreement include:

- life expectancy gap
- potentially preventable hospitalisations for physical health conditions
- rate of emergency department self-harm presentations
- stratification of all key socioeconomic and general health indicators by mental health status.

Reporting of the Fifth Plan indicators

The data included in this report is the most recent data available for each indicator as at 31 March 2022. However, differences in the collection schedules for the data sources of each Fifth Plan performance indicator mean the number of years of data available and the periods covered vary between indicators. For some data sources, not enough data is available to establish trends over time.

Where possible, the performance indicators include data at both the national level and for community groups or mental health services. This allows performance to be reported for different age groups, genders and Indigenous status.

This section provides an update on performance indicators for which new data has been released since the 2020 Fifth Plan progress report. Data for all available indicators can be found in the accompanying Fifth Plan Performance Indicators Excel workbook, along with citations to the sources of all indicator data used in this report.

For PI 2: 'Long-term health conditions in people with mental illness' and PI 10: 'Adults with mental illness in employment, education or training', 2020–21 data is presented in a standalone Excel file (see 'Supplementary Data'). This is because comparisons of 2020–21 to earlier periods should not be made due to changes in methodology.

Australians' health and wellbeing

Early life

Early childhood development is foundational for children's later health, wellbeing and life outcomes. Therefore, detecting and intervening to tackle developmental vulnerabilities is important to children's longer-term outcomes.

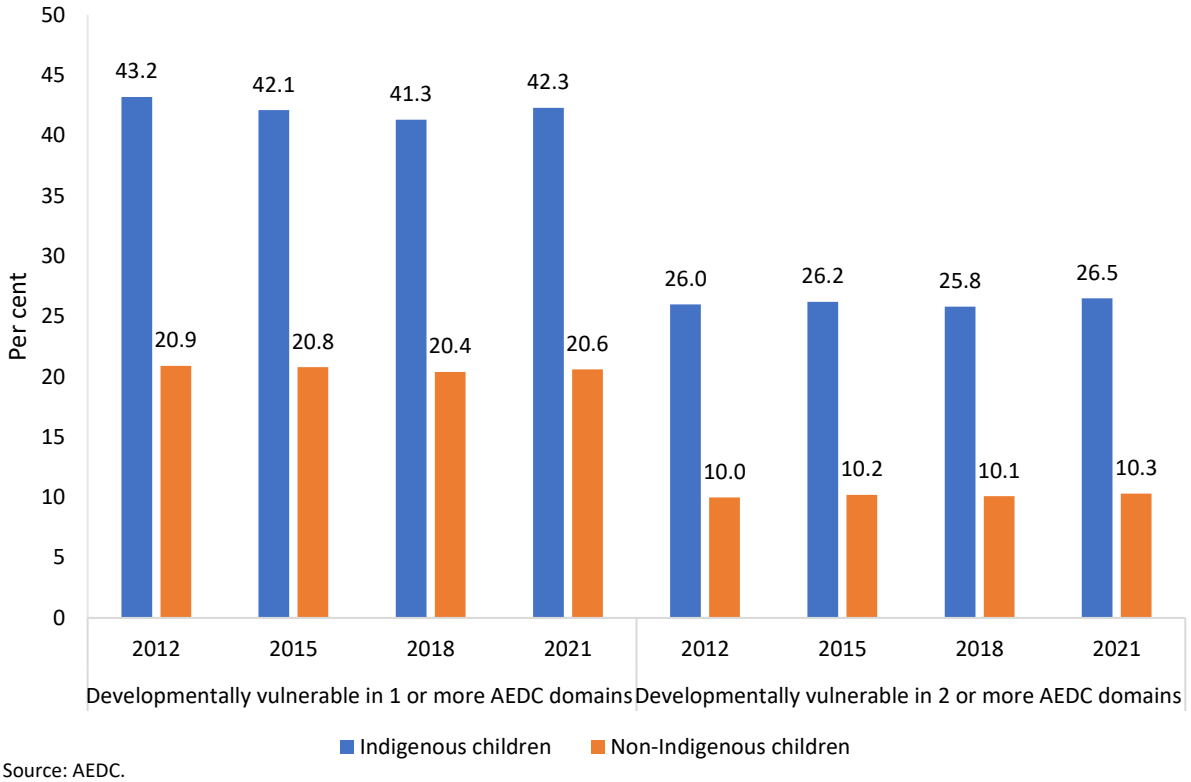
Nationally, the proportion of children entering their first year of full-time school who were developmentally vulnerable (PI 1) between 2018 and 2021 remained relatively stable. The percentage of children developmentally vulnerable on one or more domain(s) was 22.0% in 2021, compared with 21.7% in 2018. Data for 2019 and 2020 is not available as the Australian Early Development Census (AEDC) is administered every 3 years.

In both 2018 and 2021, the percentage of Aboriginal or Torres Strait Islander children who met the criteria for developmentally vulnerable in one or more areas of their development was more than double that of non-Aboriginal and Torres Strait Islander children (Figure 2).

Like previous years, in 2021, the proportion of children who were developmentally vulnerable increased as distance from metropolitan centres increased, with almost half (46.2%) of children in very remote areas meeting the criteria for developmentally vulnerable in one or more AEDC domains.

These findings highlight that substantial support is still needed for children to have the best chance of thriving later in life, particularly among children living in regional and remote areas and Aboriginal and Torres Strait Islander children.

Figure 2: Children entering their first year of full-time school who are developmentally vulnerable, by Indigenous status, 2012, 2015, 2018 and 2021



Source: AEDC.

Physical health

Several studies have highlighted that people living with mental illness have an increased risk of premature death. Most of the causes of early death relate to physical illnesses such as cardiovascular disease, diabetes and cancer. Monitoring the proportion of people with mental illness who have comorbid physical health conditions is essential to shed light on whether there has been any progress in improving the physical health of Australians with mental illness, and potentially reduce the mortality gap among people with mental illness.

The 2020–21 National Health Survey was collected online during the COVID-19 pandemic and is a break in time series. Although the data is not comparable to previous years due to differences in methodology, in 2020–21, long-term physical health conditions were more common among people with mental illness (50.6%; PI 2) than among people without mental illness (33.6%).

The proportion of people with a long-term physical health condition among people with mental illness also varied according to level of socio-economic advantage. Among people with mental illness, those living in the lowest socio-economic areas were more likely to report a long-term physical health condition than those living in the highest socio-economic areas. These patterns are consistent with previous survey results and research.

Suicide

Suicide rates provide a high-level indication of community mental health and wellbeing and its distribution across different population groups and geographic location.

In 2020, the national suicide rate (PI 19) was the lowest since 2016, at 12.1 per 100,000 people (see Table PI 19.3). However, when interpreting this data, it is important to recognise that 2020 marked the beginning of the COVID-19 pandemic, which may have affected the suicide rate in various ways.

Various protective and risk factors (such as employment, financial security, social connection and resilience) that occurred during this period are still not completely understood, and it is not yet possible to draw conclusions about longer-term impacts of the pandemic on suicide.

From 2011 to 2020, Australia's suicide rate:

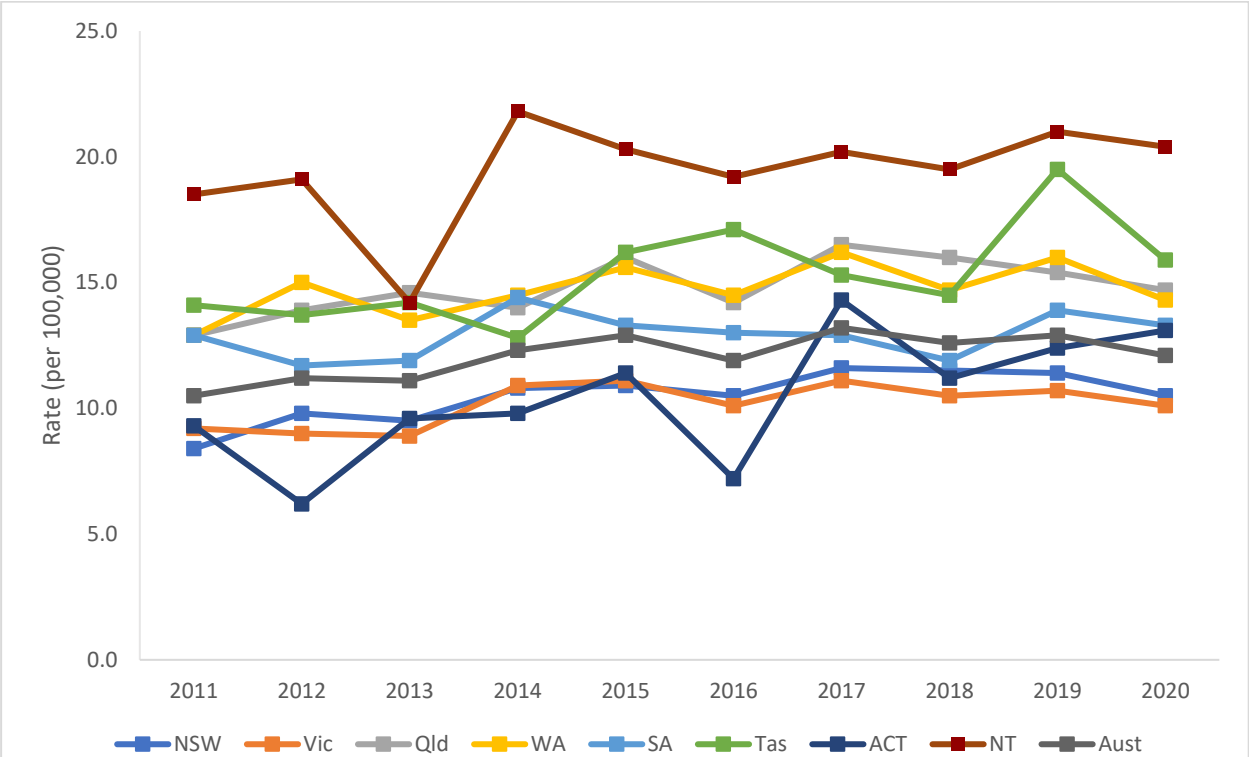
- increased slightly from 10.5 to 12.1 deaths per 100,000 (see Table PI 19.3)
- did not show a sustained reduction in any state or territory (Figure 3)
- fluctuated across age groups—over the past 10 years, no age group has shown a sustained reduction in suicide rates.

In 2011–2015, Aboriginal and Torres Strait Islander peoples had a suicide rate (PI 19) almost double that of non-Indigenous Australians; this difference persisted through 2016–2020.

The suicide rate for Aboriginal and Torres Strait Islander peoples increased from 22.2 per 100,000 population in 2011–2015 to 25.6 per 100,000 population in 2016–2020.

The non-Indigenous suicide rate was 11.5 per 100,000 population in 2011–2015 and 12.4 per 100,000 population in 2016–2020. The number of suicides of Aboriginal and Torres Strait Islander people increased across all jurisdictions, except South Australia and Western Australia, when comparing 2011–2015 with 2016–2020.

Figure 3: Suicide rate (per 100,000 population), by state and territory, 2011 to 2020



Source: ABS Causes of Death, Australia, 2020.

Contributing life

In 2020–21, a lower proportion of people with mental illness were in employment, education or training (PI 10; 73.0%) than people without mental illness (83.9%). Although this data is not comparable with previous years because of changes in survey methodology, this disparity is consistent with previous reporting periods (2014–15 and 2017–18).

In 2020–21, people aged 15–24 years with a mental illness were more likely (82.9%) to be in employment, education or training than any other age group of people with a mental illness. Those with a mental illness living in major cities were more likely to be in employment, education or training than those with a mental illness in regional or remote areas.

Participation in employment, education or training among people with mental illness varied according to socio-economic disadvantage: those living in higher socio-economic areas were more likely to be in employment, education or training than those living in lower socio-economic areas.

For people with mental illness, experiencing discrimination can increase feelings of isolation and create barriers to seeking help.

In 2020, the proportion of people with a mental illness who experienced discrimination (20.8%; PI 24) in the previous 12 months was almost double that of people without a mental illness (12.3%). This difference was more pronounced for females (24.3% and 12.3%, respectively) than for males (14.9% and 12.3%, respectively). Rates of discrimination among people with mental illness were comparatively lower than in 2019 (31.7%), but care should be taken when making comparisons with 2019, as the methodology changed. Currently, not enough data is available to identify trends over time.

Comparisons across age groups and Indigenous status are also unavailable due to high margins of error.

Performance of the mental health system

Lived experience workers

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

Higher proportions of consumer and carer workers (PI 18) may point towards a more responsive mental health system that provides appropriate and consumer-responsive care, support and treatment.

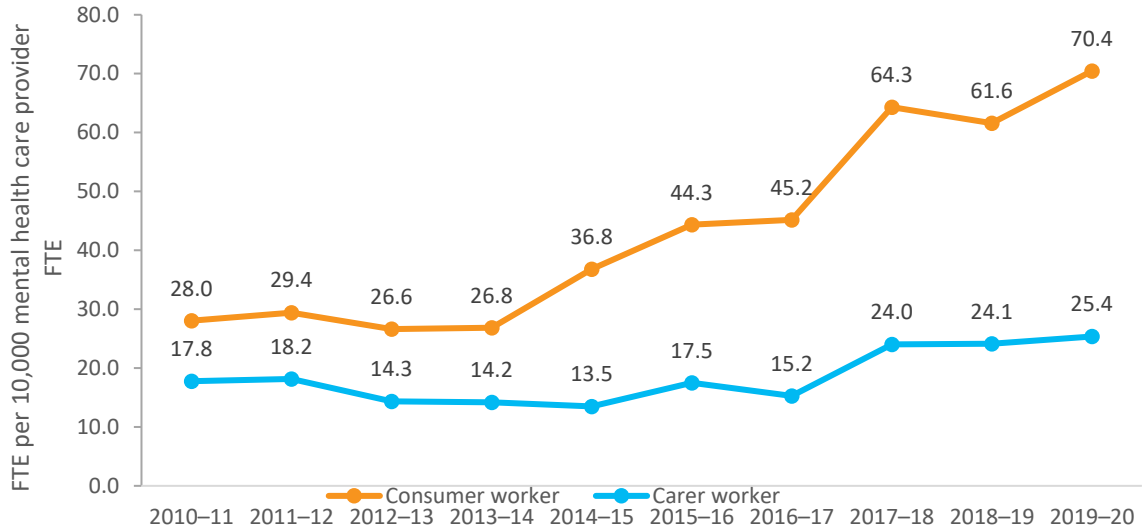
Nationally, the rate of full-time equivalent (FTE) lived experience (consumer) workers employed in specialised mental health care facilities managed or funded by state or territory health authorities increased from 44.3 per 10,000 mental health care provider FTE staff in 2015–16 to 70.4 in 2019–20. This was an average annual increase of 12.3%.

Over the same period, the rate of FTE lived experience (carer) workers increased from 17.5 to 25.4 per 10,000 mental health care provider FTE, an average annual increase of 9.7% (Figure 4).

However, for both consumer and carer workers, this increase was not seen consistently for all states and territories. Caution is required when interpreting this data, because consumer worker and carer worker FTE is relatively small, so small changes in these FTE may have a relatively large percentage impact on the rates of change.

Also, note that this data also does not speak to the experiences of consumer and carer workers, and whether they are provided appropriate supports and infrastructure to promote the development of consumer-responsive services.

Figure 4: Mental health consumer and carer worker FTE staff per 10,000 mental health care provider FTE, by staffing category, 2010–11 to 2019–20



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

Mental health service access

Measuring population treatment rates against what is known about the distribution of mental illness in the community gives a broad estimate of unmet need. If the prevalence of mental illness is stable, then higher proportions of people accessing clinical mental health care suggest less unmet need.

From 2015–16 to 2019–20, the proportion of people accessing public and private clinical mental health care (PI 15) was stable, at 1.9% and 0.2%, respectively. But from 2016–17 to 2020–21, the proportion of people accessing Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care increased from 10.2% to 11.6%.

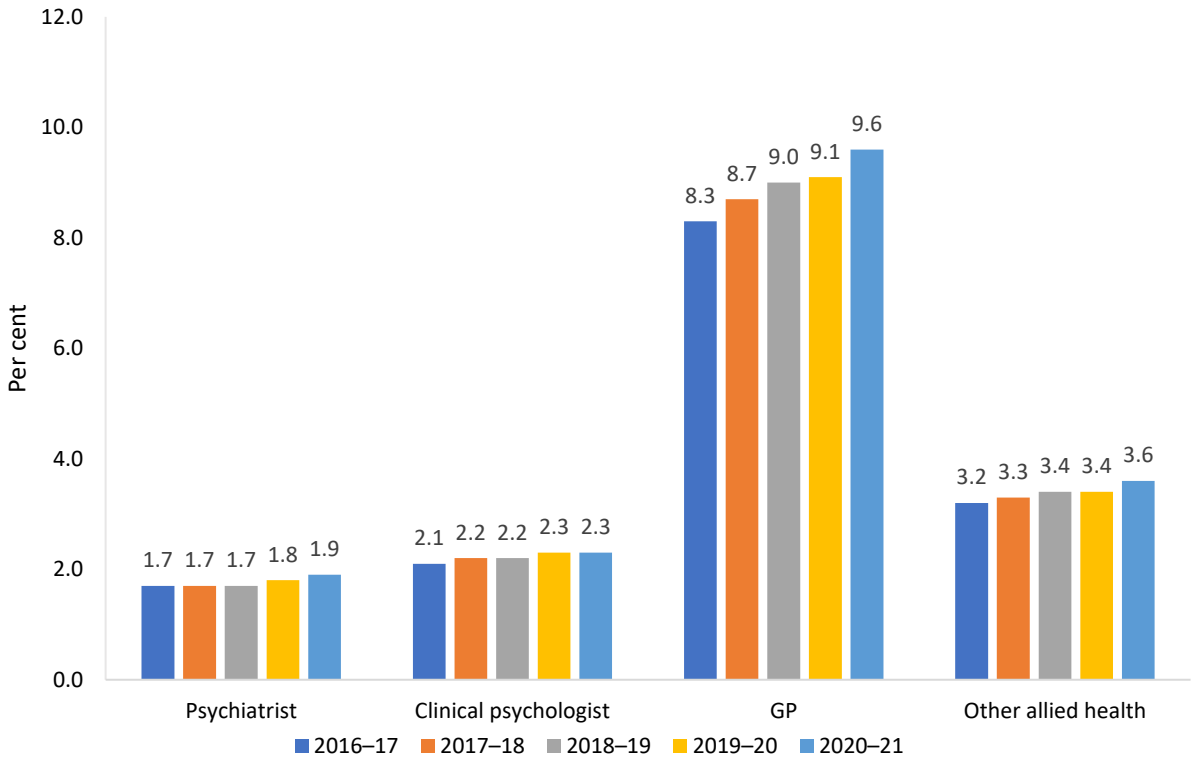
A higher proportion of the population accessed clinical mental health care via general practitioners (GPs), compared with other provider types (Figure 5).

From 2015–16 to 2019–20, the proportion of Aboriginal and Torres Strait Islander peoples accessing public clinical mental health care increased from 5.0% to 5.9%, an average annual increase of 4.1%. In contrast, the proportion of non-Indigenous Australians accessing public clinical mental health care was relatively stable, at 1.6% to 1.7%, an average annual increase of 0.8%.

From 2015–16 to 2019–20, the proportion of Aboriginal and Torres Strait Islander peoples accessing Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care increased from 9.7% to 12.0%, an average annual increase of 5.1%.

Indigenous status is not collected for private clinical mental health care.

Figure 5: Population accessing Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care services, by service provider type, 2016–17 to 2020–21



Source: Australian Government Department of Health and Aged Care Medicare Benefits Schedule statistics (unpublished); Department of Veterans' Affairs Treatment Account System data (unpublished).

Seclusion

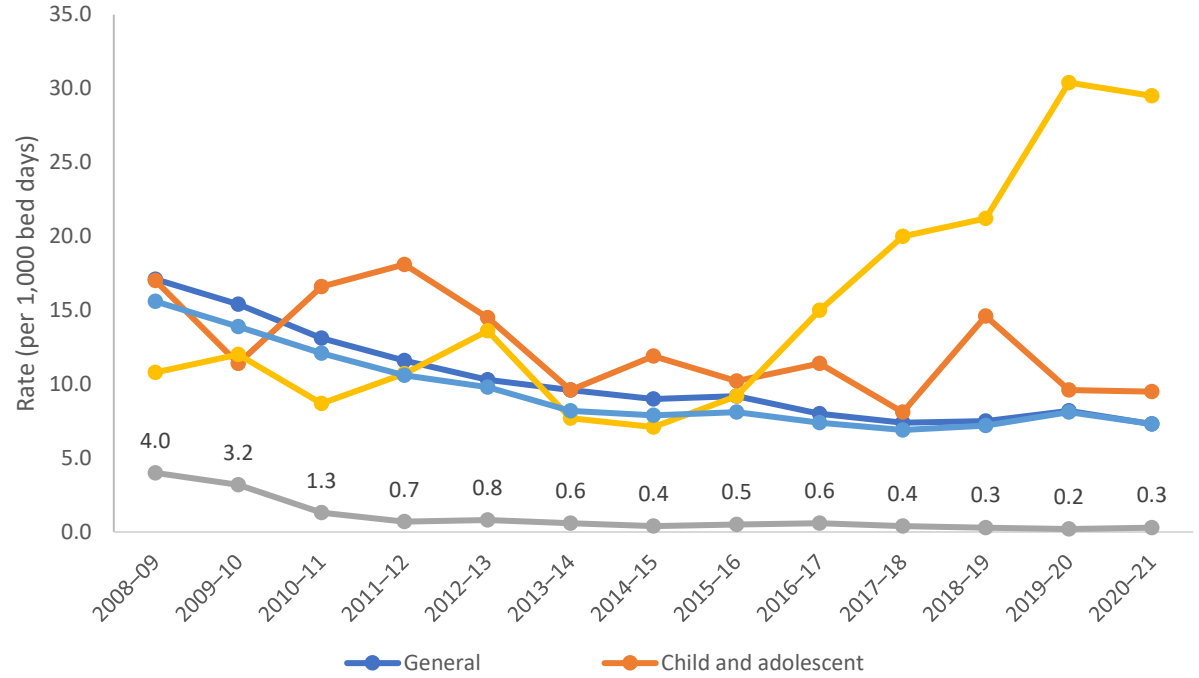
Seclusion is the confinement of a person at any time alone in a room or area from which free exit is prevented. High levels of seclusion may point to inadequacies in the functioning of the overall system, and risks to the safety of consumers receiving mental health care. Minimising and, where possible, eliminating use of seclusion among people with mental illness is a national priority.

In 2020–21, people in public acute mental health hospital care in Australia were secluded 12,371 times for 5.2 hours on average (excluding forensic services). This represents 7.3 events per 1,000 bed days.

This is a decrease from a rate of 8.1 the previous year, and from 15.6 during 2008–09 when data coverage began. The total seclusion rate (PI 22) has shown a sustained reduction from a rate of 13.9 per 1,000 bed days in 2009–10, the first year of data collection for all 8 jurisdictions. Over the 5 years between 2016–17 and 2020–21, the average annual decrease in the national seclusion rate was 0.4%.

From 2008–09 to 2020–21, seclusion rates for public acute mental health hospital services targeted at older people and the general population have shown a sustained reduction (Figure 6). However, seclusion rates fluctuated for services targeted at children and adolescents, and seclusion rates in services targeted at the forensic population has been rising sharply since 2015–16, with a slight decline in 2020–21.

Figure 6: Seclusion events per 1,000 bed days in public acute mental health hospital services, by service target population, 2008–09 to 2020–21



Source: AIHW (unpublished) National Seclusion and Restraint Database

Involuntary care

Involuntary care is a type of restrictive and coercive practice where treatment for mental illness is provided without the person's consent being given. To understand how much involuntary care occurs, the proportion of hospitalisations and patient days that involve involuntary care should be considered.

In 2019–20, 45.6% of public sector acute mental health hospitalisations with specialised mental health care involved involuntary care (PI 23). In this context, hospitalisation refers to an episode of admitted patient care, which can be a total hospital stay or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).

In 2019–20, about half of patient days in acute admitted patient units (55.6%) and non-acute admitted patient units (49.7%) were involuntary. Not enough years of data are available to identify trends over time.

Change in mental health outcomes

State or territory clinical mental health services aim to reduce symptoms and improve functioning. If services are highly effective, a high proportion of consumers will experience significant improvement, and few or no consumers will experience significant deterioration or no significant change.

In 2019–20, for inpatient care, almost three-quarters (72.2%) of consumers experienced a significant improvement between baseline and follow-up of completed mental health outcome measures (PI 14). This proportion has remained relatively stable over time, with more than 70% of consumers experiencing a significant improvement in clinical symptoms each year from 2007–08 to 2019–20

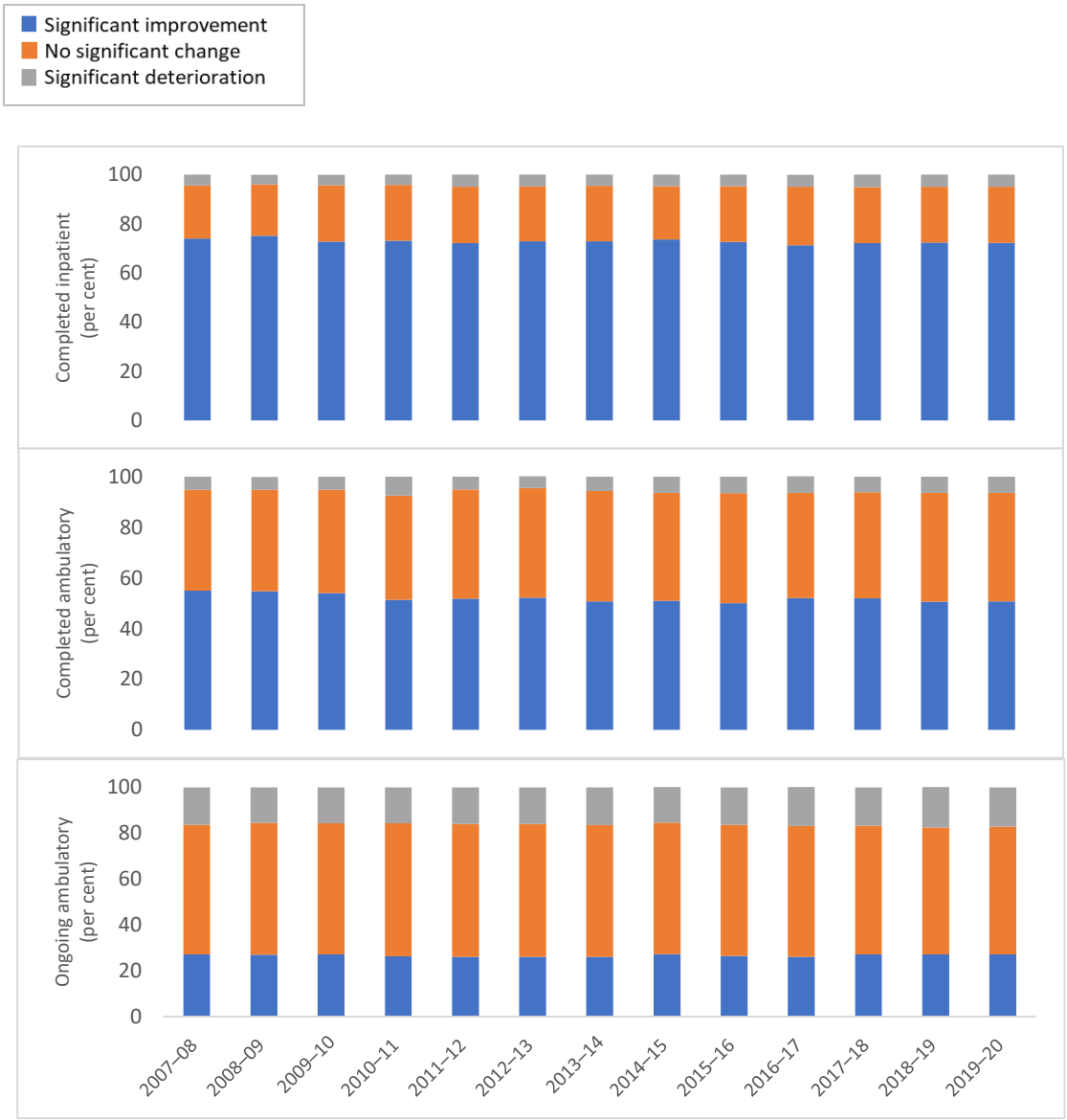
(Figure 7). Over the 5 years to 2019–20, the proportion of consumers who experienced significant deterioration or no significant change in symptoms after completing inpatient care has remained relatively stable.

In 2019–20, among those who completed ambulatory care:

- just over half (50.7%) experienced a significant improvement between baseline and follow-up
- 42.9% experienced no significant change
- 6.4% experienced significant deterioration.

Over the 5 years to 2019–20, the proportion of consumers who experienced significant deterioration or no significant change in symptoms after completing ambulatory care has remained relatively stable.

Figure 7: Mental health-related episodes of care, by consumer group, service setting and change in consumer mental health between baseline and follow-up, 2007–08 to 2019–20



Source: National Outcomes and Casemix Collection.

Experiences of care

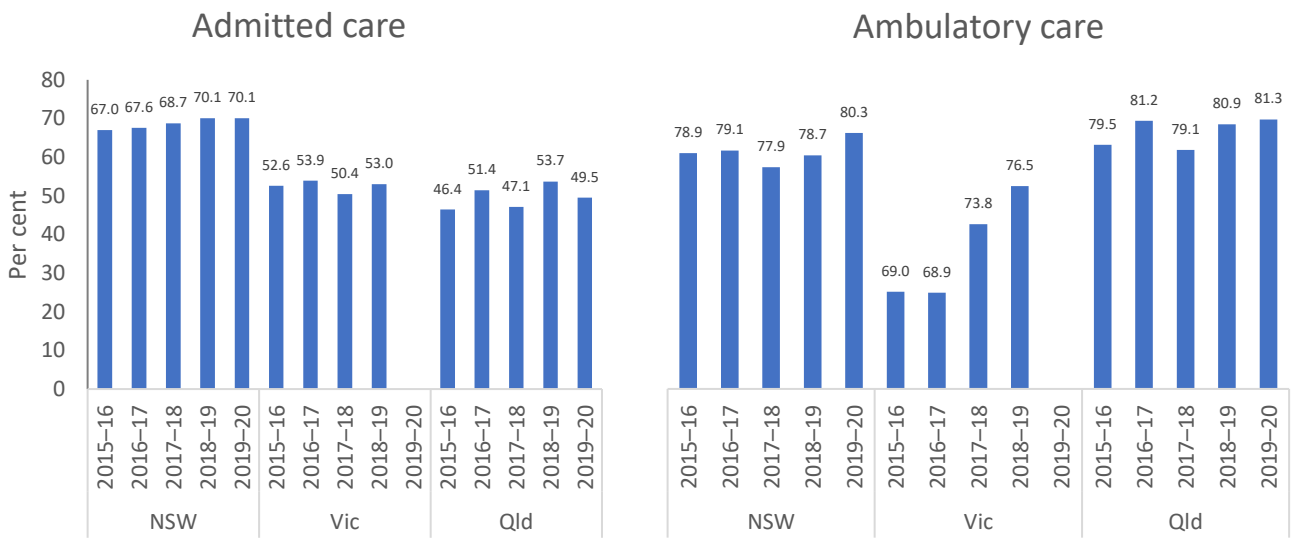
Consumer experiences of care from mental health services are a measure of the performance of the service and help inform ongoing quality improvement efforts. Higher proportions of consumers with a positive experience of service suggest a higher-performing mental health system.

In 2019–20, of mental health consumers who participated in data collection:

- the majority who accessed ambulatory care in New South Wales (80.3%) and Queensland (81.3%) reported a positive experience of service (PI 13)
- less than half (49.5%) who accessed admitted care in Queensland reported a positive experience of service
- 70.1% who accessed admitted care in New South Wales reported a positive experience of service.

Comparisons between jurisdictions should be made with caution, because of differences in survey administration methods. Over the 5 years to 2019–20, there was no sustained increase in positive experiences of service among mental health consumers who participated in data collection (Figure 8).

Figure 8: Mental health consumers with a positive experience of service, by service setting, New South Wales, Victoria and Queensland, 2015–16 to 2019–20



Note: Victoria did not conduct the Your Experience of Service survey in 2019–20.

Source: Your Experience of Service survey.

Community mental health care following hospital discharge

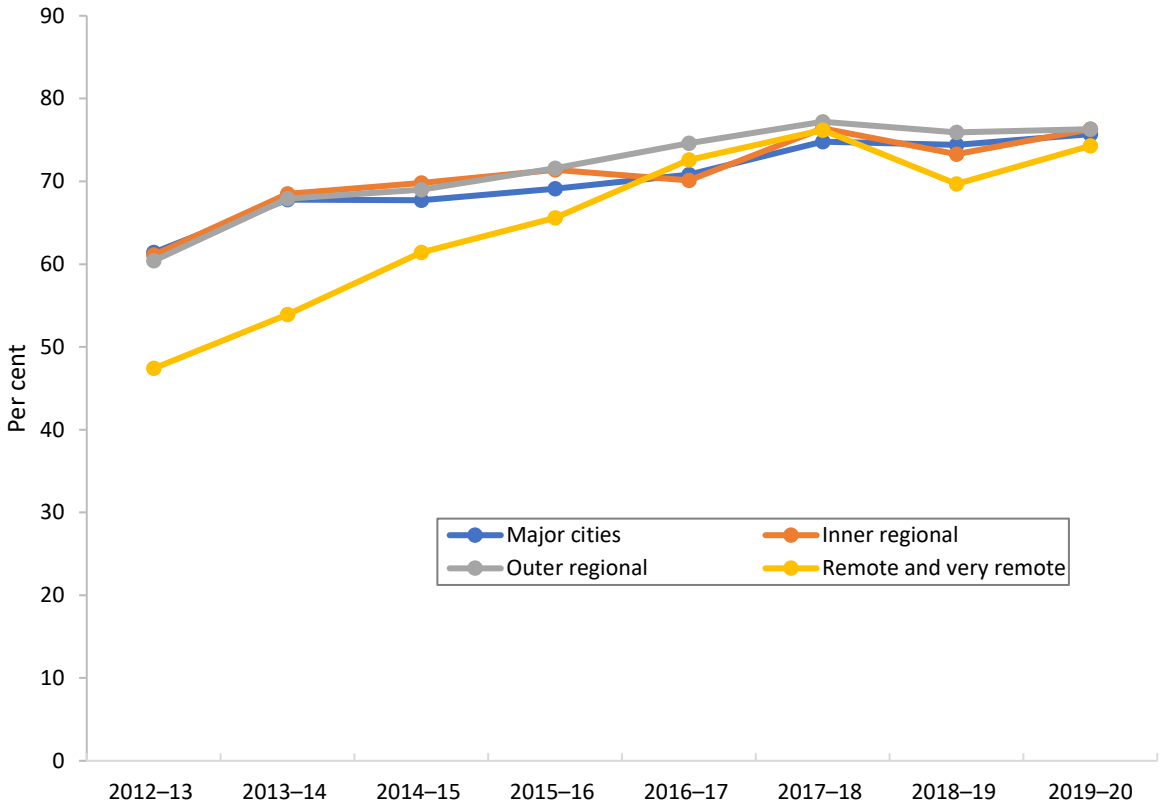
Community mental health care following hospital discharge is important to maintaining clinical and functional stability and minimising the need for hospital readmission.

Nationally, the rate of community mental health care following hospital discharge (PI 16) increased each year from 53.6% in 2010–11 to 75.1% in 2019–20. The largest average annual increase (3.2%) in post-

discharge community mental health care for 2015–16 to 2019–20 was for remote and very remote areas. These areas now have rates of post-discharge community mental health care that are comparable to those in major cities, inner regional and outer regional locations (Figure 9).

Nationally, the rate of community mental health care following hospital discharge for Aboriginal and Torres Strait Islander peoples increased from 55.0% in 2012–13 to 69.7% in 2019–20.

Figure 9: Public acute admitted patient separations with 7-day post-discharge community mental health care, by remoteness area, 2011–12 to 2017–18.



Source: State and territory governments, unpublished

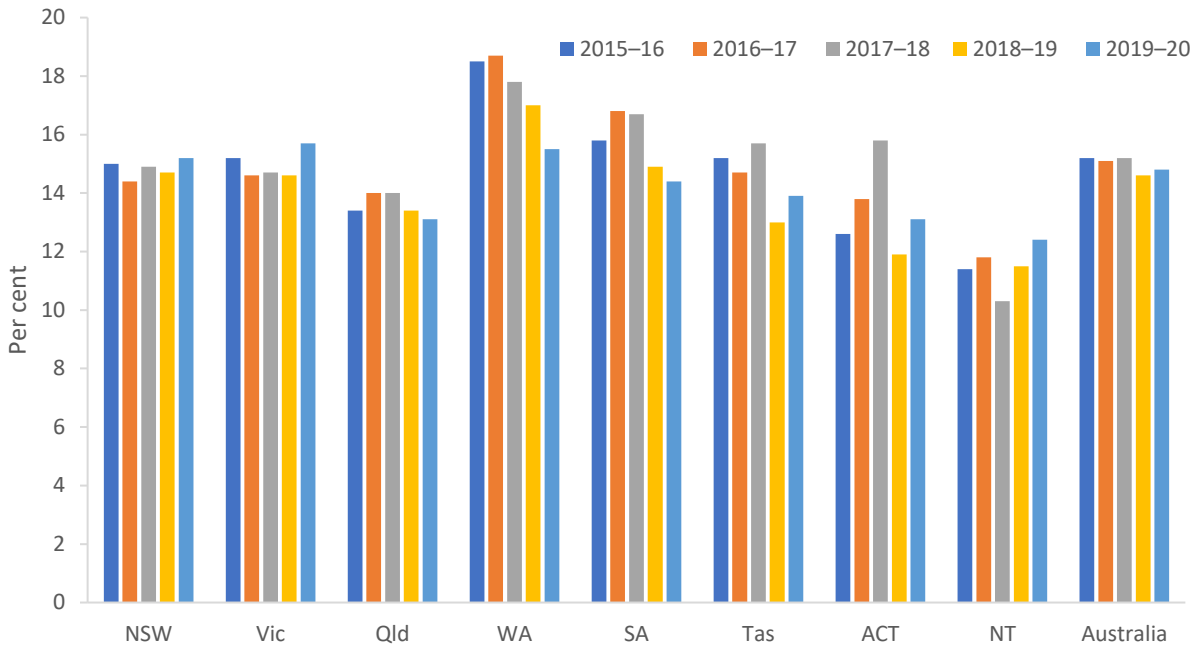
Mental health readmissions to hospital

Readmission to hospital within 28 days of 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. As such, these readmissions may point to deficiencies in the functioning of the overall mental health system.

Nationally, the proportion of mental health-related hospitalisations that were followed by readmission within 28 days of discharge (PI 17) was relatively consistent from 2015–16 (15.2%) to 2019–20 (14.8%), but this varied across states and territories (Figure 10).

When interpreting this data, note that it does not differentiate between planned or unplanned readmissions, so an unknown proportion of readmissions are likely to be planned readmissions.

Figure 10: Overnight acute admitted patient mental health care separations that were followed by mental health readmissions to hospital within 28 days, by state or territory, 2015–16 to 2019–20



Source: State and territory governments, unpublished

Performance indicator summary

Overall, the data available during the life of the Fifth Plan shows that, at the national level, we are seeing improvements in the rates of:

- access to Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care

- seclusion
- employment of mental health consumer and carer workers
- community mental health care access following hospital discharge
- daily smoking among people with mental illness.

Improvements have not been seen in the rates of:

- access to public and private clinical mental health care
- mental health-related hospitalisations that are followed by readmission within 28 days of discharge
- consumers who experienced no significant change or significant deterioration of clinical symptoms following clinical mental health care
- alcohol consumption, illicit drug use and misuse of pharmaceuticals
- children who are developmentally vulnerable
- adults with very high levels of psychological distress
- suicide.

Taken together, there are some encouraging signs that progress is being made on key safety and consumer considerations, with changes in workforce composition underway to include more consumer and carer workers and a reduction in seclusion rates. Available evidence also suggests that more streamlined processes for hospital to community care may also be operating. But the data is not showing improvements in the system's ability to meet demand or prevent distress. Further, data suggests that the quality of mental health care – in terms of reducing clinical symptoms and preventing the onset of future deterioration of mental health – needs urgent attention over the longer term.

Although not enough years of data are available to establish a trend, the disparity between people with and without mental illness in long-term physical health conditions, participation in employment, education and training and experience of discrimination also suggests that more work is needed in these areas.

Although the improvements in many aspects of mental health system performance are important, the number of indicators that do not show positive change remains concerning. It is clear that sustained attention is needed, through future reforms, to ensure we change the trajectory of psychological distress levels, alcohol and other drug use, and childhood vulnerability, and to eliminate the disparity in wellbeing and community participation between people with and without mental illness.

Noting that it is not currently possible to ascertain what is driving changes in the performance indicators over time, there is a clear need for greater investment and resourcing in evaluation and research to understand why improvement or deterioration is occurring.

Securing knowledge about the mechanisms that are driving change is paramount in scaling improvements and altering the trajectory of measures that are deteriorating.

Fifth Plan review

With the conclusion of the Fifth Plan reporting cycle and the start of a new National Mental Health and Suicide Prevention Agreement (National Agreement), now is an opportune time to reflect on the relative successes and failures of the Fifth Plan in making meaningful progress towards fulfilling its vision.

In this review, we consider how effective and appropriate the Fifth Plan has been in achieving its objectives since its inception in 2017, to help inform the way forward for future mental health reform.

The review draws together data on implementation from annual progress reports and performance indicators, along with data from consumer and carer surveys to understand the extent to which the Fifth Plan's objectives have been converted to action.

We reflect on what has worked well, outline remaining obstacles in achieving the Fifth Plan's objectives and provide an overview of the lessons learned. These lessons will be instrumental in guiding future reform efforts and bringing us closer to achieving an integrated mental health system that meets the needs of all Australians.

Taking stock

The primary aim of the Fifth Plan was to improve the lives of people living with a mental illness, as well as the lives of their families, carers and communities. The Fifth Plan sought to achieve this by committing to a nationally agreed set of priority areas and actions designed to build stronger, and more transparent, accountable, efficient and effective mental health and suicide prevention systems.

Of note, the Fifth Plan marked the first time that all governments committed to working together in delivering actions to:

- achieve integration in planning and service delivery at a regional level (Priority Area 1)
- more effectively address the issue of suicide (Priority Area 2)
- address social and emotional wellbeing, mental illness and suicide among Aboriginal and Torres Strait Islander peoples (Priority Area 4)
- elevate the importance of addressing the physical health needs of people who live with mental illness (Priority Area 5)
- elevate the importance of reducing the stigma and discrimination that accompanies mental illness (Priority Area 6).

As outlined in the 'Implementation progress' section of this report, despite some delays caused by various barriers, the majority of actions have now been completed.

Although the successful implementation of the Fifth Plan's actions may point to it having successfully achieved its intent, it does not tell the whole story. To understand whether the Fifth Plan successfully led to 'improvement in the lives of people living with a mental illness, as well as the lives of their families, carers and communities', broader investigation beyond monitoring implementation progress is required. Despite new initiatives since the Fifth Plan's introduction, several expected benefits for consumers and carers or the general population are yet to be observed in available data.

However, several limitations of the performance indicators significantly limit conclusions around the extent to which the Fifth Plan did or did not achieve its objectives. In particular, the performance indicators cannot provide information about why a measure of health, wellbeing or system performance has or has not changed over time, or what is needed to achieve the desired changes. Further, the performance indicators identified in the Fifth Plan are not closely aligned with its actions, so they cannot be used to determine whether the actions have been effective in achieving their intent.

In addition, observable changes for some of the indicators are not expected in the short term, as they represent progress towards long-term outcomes. For example, reducing rates of suicide is unlikely to be realised in the short term, given the long timeframes between certain interventions and expected outcomes (such as actions under a strategy to build resilience or prevent the onset of suicidal ideation or mental ill health).

Suicide rates are also often influenced by many risk and protective factors, including various personal characteristics, socio-cultural factors such as economic conditions, stigma relating to mental illness and suicide, and access to means of suicide.

Given that interventions to prevent suicide do not operate in isolation, reducing suicide rates will likely require significant long-term investment and collaborative effort before the impact of incremental improvements become evident in the data. This is further complicated by the fact that suicide is a statistically rare event, which makes it difficult to achieve the statistical power necessary to identify patterns over time and causation.

An additional issue in interpreting the performance indicator data is that many indicators are measured infrequently. This means that data is not up to date for many indicators, and short-term trends are not observable. The following indicators are measured every 3 or more years:

- PI 1: Children who are developmentally vulnerable
- PI 2: Long-term health conditions in people with mental illness
- PI 3: Tobacco and other drug use in adolescents and adults with mental illness
- PI 6: Prevalence of mental illness
- PI 7: Adults with very high levels of psychological distress
- PI 9: Social participation in adults with mental illness
- PI 10: Adults with mental illness in employment, education or training
- PI 11: Adult carers of people with mental illness in employment
- PI 24: Experience of discrimination in adults with mental illness.

Given the Fifth Plan had a 5-year life, many of these indicators only have 1 or 2 datasets available to assess change over the time the Fifth Plan was being implemented.

Further, similar to suicide rates, many of these indicators (including prevalence of psychological distress and mental illness) may be influenced by a broad variety of environmental and socio-cultural factors. As such, even if fluctuations are detected, it is very difficult to determine whether the Fifth Plan has had its intended impact on these outcomes or whether the change is the result of other influencing factors.

Finally, although improvements were seen across some indicators over the Fifth Plan's life (including seclusion rates, rates of daily smoking and employment of consumer and carer workers), it is important to not link these improvements with improvements to the experiences of consumers and carers. In and of themselves, the performance indicators cannot determine whether implementation of the Fifth Plan resulted in any tangible improvement to the lives of people living with mental illness, as well as the lives of their families, carers and communities.

To help understand whether the experiences of consumers and carers had improved over time, in keeping with the Fifth Plan's objectives, in 2019 and 2020, the Commission undertook consumer and carer surveys that captured the experiences of consumers and carers within each priority area of the Fifth Plan.

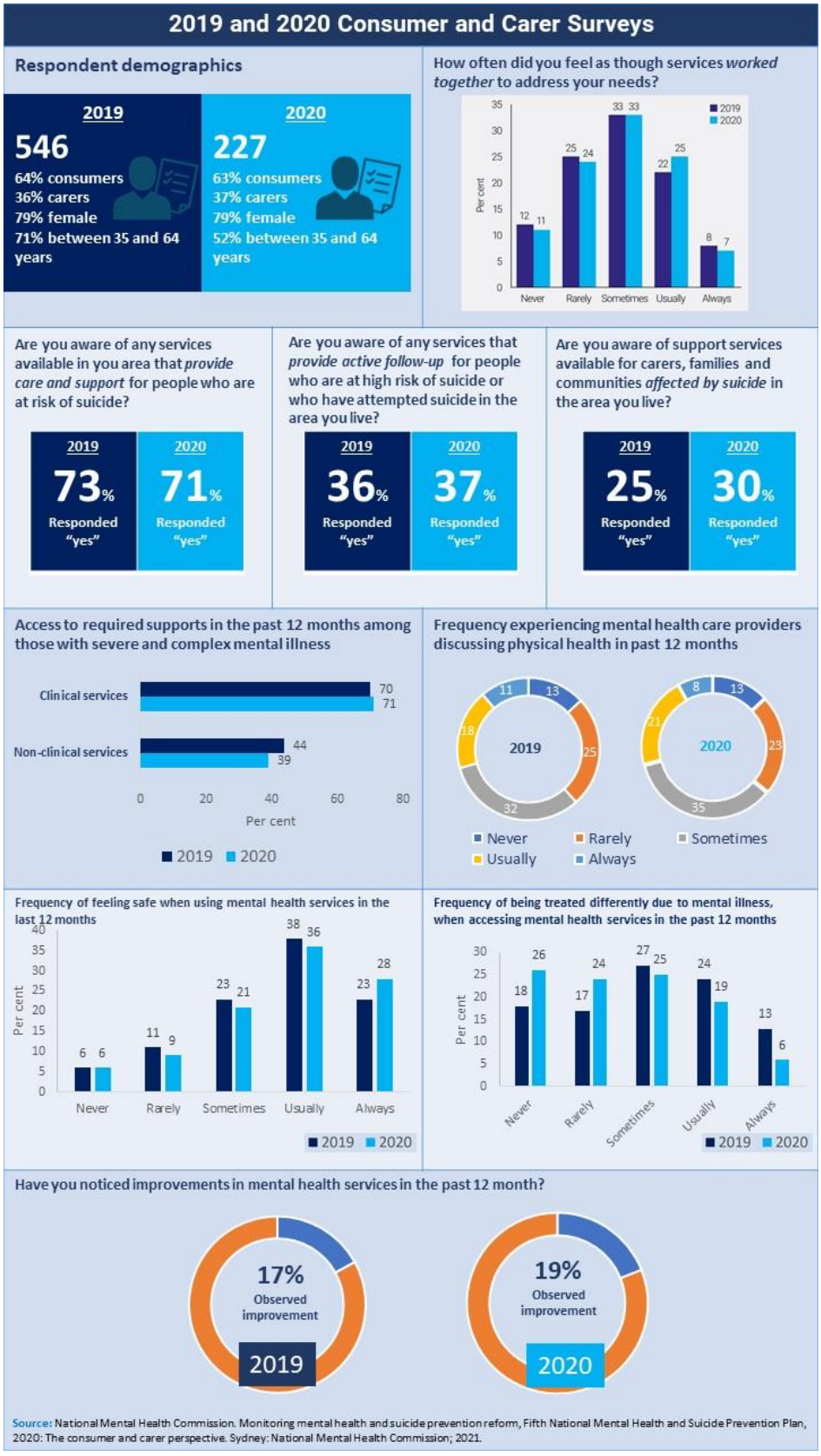
The questions addressed various factors, including:

- consumer and carer experiences of using mental health services
- awareness of suicide prevention services and postvention support
- experiences of using mental health services among people living with a severe and complex mental illness
- experiences of using mental health services among people who are Aboriginal and/or Torres Strait Islander
- whether relevant physical health needs are also being considered when consumers receive mental health treatment, care or support
- experiences of stigma and discrimination
- whether improvements in the mental health system had been observed in the previous 12 months.

The 2019 survey sought to establish a baseline from which to measure progress over the life of the Fifth Plan. However, due to the impact of the COVID-19 pandemic, only one other survey was administered in 2020. The 2020 survey sample was less than half the size of the 2019 sample, and some demographic groups were under-represented. This means that results may not represent the typical experience of consumers and carers in Australia. Further, the small sample size means that the survey is unlikely to detect small changes in consumer and carer experiences between years.

Figure 11 shows key findings from the 2019 and 2020 consumer and carer surveys.

Figure 11: Overview of key findings from 2019 and 2020 consumer and carer surveys



Overall, findings from the consumer and carer's surveys suggested that the objectives of the Fifth Plan had not yet been translated into the expected benefits for consumers, carers or the general population, at the time data was collected.

The findings suggested that a significant proportion of consumers and carers were not experiencing integrated care, and that many consumers with severe or complex mental illness did not have access to the clinical and non-clinical services they needed. There were no improvements in awareness of suicide prevention services among consumers and carers, or in the coordination of physical and mental health care.

For both surveys, about two-thirds of respondents (66% in 2020 and 69% in 2019) said that they had not observed any improvement in mental health services in the previous 12 months.

Although experiences of being treated differently because of mental illness declined somewhat between 2019 and 2020, because of the limitations of the survey, it is not possible to know whether the changes are caused by real improvements in the experience of consumers and carers, or whether they are the result of different people responding to the 2019 and 2020 surveys. Similarly, although the frequency of feeling safe when using mental health services increased, this must also be interpreted with caution because of the survey's limitations.

In the 2019 survey, among those who provided additional comments, consumers and carers frequently highlighted common issues in their responses. These included concerns around the availability and adequacy of mental health services (25%), affordability of services (15%) and challenges navigating the service system (15%).

Participants also drew attention to the impacts of mental health stigma, including discrimination in employment, social isolation, judgemental attitudes and a reluctance to disclose mental illness for fear of being treated less favourably. Among Aboriginal and Torres Strait Islander respondents, participants said they faced various challenges in accessing culturally appropriate care, as well as difficulties in finding information about the services specifically available to them.

Similarly, the 2020 survey results suggested that cost of services and challenges navigating the system were barriers to consumers receiving the services they need.

Of the respondents who opted to provide additional information, 26% of consumers said that the cost of services was a barrier, and 20% of carers said that to ensure the person they cared for had access to services they need, they were required to source and coordinate the provision of services without support from the mental health system, or provide the service themselves.

Participants said they experienced of stigma or discrimination, with 20% of consumers who provided additional information reporting facing this when seeking mental health support from the health system.

In interpreting these findings, note that any improvements in consumer and carer experiences resulting from the Fifth Plan's implementation are likely to be incremental. In addition, because of the small sample size and self-selection method, the findings from the surveys may not be reflective of the broader populations' experiences of care. These limitations highlight the importance of collecting robust data on the perspectives of consumers and carers in evaluation of future reform efforts. Quality data will ensure that any small improvements are detected, and that learnings about what creates improvements for consumers and carers can be applied to future reforms.

Despite the significant limitations of data available, the lack of improvement in outcomes observed over the Fifth Plan's life, in conjunction with the number of performance indicators that have shown no improvement or have shown deterioration, is undoubtedly concerning.

Available evidence suggests that Australia's mental health system still fails to meet the needs of consumers and carers despite the significant resources devoted to promoting the best possible mental health and wellbeing outcomes. Clearly, more needs to be done to drive structural and lasting reform that makes a tangible difference to individuals, families and communities.

Taken together, significant activity has been generated under the Fifth Plan, but it is not possible to ascertain its impact on consumers and carers from the data available.

Australia's National Mental Health Plans have prioritised data development and information management since the first plan was endorsed by Health Ministers in 1992. However, in reflecting on the performance of the Fifth Plan, significant data and information limitations still restrict the type and level of analysis that can be done to understand the true impact of the Fifth Plan.

On the basis of the data available, it is not possible to assess the extent to which actions have translated into effective change or produced the outcomes or systemic improvements desired. A clear link between the focus of national reform efforts and data collected is yet to be achieved nationally.

We need:

- a broader set of metrics that adequately reflect the outcomes being sought through reform
- a focus on developing measures outside of health and administrative, activity-focused data towards the broader social determinants of mental health
- metrics that capture the extent to which integration is driving improved outcomes for consumers and carers.

The Commission urges the Australian Government and state and territory governments to recognise that what has been started will need continued attention and investment.

In addition, many initiatives—particularly those focusing on service and planning integration—will likely not deliver results for several years and will need maintained momentum to ensure they deliver their intended benefits. This particularly applies to the development of strategies, plans and frameworks to reform Australia's mental health system under the Fifth Plan.

Concerted action must be undertaken to ensure commitments are honoured and implemented to produce real changes for consumers and carers. In addition, in several areas, Fifth Plan actions are yet to be fully implemented. It is imperative that these areas are prioritised to ensure they lead to tangible improvements to the mental health and wellbeing of carers and consumers.

Key barriers and challenges

Implementation

Although significant headway has been made in implementing the Fifth Plan, progress has been constrained by several unique and unprecedented challenges. Since its launch, we have seen catastrophic bushfires, droughts, floods and the COVID-19 pandemic, all of which posed significant

challenges to the mental health of Australians and required rapid policy and program responses from governments.

Resources were redirected away from some activities under the Fifth Plan to address more immediate challenges, resulting in delays in implementation for several actions. For example, work on nationally coordinated reporting on the physical health of people living with mental illness was delayed.

Action 17 will now be addressed under the National Agreement and through reforms announced in the 2021–22 Budget, including $1.9 million towards a data linkage project to monitor progress in reducing the life expectancy gap between people living with a mental illness and the general population.

During 2020–21, the COVID-19 pandemic caused some disruptions to the ongoing implementation of Equally Well in South Australia (Action 14), due to general practitioner (GP) liaisons being directed to other duties and the increased use of telehealth consultations, which reduces face-to-face contact and the opportunity for physical health assessments.

However, the impact of these events also highlighted the importance of work under the Fifth Plan, including strengthening the mental health workforce, expanding digital services and telehealth, and investing in mental health research.

The events also led to governments making significant commitments to improve the mental health and suicide prevention systems. This included an unprecedented $2.3 billion mental health and suicide prevention reform package as part of the 2021–22 Budget, and specific measures in each state and territory designed to improve mental health or address the risk factors for poor mental health outcomes.

Common strategies included improving and expanding digital and telehealth services, addressing the mental health needs of priority populations, and increasing service access for those with severe or chronic mental health concerns. These outcomes are in keeping with the Fifth Plan's vision.

A lack of funding and resources was occasionally reported as a barrier to implementation in previous progress reports. For example, PHNs reported resourcing as a common hindrance in supporting integrated regional planning and service delivery, with some stakeholders citing workforce shortages, staff turnover and the number of priorities to be addressed as key challenges. State and territory government departments also cited funding and resources as barriers to implementing certain actions.

Some stakeholders also encountered barriers during the early stages of implementation for certain actions. This included the lack of available guidance on how to implement certain actions and difficulties clarifying the roles, responsibilities and expectations involved in implementing the reforms outlined in the Fifth Plan.

For example, a material barrier reported in the 2018 progress report was a lack of guidance for the development of joint regional mental health and suicide prevention plans. Stakeholders reported they were unable to progress with their regional planning until guidance was provided that outlined expectations for PHNs and LHNs across several priority areas. Regional planning guidance material was subsequently released in November 2018 (Action 1.2).

Other stakeholders reported difficulties in achieving integration in planning and service delivery at the regional level, because of a lack of engagement from stakeholders and complexities about privacy, governance, security and access to data.

Overall, these barriers highlight the importance of ensuring all actions for future reform are specific, measurable and time-bound, and that expectations, roles and capabilities of stakeholders are clearly defined from the outset. There should also be a focus on ensuring appropriate mechanisms are built into the implementation plan that appropriately support and resource stakeholders to implement actions.

Monitoring and evaluation

The Australian Government committed to commissioning an independent evaluation of the Fifth Plan informed by annual reporting on the Fifth Plan and targeted consultation with governments, consumers, carers and the mental health sector (Action vi).

Work on the development of an evaluation plan was delayed in 2018–19 by resourcing and capacity issues, and again in 2019–20 by the COVID-19 pandemic and review of the former Council of Australian Governments (COAG) councils and ministerial forums. Action vi was subsequently closed when the COAG governance bodies ceased.

Without an independent evaluation of the Fifth Plan, conclusions around its performance in achieving its objectives are difficult to make. This is a significant shortcoming in terms of ensuring accountability and informing quality improvement. Although there was intent to evaluate the Fifth Plan, work to develop an evaluation plan started after the Fifth Plan itself had been developed, and implementation was already well underway.

Ideally, evaluation planning should have begun during the early design stages of the Fifth Plan to ensure objectives were measurable and ensure the required data for performance monitoring could be collected during implementation and aligned to existing data collections.

The performance indicators in the Fifth Plan are not closely aligned with its actions, so they cannot be used to determine whether the Fifth Plan actions have been effective in achieving their intent. For example, the proportion of adults with very high levels of psychological distress (PI 7) was selected as an indicator for Priority Action 1: 'Achieving integrated regional planning and service delivery'. However, the actions under Priority Area 1 are largely concerned with addressing service gaps, duplication and the areas of highest need at a regional level through improved integration. Although a reduction in psychological distress might occur following successful integration of planning and service delivery, the actions and indicator are not closely aligned.

Another barrier in gauging the success of the Fifth Plan relates to the limitations of the data available to measure changes in the performance indicators over time. In particular, some data sources did not have enough time-series data available to measure whether there have been improvements or deterioration over the Fifth Plan's life. In addition, each performance indicator has specific caveats that limit the conclusions that can be drawn from the data available.

Examples of limitations include reliance on self-report data for experiences of mental illness, issues with sample representativeness (for example, only measuring outcomes among those who access care) and gaps in data for specific population groups, such as children. Further, for all data sources, it is not possible to determine why performance indicators have or have not changed over time, as a wide variety of factors may affect these broad outcomes.

The focus of the indicators themselves also present issues in understanding the Fifth Plan's impact. In particular, the performance indicators are mainly focused on clinical and health outcomes, such as

psychological distress, prevalence of mental illness and population access to clinical mental health care. But there is widespread recognition that many of the factors that contribute to mental health are beyond the remit of the health system and aligned with the social determinants of health and wellbeing. Further, although the 2008 National Mental Health Policy outlines a vision for a mental health system that works to both prevent and detect mental illness early, no performance indicators assess early intervention or prevention. In addition, no performance indicators adequately assess integration or collaboration between services, despite this being a key priority of the Fifth Plan.

Although the Commission was able to supplement the performance indicator data with more specific outcome data through the consumer and carer surveys, it is important to also recognise the limitations of this data in monitoring success of the Fifth Plan.

In particular, similar to the performance indictor data, it is not possible to relate changes (positive or negative) detected in consumer and carer survey results with specific Fifth Plan actions, as various other factors might be at play. Further, the known limitations of the consumer and carer survey, including the small sample size and the volunteer sampling (self-select) method, may bias the data and obscure small changes in experiences of consumers and carers between years.

Future priorities for reform

At the end of the Fifth Plan and 20 years following the start of the National Mental Health Strategy, it is clear there have been many successes in reforming Australia's mental health system over recent years.

These successes include:

- actions to facilitate greater collaboration between jurisdictions
- mental health and suicide prevention services that are designed for and targeted towards priority groups and those who are not being reached by mainstream services
- greater recognition of the importance of improving the experiences of consumers and carers, as well capturing information on the perspectives of consumers and carers about the care they receive to drive service quality improvement.

However, the complexity of the reform process has also become increasingly evident. Reforming, reshaping and redefining mental health care in Australia is undoubtedly an ambitious undertaking, with many barriers and challenges.

A lot can be gained from reflecting on what has and has not worked well to date in driving lasting reform in mental health and suicide prevention. On the basis of lessons learned to date, the Commission has identified several key focus areas that should be considered in guiding our future reform efforts.

Continuous monitoring to inform decision-making

Recognising the broad nature of the Fifth Plan performance indicators and the length of time between data collection, sustained monitoring and reporting of the Fifth Plan performance indicators over the next decade should be a key priority. This will help determine whether predicted changes are occurring across the set of indicators.

Although it will not be possible to link improvements or deteriorations with the Fifth Plan's implementation, this data will be important in understanding what areas should be prioritised in future reform efforts.

Importantly, findings from this monitoring process should be used to adjust priorities, respond rapidly to areas of performance deficiency, and reinforce accountability for performance across the system.

Where anticipated changes do not occur over time, this should be investigated to determine why this is the case and what changes are required to make a difference. Effort should be made to seek a more in-depth and qualitative examination of consumer and carer service experiences, and this knowledge should be used to take action to design a more effective and compassionate approach to reform.

In addition to sustained long-term monitoring, a focus on monitoring more short- and medium-term outcomes would be highly valuable for incremental policy, service and system changes. Including these outcomes would make it clearer that reform is making a meaningful change, and help drive continuous improvement.

Ideally, these outcomes would be agreed in collaboration with people with lived experience of mental ill health and be decided at the outset of development of future mental health and suicide prevention plans.

These outcomes must be closely aligned with the agreed objectives of future plans, so they can adequately assess performance towards those objectives. Selection of outcomes should be informed by considerations of scientific soundness and usefulness for decision-making.

Given the importance of social determinants and the effects of mental ill health on a person's functioning, indicators that focus on factors such as employment, physical health and income should be included. While the Fifth Plan identified performance indicators to collectively measure performance of the mental health system, similar to previous National Mental Health plans, the Fifth Plan did not define a specific set of targets and timeframes.

It is well-established that setting explicit and realistic targets is an important accountability tool to send clear signals about priorities and to motivate system participants to drive change.

Gaining agreement on a set of achievable targets that specify key mental health outcomes over a defined period is advisable. To ensure targets are relevant and fit for purpose, they should be co-designed with consumers and carers, as well as the portfolios that play a role in determining outcomes (such as housing and justice); doing so will provide clarity on whether reform efforts are making a difference and will enable continuous improvement.

Following this co-design process, targets should be published with clear information on how they were set, how they will be monitored and reported on, and who will be responsible for achieving them.

Improved maturity and availability of data

Although we urgently need better outcomes reporting and performance assessment, there are barriers to measuring the effectiveness of mental health interventions, especially system-wide impacts. Mental health data collection and reporting processes are largely activity-focused and often fail to capture actual outcomes that are aligned with the priorities of mental health consumers and carers.

We need better evidence to monitor the impact of strategies and action plans, and help us understand what actions taken by government make the most difference for people vulnerable to mental ill health, under what conditions and for which individuals or communities.

This information will help guide future decision-making, improve policy and service design, promote accountability and support a more agile approach to reform that enables continuous monitoring.

Steps towards improving data have been initiated under the Fifth Plan, and this momentum must be maintained.

As stated in the National Suicide Prevention Adviser's Final Advice, all agencies and levels of government have a role to play in strengthening outcome data. Better reporting will rely on collaboration across governments and portfolios.

In terms of specific priorities, the barriers encountered in assessing the performance of the Fifth Plan highlight the importance of having regular collection and monitoring of robust data on the perspectives of consumers and carers when evaluating future mental health and suicide prevention plans.

We need to:

- improve how agencies work together so that we can better collect, record and disseminate data to address current gaps and increase the availability of reliable data, while maintaining privacy
- address barriers to timely data-sharing across governments to better share knowledge across jurisdictions and ensure insights drive continuous improvement and priority setting across governments
- measure the integration of mental health care within health systems, as data is currently lacking in this domain despite it being a key reform priority
- develop a national approach to collecting and linking data about the impact of suicide prevention and mental health initiatives on outcomes
- improve the collection and sharing of data on priority populations and their unique vulnerabilities to enable more powerful insights around what initiatives work best for whom
- ensure responses represent the full breadth of the consumer and carer population to more broadly assess whether the reform is successfully achieving its objectives, and understand what specific interventions or service improvements are having an impact, for whom and under what circumstances.

Transparent evaluation

It is well established that evaluation is critical to:

- assessing the effectiveness and efficiency of interventions
- informing the development of new systems approaches and activities and improving existing ones
- promoting accountability by increasing transparency.

However, there is no question that the process of identifying and evaluating policy successes and failures is complex, particularly at a system level. This is further complicated by the fact that, currently, there is no relevant policy framework to guide monitoring and evaluation of the mental health system and related sectors.

Evaluation planning for future reform efforts should be a priority and be guided by agreed principles that align with best practice for the planning, management and conduct of evaluations. A commitment to evaluation should be reflected in adequate resource allocation.

Critically, evaluation should not be limited to summative evaluations that assess funding and activities produced. Instead, there should be a move towards multiple forms of evaluation, including formative, outcomes-based, developmental and process evaluations, which occur in planned ways and are aligned to the purpose of system reform.

Consistent with this priority, the National Agreement has a strong focus on strengthening evaluation culture, and commits to developing a national evaluation framework to improve transparency and accountability.

The framework should:

- ensure specified outcomes and measures relate to incremental policy changes and to indicators that support long-term monitoring of system performance and responsiveness
- support knowledge and insights on what works, where and how, to support continuous improvement of system performance
- ensure future evaluations measure the attributable impact of initiatives, as well as systems level impacts within and beyond mental health, rather than simply monitoring program level outcomes; systems evaluation approaches are critical to generating evidence of how and where investment is making a real difference, and creating responsive systems with sustainable impact
- specify measurable outcomes for individual actions over time
- ensure findings and evidence from evaluations are published to support learning, evidence-based decision-making, practical improvements to policies and programs across the system, and future funding decisions.

A broader, more collective response

It is important to recognise that the Fifth Plan was heavily health-system oriented, with the majority of actions focused on the health portfolio. Although the health system plays a vital role in promoting mental health, there is widespread recognition that many of the factors that contribute to mental health are beyond the remit of the health system and aligned with the social determinants of health and wellbeing.

Several reviews have highlighted that that no single government agency or portfolio can undertake the breadth of actions that are required to address this critical issue. As such, to truly reform Australia's mental health system, there should be a focus on a broader and more collective whole-of-government approach to reform that includes private, non-government and community organisations, along with other portfolios areas such as education, justice and social services.

Future planning for reform should look to integrate health and non-health portfolios to guide the efficient allocation of resources over the long term, and ensure the wider determinants of mental health are appropriately addressed.

Indicators should be broadened from their current focus on public clinical mental health services to other sectors that provide support for Australians that may have mental ill health.

Within the health system, we need greater recognition and action on influencing the social determinants of mental health at the individual level, through better coordination of care, collaboration with non-health sectors, and linking people to ongoing supports that meet their needs. Appropriate indicators to measure the extent to which this is occurring should be identified and developed as a priority.

Rather than the current approach, which largely attributes improved outcomes to the impact of clinical treatments, an approach that recognises that mental health is determined by a complex interplay between social determinants and treatment is recommended. In particular, it is recommended that multiple portfolios beyond health play a role in measuring collective impact or outcomes to understand how and which combinations of treatment services and other interventions can better support improved mental health and wellbeing outcomes. This information would help inform long-term priorities, resource allocation and the budgeting process through a wellbeing lens.

The establishment of a new National Agreement is a critical step forward in achieving these reforms, by providing a platform to ensure different portfolios and jurisdictions work together to build better mental health and suicide prevention systems for all Australians.

It will be essential that this commitment to collaboration is translated into structural change, supported by stronger governance structures, clear roles and responsibilities and stronger monitoring and reporting on action across all portfolios.

In considering the barriers encountered in implementing the Fifth Plan, action plans under the National Agreement should be designed in a way that ensures actions are specific, measurable and time-bound and that the expectations and roles of stakeholders are clearly defined from the outset.

Appropriate mechanisms that appropriately support and resource stakeholders to implement actions should also be built into implementation plans. Actions under the National Agreement must also be sufficiently funded for implementation, and the funding landscape should be monitored to understand and respond to current gaps, and inform the scope and direction of future investment.

Promotion, prevention and early intervention

The 2008 National Mental Health Policy articulates a vision for a mental health system that works to both prevent and detect mental illness early. While the previous 4 National Mental Health Plans had a strong focus on promotion, prevention and early intervention this was not a specific priority area in the Fifth Plan.

Recent reviews and inquiries have consistently identified promotion, prevention and early intervention as a key area for reform, with particular focus on social inclusion, reducing stigma and raising the importance of psychological health and safety in workplaces.

It is well established that addressing risk factors early and investing in protective factors improves mental health and wellbeing, and is a cost-effective approach to improving life-long outcomes for people by reducing subsequent need for more complex and costly interventions.

This calls for a dedicated focus on prevention and early intervention that is prioritised by all governments and is a cornerstone of all national mental health and suicide prevention plans.

As outlined in the National Suicide Prevention Adviser's Final Advice, achieving genuine prevention and early intervention will require better coordination across portfolios and jurisdictions. Important work started under the Fifth Plan to support this, but the Fifth Plan largely focused on promoting collaboration at a regional level, with a strong emphasis on the collaborative efforts of PHNs and LHNs.

Although many issues can be solved at a regional level, collaboration at a jurisdictional or national level will be critical in creating an enabling environment for prevention and early intervention that addresses the various social, economic, health, occupational, cultural and environmental factors known to predict mental health outcomes.

This must be combined with appropriate investment in prevention and early intervention, to increase capacity across government and services to:

- provide outreach and support
- develop workforce capability to respond to people experiencing early distress
- improve data systems to identify people who may need a proactive approach.

Concluding statement

As outlined in this review, the Fifth Plan led to many innovative activities and changes over its 5-year life that have the potential to significantly improve outcomes for consumers and carers in years to come.

But it is also apparent that much work remains to be done. Despite the best effort of governments over the years, reviews and inquiries continue to highlight significant issues with Australia's mental health system, and consumers and carers consistently report that the system does not adequately address their needs. The limitations of data available also places major barriers on the extent to which conclusions that can be made about the progress of reforms to date in achieving their objectives.

System reform takes significant time and persistence to achieve, but the Commission is confident that through collaborative effort and continued investment under the new National Agreement, this ambitious vision can be realised.

Support for reform has grown among the community, government and mental health sectors in recent years, and there is increasing recognition of the importance of considered investment in mental health. With stronger focus on and awareness of mental health and wellbeing due to the impact of the pandemic and other disasters, now more than ever Australia is prepared and energised to accomplish significant reform.

To translate this commitment into observable improvements for carers and consumers, we need:

- mechanisms that ensure effective implementation and evaluation
- to define specific outcomes to evaluate the effectiveness of system reform initiatives and the extent to which these are being adopted across Australia and in ways that reach all of the population
- to ensure the sustainability of actions that have been taken so far and increase efforts and encourage innovation where change has been more difficult to achieve
- to focus on a broader and more collective whole-of-government approach to reform, where roles and responsibilities are clearly defined from the outset

- agencies to work together to improve how data is collected, recorded and disseminated to address current gaps and improve the availability of reliable data; priorities for data development should include outcomes identified by mental health consumers and carers to ensure they are relevant and fit for purpose.

The Commission thanks and acknowledges the commitment and efforts of all governments and the sector in implementing and monitoring the Fifth Plan over its 5-year life. We also thank all consumer and carer respondents who provided detailed and comprehensive data to inform the Commission's monitoring work. The perspectives and expertise of those living with mental ill health has been and will continue to be vital in building a mental health system that strengthens and supports the mental health of all Australians.

Appendix A: Status of Fifth Plan actions as at 31 December 2021

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
Governance							
i	Governments will establish a Mental Health Expert Advisory Group that will advise the Australian Health Ministers' Advisory Council (AHMAC), through the MHPC, on the implementation of the Fifth Plan and analyse progress.	• MHPC will lead the joint development of Terms of Reference and membership for the Expert Advisory Group and establish a meeting schedule. • Governments will agree on cost-shared funding arrangements.	MHPC	December 2017, first meeting before June 2018	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2019 progress report. However, the Mental Health Expert Advisory Group has since been discontinued due to the dissolution of the Council of Australian Governments (COAG) governance bodies.
ii	Governments will establish a Suicide Prevention Subcommittee that will report to MHPC on priorities for planning and investment.	• MHPC will lead the joint development of Terms of Reference and membership for the Suicide Prevention Subcommittee and establish a meeting schedule. • Governments will agree on cost-shared funding arrangements. • Refer to Action 3 for further information on implementation approach.	MHPC	First meeting mid-2018	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2019 progress report. The National Suicide Prevention Adviser's final advice was submitted to the Prime Minister in December 2020 and published by the Australian Government Department of Health in April 2021. The final advice is a comprehensive set of 4 reports providing recommendations and an evidence base for policy reform in suicide prevention. The final advice has informed the Australian Government's mental health and suicide prevention reform approach, including the 2021–22 Budget response and negotiations for the National Mental Health and Suicide Prevention Agreement.
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.	• MHPC will lead the joint development of Terms of Reference and membership for the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee and establish a meeting schedule. • Governments will agree on cost-shared funding arrangements. • The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will include	MHPC	First meeting mid-2018	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2019 Progress Report. In March 2020, the Australian Government provided support for the establishment of Gayaa Dhuwi (Proud Spirit) Australia as a national Aboriginal and Torres Strait Islander leadership body in mental health, social and emotional wellbeing and suicide prevention, to prevent suicide and promote the mental wellbeing of young people and Aboriginal and Torres Strait Islander peoples.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
		representatives from existing Aboriginal and Torres Strait Islander AHMAC subcommittees, as appropriate. • Action 11 provides further information on the requirements for the Terms of Reference.					A key role of Gayaa Dhuwi is the renewal of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, anticipated to be publicly released in 2022. The strategy provides recommendations for government investment to reduce the devastating and disproportionate impact of suicide on Aboriginal and Torres Strait Islander individuals, families and communities. The Australian Government continued support for Gayaa Dhuwi's ongoing leadership and advisory role through its investment in the 2021–22 Aboriginal and Torres Strait Islander Crisis Services and Support Budget package. This investment also allows for the development of a comprehensive implementation plan for the strategy, once finalised, and implementation of some small-scale initiatives identified in the strategy.
iv	Governments will renew the National Mental Health Policy. This review will begin in 2018 and be completed during the life of the Fifth Plan. It will be completed with sufficient time to inform development of any future National Mental Health and Suicide Prevention Plans under the strategy.	• MHPC will undertake a review of the Policy. • Secretariat support provided by the Commonwealth. • The Expert Advisory Group will provide advice to MHPC on renewal of the National Mental Health Policy.	AHMAC (progress reported by the MHPC)	Commence January 2018, completed December 2020	Early 2021	Closed	The National Mental Health and Suicide Prevention Plan released through the 2021–22 Budget outlines the Australian Government's reform commitment. The National Mental Health and Suicide Prevention Agreement, executed in March 2022, sets out the shared intention of the Australian Government and states and territories to work in partnership to improve the mental health of all Australians. [Note: the agreement was only agreed in-principle by National Cabinet as at 31 December 2021].
Measuring and reporting on change							
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. These indicators will be disaggregated by Aboriginal and Torres Strait Islander status where possible.	• The Commonwealth will negotiate this activity with NMHC. • The NMHC will consult with jurisdictions on agreed data and reporting processes. • The Commonwealth will contribute Commonwealth data and information to the NMHC to facilitate the NMHC monitoring and reporting role. • States and territories to participate in consultations with NMHC and agree to	MHPC	Negotiations commence January 2018 and implementation will be ongoing	2023	Progressing through business-as-usual activities	The current report is the final report under the Fifth Plan. Performance indicators will continue to be reported through other reforms and business-as-usual activities. Reporting from 2022 onwards will be undertaken as part of the new National Mental Health and Suicide Prevention Agreement.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
		contribute data and information to the NMHC to fulfil the agreed monitoring and reporting role. • 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.					
vi	Governments will evaluate the Fifth Plan, commencing in the final year of the Plan, to inform future directions in mental health policy. This evaluation will be principally informed by annual reporting on the Fifth Plan and targeted stakeholder consultation with governments, consumers and carers and the mental health sector.	• The Commonwealth will commission an independent evaluation of the Fifth Plan, including development of an evaluation plan that will be cleared through MHISSC. • The Commonwealth contracted provider will be required to consult with MHISSC, Safety and Quality Partnership Standing Committee (SQPSC) and NMHC and other key stakeholders on the development of an evaluation plan. • Development of evaluation plan to precede commencement of evaluation in the final year of the Plan.	AHMAC (progress reported by the MHPC)	Evaluation plan agreed December 2018. Evaluation completed June 2022	n/a	Closed	The Productivity Commission Inquiry into Mental Health (2020) and National Suicide Prevention Adviser's final report (2020) provided a detailed and comprehensive review and evaluation of mental health and suicide prevention system, including by extension the Fifth Plan. The Fifth Plan has come to a natural end, but incomplete actions will continue through other reform activities and business-as-usual.
vii	Governments will develop a longer term strategy for information and indicator development. This strategy will be published as a Third Edition of the National Mental Health Information Development Priorities. It will include the identification	• Refer to Action 24 for implementation approach.	MHISSC	Published by December 2018	Mid-2020	Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report. The third edition of the National Mental Health and Suicide Prevention Information Priorities is available on the Australian Institute of Health and Welfare (AIHW) website.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	of information development priorities and the development of additional national reform and system performance measures in consultation with consumers and carers and other key stakeholders.						
Priority Area 1: Achieving integrated regional planning and service delivery							
1.1	Governments will support integrated planning and service delivery at the regional level by: • requiring development and public release of joint regional mental health and suicide prevention plans	• The Commonwealth will direct PHNs to jointly develop regional plans with LHNs and direct to publicly release draft plans for public comment. • States/territories will direct LHNs (or equivalent) to jointly develop regional plans with PHNs for public release. • The NMHC will include information on the status of joint plans as part of its annual reporting on the Fifth Plan.	MHPC	Progressively from December 2017	n/a	Completed	In the first half of 2021, PHNs and LHNs released their respective regional mental health and suicide prevention plans on their websites.
1.2	• providing guidance for the development of joint, single regional mental health and suicide prevention plans	• Governments will jointly develop and release guidance material for a single regional plan that will cover scope, timeframes, governance arrangements, consultation processes, and requirements for government endorsement.	MHPC	Completed mid-2018	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report. Regional planning guidance material was released in November 2018.
1.3	• developing a plan for ongoing development, refinement and application of the National Mental Health Service Planning Framework (NMHSPF)	• Governments will agree on the process for the ongoing refinement, application and resourcing of the NMHSPF. • The Commonwealth will manage contractual arrangements with an expert	NMHSPF Steering Committee	December 2017	March 2021	Completed	Development of the National Mental Health Service Planning Framework is ongoing.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
		provider for ongoing development of the NMHSPF.					
1.4	• developing and releasing planning tools based on the NMHSPF and an evidence based stepped care model	• Governments will agree on licensing arrangements/ agreements. • The Commonwealth will issue licences to authorised users of the NMHSPF. • 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.	NMHSPF Steering Committee	Progressively to June 2018	n/a	Completed	Development of the National Mental Health Service Planning Framework is ongoing.
1.5	• making available key national data to inform regional level understanding of service gaps, duplication and areas of highest need	• Governments will contribute relevant data for the development of regional data. • The Commonwealth will use existing funding arrangements with the AIHW to facilitate this action. • Steering and coordination of the development of regional data reporting will occur through MHISSC.	MHISSC	Completed June 2018	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report.
2.1	Governments will work with PHNs and LHNs to implement integrated planning and service delivery at the regional level. This will include: • utilising existing agreements between the Commonwealth and individual state and territory governments	• The Commonwealth will use existing agreements (such as bilateral agreements and other existing agreements, including National Partnership Agreements or MOUs) with state and territory governments to facilitate a coordinated approach to	AHMAC (progress reported by the MHPC)	Commencing early 2018	n/a	Closed	The National Mental Health and Suicide Prevention Agreement supersedes this action.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	for regional governance and planning arrangements	regional planning and service delivery.					
2.2	• engaging with the local community, including consumers and carers, community managed organisations, Aboriginal Community Controlled Health Services (ACCHS), National Disability Insurance Scheme (NDIS) providers, the National Disability Insurance Agency private providers and social service agencies	• PHNs and LHNs will work collaboratively to engage regional stakeholders in the regional planning and service delivery process. • Governments will strengthen existing partnerships with stakeholders to engage with the local community. • The Expert Advisory Group will provide advice to governments on strategies to maximise engagement.	AHMAC (progress reported by the MHPC)	Commencing early 2018	n/a	Completed	This action was reported as ‘completed’ in the Fifth Plan 2020 progress report.
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	• PHNs and LHNs will work towards data sharing to map regional service provision and identify areas of duplication, inefficiency and service gaps. • PHNs and LHNs will utilise the NHMSPF and other planning tools to facilitate regional needs assessment and planning.	MHPC	Progressively from June 2018	n/a	Completed	This action was reported as ‘completed’ in the Fifth Plan 2020 progress report.
2.4	• examining innovative funding models, such as joint commissioning of services and fund pooling for packages of care and support, to create the right incentives to focus on prevention, early intervention and recovery	• PHNs and LHNs will explore opportunities for resource sharing and other innovative use of available funds to improve efficiencies, remove duplication and improve outcomes.	MHPC	Commencing mid-2020	n/a	Completed	This action was reported as ‘completed’ in the Fifth Plan 2020 progress report.
2.5	• developing joint, single regional mental health	• PHNs and LHNs will jointly develop comprehensive	MHPC	Commencing late 2017.	n/a	Completed	This action was reported as ‘completed’ in the Fifth Plan 2020 progress report.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	and suicide prevention plans and commissioning services according to those plans	regional mental health and suicide prevention plans. These plans should cover the lifespan from children through young adults to older people. • PHNs and LHNs will use these plans to progressively guide service development and commissioning.		Completed mid-2020			
2.6	• identifying and harnessing opportunities for digital mental health to improve integration	• Regional plans developed by PHNs and LHNs will make best use of existing and emerging technology and digital mental health services within an integrated, stepped care approach. • Refer to Action 32 for information on implementation of a National Digital Mental Health Framework.	MHPC	Commencing 2017. Completed mid-2020	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report.
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	• PHNs and LHNs will work towards integrating existing bilateral agreements (such as COAG agreements and new Health Reform Agreements) and broadening these to be regional in coverage. The new agreements will be developed to ensure engagement of all relevant service providers. • The Expert Advisory Group will provide advice to MHPC on mechanisms to improve integration, including best practice approaches to shared care, triage and information sharing.	MHPC	Mid-2021	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
2.8	• developing shared clinical governance mechanisms to allow for agreed care pathways, referral mechanisms, quality processes and review of adverse events	• PHNs and LHNs will jointly develop shared clinical governance mechanisms to ensure service pathways established and services commissioned across the system are clinically appropriate.	MHPC	Mid-2021	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report.
Priority Area 2: Suicide prevention							
3	Governments will establish a new Suicide Prevention Subcommittee of MHPC, as identified in the Governance Section of this Plan, to set future directions for planning and investment.	• MHPC will establish the Suicide Prevention Subcommittee to lead the joint development of Terms of Reference and membership, followed by the development of a Project Plan. • • The Terms of Reference will include, but will not be limited to: defining scope, establishing timeframes, outlining governance arrangements and developing a consultation strategy.	MHPC	December 2017. First meeting early 2018	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report. The National Mental Health and Suicide Prevention Agreement continues focused actions on suicide prevention.
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 with a priority focus on: • the consistent and timely provision of follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on	• MHPC, through the Suicide Prevention Subcommittee, will lead the development of the National Suicide Prevention Implementation Strategy. The Strategy will include a focus on Aboriginal and Torres Strait Islander suicide prevention and will include releasing a version for public consultation to ensure stakeholder input.	MHPC	Commence 2018. Release of strategy for public consultation by mid-2019. Release of final strategy by 2020.	n/a	Completed	The National Suicide Prevention Strategy for Australia's Health System: 2020–2023 was completed and endorsed. The final advice of the National Suicide Prevention Adviser also references this document. As noted in the Fifth Plan 2020 progress report, it was decided that an implementation plan would not be developed specifically for the strategy (as agreed by the MHPC).

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	clear roles and responsibilities for providers across the service system; • timely follow up support available to people affected by suicide; • improving cultural safety across all service settings; • improving relationships between providers, including emergency services; and • improved data collections and combined evaluation efforts in order to build the evidence-base on 'what works' in relation to preventing suicide and suicide attempts.						
5	Governments will support PHNs and LHNs to develop integrated, whole-of-community approaches to suicide prevention. This will include engaging with local communities to develop suicide prevention actions as part of a joint, single regional plan. • These regional plans will be consistent with the 11 elements above and informed by the National Suicide Prevention Implementation Strategy as it is developed.	• The Commonwealth will direct PHNs and states/ territories will direct LHNs to jointly develop suicide prevention approaches as a discrete component of Actions 1.1 and Action 10. • Governments will jointly develop and provide guidance to PHNs and LHNs on regional approaches to suicide prevention, informed by the systems-based approach outlined in the WHO's Preventing suicide: A global imperative.	MHPC	Commence 2019 and ongoing	n/a	Progressing through other reforms	The National Mental Health and Suicide Prevention Agreement continues focused actions on suicide prevention.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	• At a regional level, PHNs and LHNs will work together to map providers across the service system, develop stronger referral pathways and build community knowledge of the range of available services and how to access them.						
Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness							
6	Governments will negotiate agreements that prioritise coordinated treatment and supports for people with severe and complex mental illness. This will include planning for the community mental health support needs of people who do not qualify to receive supports under the NDIS, including fulfilment of agreed continuity of support provisions and ensuring any mainstream capacity is not lost for the broader population as a result of transition to the NDIS.	• The Commonwealth negotiation of agreement/s with states and territories for psychosocial support services. • States and territories will negotiate agreement with Commonwealth for psychosocial support services.	A formal Coordination Point was not allocated for this action in the Implementation Plan. As the NMHC has been advised that this work is being led by all jurisdictions via MHPC, the NMHC requests the MHPC provides a status update on this action.	Commence in 2017. Finalised by the end of 2018	June 2021	Completed	As part of the 2021–22 Budget, the Australian Government has committed: • $11.1 million over 2 years from 2021–22 to improve the experience of and outcomes for people with complex mental health needs through targeted initiatives, including: ○ funding for SANE Australia to pilot specialised mental health services and interventions for people with complex mental health needs ○ additional training and education for the mental health workforce to better meet the needs of people with cognitive disability and autism. • $171.3 million over 2 years from 2021–22 to continue Australian Government psychosocial support services for people with severe mental illness who are not supported through the National Disability Insurance Scheme. The National Mental Health and Suicide Prevention Agreement includes actions to support people with severe mental illness. [Note: the agreement was only agreed in-principle by National Cabinet as at 31 December 2021].
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	• The Commonwealth will direct PHNs to plan and commission services for people with severe and complex mental illness	A formal Coordination Point was not allocated for this action in the	Completed mid-2018	n/a	Completed	This action was reported as ‘completed’ in the Fifth Plan 2020 progress report.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	and reflect this in regional planning and service delivery.	through PHN funding agreements. • Governments will use joint guidance material on regional plans (refer to Action 1.2) to outline their expectations of PHNs and LHNs for coordinated treatment and supports for people with severe and complex mental illness. This will include specific consideration of the requirements of children and adolescents with or at risk of severe mental illnesses.	Implementation Plan. As the lead on this action, as identified by the MHPC, the NMHC requests that the Commonwealth provide a status update for this action on behalf of all relevant stakeholders.				
8	Governments will establish a time-limited Mental Health Expert Advisory Group, as identified in the Governance Section of this Plan, that will: • advise on the implementation of the Fifth Plan and analyse progress; • where requested by AHMAC, provide advice on broader mental health policy issues, which may include cross-portfolio consideration of issues that may arise from the implementation of mental health reforms and the NDIS for people with severe and complex mental illness, and opportunities to harmonise data collection strategies.	• Refer to Action i in Governance section for implementation roles.	A formal Coordination Point was not allocated for this action in the Implementation Plan. As the lead on this action, as identified by the MHPC, the NMHC requests that the Commonwealth provide a status update for this action on behalf of all relevant stakeholders.	2019		Closed	The Mental Health Expert Advisory Group was discontinued. The National Mental Health and Suicide Prevention Agreement and associated governance structures supersedes work on this action.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
9	Governments will develop, implement and monitor national guidelines to improve coordination of treatment and supports for people with severe and complex mental illness. These guidelines will: • clarify roles and responsibilities across the health and community support service sectors; • be consistent with the COAG mainstream interface principles (which determine the responsibilities of the NDIS and other service providers); • specify criteria to guide targeting service delivery to consumers, including identifying pathways for culturally competent services; • promote the roles of multi-agency care plans, care pathways and information sharing protocols; • identify opportunities for the use of digital mental health and electronic health records in coordinating care; and • highlight the role of data in supporting these activities.	• The Commonwealth will lead the joint development of national guidelines to be endorsed by AHMAC. This will include consultation with the social services sector. • The Commonwealth to undertake a targeted consultation process will be undertaken to inform the development of the guidelines.	A formal Coordination Point was not allocated for this action in the Implementation Plan. As the lead on this action, as identified in the Implementation Plan, the NMHC requests that the Commonwealth provide a status update for this action.	Commence in 2018. Release in 2020	n/a	Progressing through business-as-usual activities	The Action 9 Working Group of the Mental Health Principal Committee completed the National Guidelines to Improve the Co-ordination and Treatment of People with Severe and Complex Mental Illness and its associated plain language summary document in late 2020. These documents were endorsed by all states and territories in March 2022 and are published on the Australian Government Department of Health and Aged Care's website under mental health resources.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention							
10	Governments will work with PHNs and LHNs to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples at the regional level. This will include: • Engaging Aboriginal and Torres Strait Islander communities in the co-design of all aspects of regional planning and service delivery; • Collaborating with service providers regionally to improve referral pathways between General Practitioners (GPs), ACCHS, social and emotional wellbeing services, alcohol and other drug services, and mental health services, including improving opportunities for screening of mental and physical wellbeing at all points; connect culturally informed suicide prevention and postvention services locally and identify programs and services that support survivors of the Stolen Generation; • Developing mechanisms and agreements that	Guidance developed by governments for PHNs and LHNs on joint regional plans (Refer to Action 1.2) will outline expectations regarding integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples, including: • expectations for involvement of ACCHS and Aboriginal and Torres Strait Islander communities; • engagement of Aboriginal and Torres Strait Islander helpers and peer workers; • operationalising the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026 within regional mental health service systems; and • governance structures and mechanisms being inclusive of Aboriginal and Torres Strait Islander perspective.	MHPC	Commence mid-2018	Ongoing	Completed	The Australian Government provides funding to PHNs (included in their mental health funding) to plan and commission regionally appropriate mental health and suicide prevention services. As part of this role, PHNs are working with mainstream service providers, ACCHSs and communities to plan and commission culturally appropriate evidence-based services for Aboriginal and Torres Strait Islander peoples.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	enable shared patient information, with informed consent, as a key enabler of care coordination and service integration; • clarifying roles and responsibilities across the health and community support service sectors; • ensuring that there is strong presence of Aboriginal and Torres Strait Islander leadership on local mental health service and related area service governance structures.						
11	Governments will establish an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee of MHPC, as identified in the Governance Section of this Plan, that will set future directions for planning and investment and: • provide advice to support the development of a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander peoples for inclusion in the National Suicide Prevention Implementation Strategy;	• Refer to Action iii in Governance section for information on the implementation approach.	MHPC	First meeting mid-2018	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2019 progress report. Work under the National Mental Health and Suicide Prevention Agreement and the soon-to-be-released National Mental Health Workforce Strategy (2022) responds to implementation of sub-actions under this action. The Australian Government is continuing to work in partnership with state and territory governments to develop the 10-year National Mental Health Workforce Strategy (2022) which will provide options to attract, train, maximise, support and retain the mental health workforce required to meet the current and future demands of the mental health system, including planning for and managing demand and surge capacity. The strategy is expected to be finalised in early 2022 and is being informed by advice from an independent taskforce and feedback from state and territory governments and broader public consultation. The independent taskforce provided their final advice to Government in March 2022.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	• provide advice on models for co-located or flexible service arrangements that promote social and emotional wellbeing incorporating factors including a person's connection to country, spirituality, ancestry, kinship, and community; • identify innovative strategies, such as the use of care navigators and single care plans, to improve service integration, support continuity of care across health service settings and connect Aboriginal and Torres Strait Islander peoples with community based social support (non-health) services; • provide advice on suitable governance for services and the most appropriate distribution of roles and responsibilities, recognising that the right of Aboriginal and Torres Strait Islander communities to self-determination lies at the heart of community control in the provision of health services; • overseeing the development, dissemination and promotion in community,						The Australian Government continues to partner with Gayaa Dhuwi to finalise the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy in 2022. The strategy will provide recommendations for key government investment to improve mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples. Measures that will support the implementation of the strategy (once agreed) were announced in the 2021–22 Budget, and include: • investing in the National Aboriginal Community Controlled Health Organisation to deliver Indigenous Suicide Prevention and Aftercare Service Networks across the country. • continuing to support Black Dog Institute's Lived Experience Centre for Aboriginal and Torres Strait Islander people with lived or living experience of suicide • establishing a culturally appropriate 24/7 crisis line to be governed by Aboriginal and Torres Strait Islander peoples. The Australian Government committed $6.1 million over 3 years (2021–22 to 2023–24) to continue support for Gayaa Dhuwi's leadership and advisory role through its investment in the 2021–22 Aboriginal and Torres Strait Islander crisis services and support Budget package. This investment also allows for the development of a comprehensive implementation plan for the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, once finalised, and implementation of some small-scale initiatives identified in the strategy.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	hospital and custodial settings of resources that articulate a model of culturally competent Aboriginal and Torres Strait Islander mental health care across the healthcare continuum and brings together (a) the holistic concept of social and emotional wellbeing and (b) mainstream notions of stepped care, trauma-informed care and recovery-oriented practice; • provide advice on workforce development initiatives that can grow and support an Aboriginal and Torres Strait Islander mental health workforce, incorporates Aboriginal and Torres Strait Islander staff into multidisciplinary teams, and improves access to cultural healers; • provide advice on models of service delivery that embed cultural capability into all aspects of clinical care and implements the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026 in mental health services; and						

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	• provide advice on culturally appropriate digital service delivery, and strategies to assist Aboriginal and Torres Strait Islander peoples to register for 'My Health Record' and understand the benefits of shared data.						
12.1	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: • developing and distributing a compendium of resources that includes: (a) best practice examples of effective Aboriginal and Torres Strait Islander mental health care, (b) culturally safe and appropriate education materials and resources to support self-management of mental illness and enhance mental health literacy and (c) culturally appropriate clinical tools and resources to facilitate effective assessment and to improve service experiences and outcomes	• The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will develop and distribute sector resources. The subcommittee will be required to consult widely on the development and distribution of this compendium to ensure strong sector engagement. • This role for the Subcommittee will be articulated in its Terms of Reference (Refer to Action iii).	MHPC	Commence 2018. Completed 2020	n/a	Completed	The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention has established a clearinghouse of best-practice services, programs and resources (https://www.indigenousmhspc.gov.au/) to recognise the work of communities and support others to further develop their own suicide prevention initiatives. Administrative activities are ongoing.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
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 Subcommittee will develop joint guidance for mental health providers to increase knowledge and improve cultural competence. • This guidance will articulate government expectations for funded service providers and provide practical advice based on existing agreed policy documents, including the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023, the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026 and the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 and relevant state/territory strategies.	MHPC	Commence 2018 and ongoing		Completed	The Australian Government provides funding to PHNs to plan and commission regionally appropriate mental health and suicide prevention services. PHNs are expected to promote a culturally competent workforce with training in trauma-informed care and in identification of risk to deliver services to Aboriginal and Torres Strait Islander peoples, and which is supported to holistically meet their needs. PHNs are required to undertake a needs assessment to meet the mental health needs of Aboriginal and Torres Strait Islander peoples in their regions.
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 Subcommittee will provide advice to MHPC on practical strategies to improve Aboriginal and Torres Strait Islander leadership. • This role for the Subcommittee will be articulated in its Terms	MHPC	Commence 2018 and ongoing	Ongoing	Completed	The Australian Government provides funding to Gayaa Dhuwi (Proud Spirit) Australia as a national Aboriginal and Torres Strait Islander leadership body in social and emotional wellbeing, mental health and suicide prevention. Gayaa Dhuwi is governed and controlled by Indigenous experts and peak bodies working in these areas, promoting collective excellence in mental health care. As part of their current funding agreement, Gayaa Dhuwi is developing a national Gayaa Dhuwi (Proud Spirit) Declaration implementation plan.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
		of Reference (Refer to Action iii).					
12.4	• training all staff delivering mental health services to Aboriginal and Torres Strait Islander peoples, particularly those in forensic settings, in trauma-informed care that incorporates historical, cultural and contemporary experiences of trauma	• Informed by advice from the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee, all governments will ensure training in trauma-informed care is provided to all staff in their mental health services. • All governments will put in place strategies for delivering training in trauma-informed care to providers of mental health services to Aboriginal and Torres Strait Islander peoples.	MHPC	Commence 2018 and ongoing	Completion expected early 2021	Completed	The Australian Government provides funding to PHNs to plan and commission regionally appropriate mental health and suicide prevention services. PHNs are expected to promote a culturally competent workforce with training in trauma-informed care and in identification of risk to deliver services to Aboriginal and Torres Strait Islander peoples, and which is supported to holistically meet their needs.
13.1	Governments will strengthen the evidence base needed to improve mental health services and outcomes for Aboriginal and Torres Strait Islander peoples through: • establishing a clearinghouse of resources, tools and program evaluations for all settings to support the development of culturally safe models of service delivery, including the use of cultural healing and trauma-informed care	• Utilising AIHW's Close the Gap Clearinghouse, the Commonwealth will commission the establishment of a clearinghouse of resources, tools and program evaluations. • MHPC will request the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee to advise on implementation of this action. • This role for the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will be articulated in its Terms of Reference (Refer to Action iii).	MHPC	Commence 2018 and ongoing		Completed	The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention has established a clearinghouse of best-practice services and programs (https://www.indigenousmhspc.gov.au/) to recognise the work of communities and support others to further develop their own suicide prevention initiatives. Administrative activities are ongoing.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
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	• MHISSC will develop strategies for ongoing testing and reporting on the accuracy of identification of Aboriginal and Torres Strait Islander people within key national mental health data collections.	MHISSC	Commence 2018. Completed 2021.	n/a	Completed	Funding has been provided to PHNs through a Primary Mental Health Care Funding Pool to support commissioning of mental health and suicide prevention services in 6 key service delivery areas, one of which is enhanced Aboriginal and Torres Strait Islander mental health services. The Primary Mental Health Care Minimum Data Set is designed to capture data on PHN-commissioned mental health services delivered to individual clients—such as group-based delivery to individual clients—which includes services delivered to Aboriginal and Torres Strait Islander clients. The Primary Mental Health Care Minimum Data Set identifies clients who receive indigenous-specific services, which are defined as services where the treatment plan for the client is primarily based around delivery of mental health services that are specifically designed to provide culturally appropriate services for Aboriginal and Torres Strait Islander peoples. The Primary Mental Health Care Minimum Data Set needs work to address issues around Indigenous data sovereignty, which is being considered by the Australian Bureau of Statistics (ABS) and AIHW.
13.3	• ensuring future investments are properly evaluated to inform what works	• All governments commit to embedding appropriate evaluation of their respective investments in mental health initiatives for Aboriginal and Torres Strait Islander peoples and report annually on achievement of this requirement through MHPC. • The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will provide advice on how to best embed evaluation of government investment into program design.	MHPC	From 2017 and ongoing	n/a	Completed	The Australian Government is ensuring that investments in mental health initiatives for Aboriginal and Torres Strait Islander peoples are appropriately evaluated. The 2021–22 Budget included funding for the evaluation of various measures relating to Aboriginal and Torres Strait Islander mental health and suicide prevention.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
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; and	• MHISSC will work with stakeholders to ensure that the development and construction of mental health performance indicators include the capacity to disaggregate by Indigenous status wherever possible.	MHISSC	Commencing 2018 and ongoing	n/a	Completed	The 2021–22 Budget included funding for nationally consistent data collection to bring together data from mental health services delivered in the community, including services delivered by state and territory governments, regionally commissioned providers and non-government organisations, to enable services to be delivered to those who need them, and improve mental health outcomes for Australians. Further, $30.5 million over 7 years (2021–22 to 2027–28) was committed for a national survey to measure, for the first time, the prevalence of mental health in the Aboriginal and Torres Strait Islander population. Funding over the forward estimates is $9.2 million (2021–22 to 2024–25). The survey will be co-designed and implemented with Aboriginal and Torres Strait Islander peoples. The survey will be designed to be culturally appropriate and meet the needs of the community.
13.5	• utilising available health services data and enhancing those collections to improve services for Aboriginal and Torres Strait Islander peoples.	• MHISSC will work with stakeholders to create opportunities for collating and reporting data on provision of mental health services to Aboriginal and Torres Strait Islander peoples. • The Commonwealth will facilitate this through existing funding arrangements with the AIHW and will ask AIHW and MHISSC to scope the development of mental health indicator/s in the Key Performance Indicators (KPIs) for Aboriginal and Torres Strait Islander primary health care.	MHISSC	Commence 2018. Completed 2021.	n/a	Completed	See responses to Action 13.2 and Action 13.4.
Priority Area 5: Improving the physical health of people living with mental illness and reducing early mortality							
14	Governments commit to the elements of Equally Well – The National Consensus Statement for improving the	• All governments and mental health commissions will embed the elements of Equally Well	All jurisdictions and mental health commission	From 2017 following release of Equally Well	n/a		A national status rating is not possible, as states and territories are implementing this action independently. See status ratings and context for each jurisdiction in the following rows of this table.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	physical health of people living with mental illness in Australia.	and take action in their areas of influence to make changes towards improving the physical health of people with mental illness. • The NMHC will monitor and report on implementation of the National Consensus Statement across jurisdictions.	National Mental Health Commission			Completed	The Commission has monitored and reported on the implementation of the National Consensus Statement across jurisdictions through the annual Fifth Plan progress report (Action v). The Fifth Plan 2021 progress report is the final report and reports on the progress of the National Consensus Statement between 1 July 2020 to 31 December 2021. The Equally Well Alliance was funded in the 2021–22 Budget and is now being managed by the Australian Government Department of Health and Aged Care. The alliance now reports directly to the department. The Commission continues to participate in the Equally Well Alliance. The Commission has provided Grant funding of $22,000 (including GST) for bursaries for consumers, carers and lived experience workers to attend the Equally Well National Symposium in April 2022. The Commission has funded the Equally Well Healthtalk Project, managed by the Royal Melbourne Institute of Technology, to develop online resources that can be used to inform and support people with lived experience of mental and physical health issues. The grant started on 12 June 2020 and runs until 30 September 2022 at a total cost of $132,000 (including GST). This project is currently on track.
			Australian Government Department of Health			Completed	As part of the National Mental Health and Suicide Prevention Plan (2021) released alongside the 2021–22 Budget, the Australian Government is providing additional funding for the Equally Well Program to support improvements to the physical health of those living with a mental illness. The National Mental Health and Suicide Prevention Agreement, executed in March 2022, reaffirms the commitment of all Australian governments to the principles of the Equally Well National Consensus Statement. [Note: the agreement was only agreed in-principle by National Cabinet as at 31 December 2021].
			New South Wales—NSW Health			Completed	On 30 April 2021, NSW Health published the Physical Health Care for People Living with Mental Health Issues Guideline. The guideline embeds the principles of Equally Well. It sets out a responsibility of New South Wales health districts and networks to work alongside

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
							people with lived experience of mental health issues to improve their physical health outcomes and quality of life.
			New South Wales—Mental Health Commission			Progressing through business-as-usual activities	The Mental Health Commission of New South Wales continues to advocate for the improvement of the physical health of people living with mental illness in New South Wales. As part of the Commission's function under the *Mental Health Commission Act 2021* to establish the Mental Health Commission of New South Wales for the purpose of monitoring, reviewing and improving the mental health and wellbeing of the people of New South Wales, the Mental Health Commission of New South Wales has published a set of outcome areas and indicators to track the mental health and wellbeing of people living in New South Wales over time. The indicators were published on the New South Wales Mental Health Commission's website in July 2021. The development of these indicators allows the Mental Health Commission of New South Wales to measure the collective efforts of government, advocate for better data where there are gaps and share whole-of-person data about mental and physical health outcomes and wellbeing in one place. The indicator framework is structured across 3 domains, 17 outcome areas and 40 indicators. The Living Well Indicators are focused on measuring outcomes across the domains of a person's life. The importance of physical health and wellbeing is also reflected in the Whole Person Health Outcome Area, which aims to measure the extent that mental health and physical health are integrated in New South Wales. The current published indicator set has 3 indicators for the Whole Person Health Outcome Area, but the Commission is updating it to 6 indicators: • Cancer screening rates (breast, cervical, prostate) by mental health status • General practitioner visits in the previous 12 months by mental health status • Long-term health conditions by mental health status • People with a mental health diagnosis who are overweight or obese

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
							• Potentially preventable hospitalisations by mental health status • Service provided advice about physical health care. The new indicators will be published in 2022, or as data becomes available. The Commission seeks to continually review and improve the indicators that track the mental health and wellbeing of people in New South Wales. The Commission's data development plan is driving the improvement process along with the changing landscape of information needs and data availability.
			Victoria—Department of Health and Human Services			Completed	In March 2019, Victoria's Chief Psychiatrist and Chief Mental Health Nurse published the Equally Well in Victoria: Physical Health Framework for Specialist Mental Health Services. This framework describes initiatives for organisations and clinicians to work in partnership with consumers and carers to discuss physical health in the context of a recovery plan.
			Queensland—Department of Health			Progressing through business-as-usual activities	The Queensland Health Statewide Mental Health Clinical Collaborative hosts multiple virtual forums each year for clinicians and managers to support prioritisation of physical health initiatives. These include reviewing statewide data, services presenting their work and sharing experiences in implementing changes in the local area, and expert speakers to provide educational components. The collaborative works with services using clinical indicators in smoking cessation, physical health assessment and physical health interventions to assist services to monitor progress, review service improvement and benchmark against other services. Data from Queensland Health adult community-based mental health services shows that the smoking rate in consumers has dropped from 51.6% in 2018 to 50.2% in 2021. On behalf of the Mental Health, Alcohol and Other Drugs Statewide Clinical Network, the collaborative is leading a working group in partnership with the Diabetes Statewide Clinical Network and the Queensland Mental Health Benchmarking Unit to explore the potential for collaboration between Queensland Health mental health, alcohol and other drugs services and endocrine services to improve the physical health of people with serious mental illness and co-occurring metabolic disorders.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
							The Queensland Mental Health Benchmarking Unit is supporting the benchmarking of community care units and secure mental health rehabilitation units with a focus on the physical health of consumers. This work is informing the development of tailored quality improvement plans for community care units and secure mental health rehabilitation units. A statewide consultation process with hospital and health services on strategies to address the physical health of mental health, alcohol and other drugs service consumers is underway to inform quality improvement initiatives for the prevention and management of multimorbidity.
			Queensland—Mental Health Commission			Progressing through business-as-usual activities	The Queensland Mental Health Commission has supported the Equally Well movement to improve physical health outcomes for Queenslanders with lived experience. In 2019, the Queensland Mental Health Commission published 2 key reports (a case for change and a strategic position paper) that identified the key themes, barriers and enablers for reform opportunities. In 2021, the findings were put to a group with lived experience for consultation, and the feedback was shared with key stakeholders to drive ongoing integrated reform. In April 2022, the Queensland Mental Health Commission sponsored the Equally Well Symposium at Griffith University. The event brought together key players across sectors and the peer workforce, laying the foundation for future collaboration. Queensland Mental Health Commissioner Ivan Frkovic was among the guest speakers, all representing social and community organisations, government agencies, allied health bodies, research institutes and university partners. The Queensland Mental Health Commission continues to connect allied health and mental health providers to drive integrated approaches that deliver better holistic outcomes for people. Additionally, consultation is currently underway with Equally Well Australia and the Mitchell Institute to develop communications resources that progress Equally Well principles across the sector.
			South Australia—SA Health			Progressing through business-as-usual activities	Although significant work has started, and some project achievements have been met, an overall approach to improving the physical health of mental health consumers

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
							has not yet been embedded into the state mental health services everyday practice. Work began in some regions on the Equally Well physical health action and implementation plans in collaboration with GPs and consumers, progressing to executive endorsement and service-wide implementation of the plan which uses the Equally Well Roadmap. Achievements to date are the: • establishment of a GP/mental health shared-care group aiming to improve the physical health of mental health consumers by increasing the connections between GPs and mental health services • development and launch of the GP mental health shared care webpage, a one-stop shop for mental health information and resources aimed at GPs • review and relaunch of the metabolic health webpages for consumers and clinicians • improvement of data collection and reporting on consumer physical health assessments available at the local level • partnering of LHN GP Integration Officers with mental health services to review GP communication tools and correspondence to ensure a more collegial approach • collaboration with Choice and Medication to update specific COVID and clozapine fact sheets to better inform clinicians and consumers • establishment of GP liaison roles in some networks to better improve shared care and physical wellbeing • continuation of physical/metabolic health, intramuscular injection and comprehensive clozapine training programs statewide • establishment of SA Health High Risk Medicine—Clozapine training as the national online training program • facilitation of GP/mental health services focus groups and forums to improve clinician education and the physical health of shared consumers

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
							• attendance at the Equally Well community of practice update and expansion of physical health reporting screens in the Community Based Information Systems partnering with the Adelaide PHN in the launch of the Towards Wellness Plan.
			South Australia—Wellbeing SA			Progressing through business-as-usual activities	Wellbeing SA's Vaccine Hesitancy Project has been working to increase COVID vaccination rates in communities where there is known hesitancy. People who have experienced mental health challenges are 1 of the 5 priority populations for this project. The project has built vaccine confidence and improved vaccination rates through community capacity-building activities and partnerships. This has included supporting community events and information sessions that are built around sporting, cultural or social activities, provision of community grants and bringing together stakeholders to focus on vaccine outcomes for specific communities. Wellbeing SA is leading planning to implement Equally Well across all state-funded specialist mental health services in partnership with SA Health's Office of the Chief Psychiatrist.
			Western Australia—Department of Health and Mental Health Commission			Progressing through business-as-usual activities	The Western Australia Mental Health Commission has started a statutory review of the *Mental Health Act 2014* to identify elements of the Act that work well, identify opportunities where the Act could be improved, and make recommendations to the Minister and Parliament by a formal report. A public submission period started in August 2021, closing at the end of January 2022. The Western Australia Mental Health Commission is developing a Mental Wellbeing Guideline, which will define the guiding principles, foundations and best-practice evidence-based initiatives for the promotion of mental wellbeing and prevention of mental health issues in Western Australia. The guideline will be developed to promote mental wellbeing at a population level across the Western Australian community, with a focus on particular life stages and settings. The development of the guideline is on track for targeted consultation in 2022. The Western Australia Mental Health Commission has embedded a contractual requirement for the community-

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
							managed organisations it funds to engage in an independent evaluation of their compliance with the National Standards for Mental Health Services (NSMHS), including a requirement to support the physical health needs of consumers. All contracts now include clauses that embed a contractual requirement for community-managed organisations funded by the Western Australia Mental Health Commission to engage in an independent evaluation of their compliance with NSMHS. All mental health non-government organisations are now accredited against the NSMHS, except for 3. Of these, 1 has been acquired by another non-government organisation, with accreditation deferred until September 2022, and the remaining 2 have new service agreements with accreditation expected within 12 months (by 31 December 2022).
			Tasmania—Department of Health			Progressing through other reforms	Rethink 2020, Tasmania's state mental health plan, was updated in November 2020, and includes a new focus area: Improving the physical health of people with mental illness. Five actions are included under this new focus area: 1. identify Tasmanian organisations signed up to the Equally Well Consensus Statement and form a working group 2. in partnership with the working group, review available data to identify priority areas of need 3. in consultation with relevant stakeholders, develop an action plan to address agreed priority areas, noting activity already underway 4. commence delivery of activity in action plan in partnership with working group and relevant key stakeholders 5. communicate and share best-practice activity to support improvement of physical health for people with mental illness. Annual Rethink 2020 Implementation Plans offers an opportunity to add additional actions to improve the physical health of people with mental illness.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
							In addition, other measures are occurring within the Statewide Mental Health Services, including the establishment of a metabolic working group. Closer ties have also been forged with Primary Health Tasmania to work together on health pathways, with a view to statewide coordination of activity, to better manage the physical health of people with mental illness. In line with Comprehensive Care Standard of the National Safety and Quality Health Service Standards (Action 5.10), Statewide Mental Health Services clinicians deliver care in accordance with the PARIS protocol and the Statewide Mental Health Services Physical Assessment Protocol, with the assessment of issues identified during screening or raised in referrals or by the consumer.
			Northern Territory—Department of Health			Completed	The Northern Territory Department of Health has widely promoted the elements of Equally Well to the sector and they are embedded in Department of Health models of care and service agreements. Tertiary services complete full medical screening before any inpatient admissions. Metabolic screening of the consumers is also an essential component of the care plan for consumers with chronic mental illness. Multidisciplinary teams within the Northern Territory Department of Health provide a holistic approach in developing care plans by looking at physical health, psychosocial determinants and mental health as part of this process.
			Australian Capital Territory—ACT Office for Mental Health and Wellbeing			Progressing through business-as-usual activities	The ACT Office for Mental Health and Wellbeing is working with the ACT Health Directorate to identify areas of vulnerability for people with mental illness in the ACT Preventative Health Plan. The ACT Office for Mental Health and Wellbeing commissioned a project to consider responses to smoking rates of people with enduring mental illness.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
			Australian Capital Territory—ACT Health Directorate			Progressing through business-as-usual activities	Whole-of-person care, including promoting physical health and wellbeing is a focus area for the regional ACT Mental Health and Suicide Prevention Plan. It requires stakeholders to monitor activity against the Australian Capital Territory's commitment to Equally Well and to deliver activities that support the physical health of people with mental illness. Promotion of physical and mental health outcomes will be increasingly incorporated into procurement criteria and funding agreements. Government-funded mental health services in Canberra Health Services established the Physical Health Steering Committee in 2017 and finalised the Guidelines for Providing Physical Health Care Across Mental Health, Justice Health and Alcohol and Drug Services in 2019. Since then the focus has been to embed implementation of the guidelines across all teams. Teams have identified appropriate KPIs, and established protocols and relevant screening/monitoring tools. Regular presentations highlight initiatives, research activities and monitoring of KPIs and challenges. Notable achievements include: • the establishment of a quality improvement collaboration made up of 6 teams; this work was commended in the 2020 Australian Council on Healthcare Standards Quality Improvement Awards • the research subcommittee of the Physical Health Steering Committee successfully applying for a grant of $200,000 from the Research Innovation Fund to conduct a randomised controlled trial to evaluate the effects of structured exercise and dietary interventions among first episode psychosis patients; the trial is a partnership between Canberra Health Services and the University of Canberra and is about to start.
15	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. Implementation of the	• The Commonwealth and states and territories will review existing guidelines and resources and determine whether these require updating or whether additional	MHPC	Commence mid-2018. Completed late 2019. Annually from 2020.	n/a	Completed	On Thursday 26 August 2021, the then Minister for Health and Aged Care, The Hon. Greg Hunt, launched the Being Equally Well Roadmap. The Roadmap Report is a collaborative project between the Mitchell Institute at Victoria University, the Australian Health Policy Collaboration and Equally Well Australia. The Roadmap Report provides guidance and resources for health practitioners, and proposes developing tools for effective,

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	guidelines and resources will be monitored and reported. These guidelines and resources will: • provide advice on how to ensure physical health checks are part of the routine care of individuals with mental illness; • provide advice on screening, detection, treatment and early medical intervention for people known to be at high risk of physical ill health; and • define the roles of GPs, other primary care providers and specialist health providers in supporting integrated physical and mental health care.	guidelines and resources are required.					proactive and quality shared care between general practice and mental health services. As part of the $1.9 million of additional funding provided by the Australian Government through the 2021–22 Budget for the Equally Well program, Charles Sturt University will develop consumer and carer resources and guidelines consistent with Action 15 of the Fifth Plan, and Action 14.1 of the Productivity Commission Inquiry Report into Mental Health. The finalisation of these resources and guidelines will include seeking endorsement from key sector partners, including the Royal Australian and New Zealand College of Psychiatrists and the Royal Australian College of General Practitioners.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
16.1	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: • including it as part of joint service planning activity between PHNs and LHNs	• Governments will use joint guidance material on regional plans (Refer to Action 1.2) 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. • PHNs and LHNs will jointly release regional plans that include mechanisms to support the physical health needs of people living with mental illness.	MHPC	June 2018. By mid-2020	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report.
16.2	• including it as part of joint clinical governance activity	• Governments will use joint guidance material on regional plans to outline their expectation of PHNs and LHNs that joint clinical governance activity should include mechanisms for supporting the physical health of people with mental illness. • Refer to Action 1.2 for information on joint guidance.	MHPC	June 2018	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report.
16.3	• requiring roles and responsibilities to be documented as part of local service agreements	• The Commonwealth will direct PHNs to document roles and responsibilities for supporting the physical health of people living with mental illness in local service agreements. • States and territories will direct LHNs to document roles and responsibilities for supporting the physical health of people	MHPC	From mid-2020.	n/a	Completed	The Australian Government has directed PHNs to document roles and responsibilities for supporting the physical health of people living with mental illness in local service agreements.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
		living with mental illness in local service agreements.					
17	Governments will commence regular national reporting on the physical health of people living with mental illness. This will include: • building on existing datasets and reporting mechanisms; • identifying and addressing data gaps; and • seeking opportunities to share data across traditional boundaries.	MHISSC will: • identify mechanisms for reporting on the physical health of Australians with mental illness. • develop one or more nationally-consistent performance indicators on the physical health of Australians with mental illness. • identify strategies for ongoing analysis and reporting of the mortality gap for Australians with mental illness.	MHISSC	Commence October 2017. Completed 2022.		Progressing through other reforms	Action 17 was disrupted due to COVID-19 priorities and still requires work by the committee formerly known as MHISSC. MHISSC agreed Action 17 should be completed, and it remains on the work program, subject to priorities based on the National Mental Health and Suicide Prevention Agreement. As part of the $1.9 million of funding provided by the Australian Government through the 2021–22 Budget for the Equally Well program, Charles Sturt University are undertaking a data linkage project. This project will produce a data report on early death rates using Medicare Benefits Schedule and Pharmaceutical Benefits Scheme mental health-related services and death register linkage to assess impact. This is a 5-year replication of the ABS *Mortality of people using mental health services and prescription medications* (2017) report, designed to monitor progress in reducing the life expectancy gap between people living with a mental illness and the general population.
Priority Area 6: Reducing stigma and discrimination							
18	Governments will take action to focus on the stigma and discrimination experienced by people with mental illness that is poorly understood in the community. This will: • involve consumers and carers, community groups and other key organisations; • build on existing initiatives, including the evidence base of what works in relation to	• The Commonwealth will engage an expert provider to undertake a review of existing initiatives and evidence to inform the approach to implementation of this action. • MHPC and the Commonwealth will lead targeted consultations on options for a nationally coordinated approach to stigma and discrimination reduction with a focus on that experienced by people with mental illness that is poorly understood in the community.	MHPC	Completed mid-2018. Completed late 2018. Completed early 2019.	September 2020	Progressing through other reforms	The University of Melbourne held targeted consultations with consumers, carers, community groups and other key organisations on options for a nationally coordinated approach to stigma and discrimination reduction, in consultation with the Reducing Stigma and Discrimination Working Group. The Final Report from the University of Melbourne has been provided to the Commission to inform the development of the National Stigma Reduction Strategy, and provided to Health Chief Executives for noting. In December 2020, all governments agreed to the Commission leading the development of a national strategy to significantly reduce stigma and discrimination towards people affected by mental ill health.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	reducing stigma and discrimination; and • account for the specific experience of groups already at high risk of stigma including Aboriginal and Torres Strait Islander peoples and LGBTI.	• MHPC to propose direction to AHMAC for collaborative future government action.					
19.1	Governments will reduce stigma and discrimination in the health workforce by: • developing and implementing training programs that build awareness and knowledge about the impact of stigma and discrimination	• MHPC will seek advice from the Expert Advisory Group about an approach for developing and implementing training programs for the health workforce that build awareness and knowledge about the impact of stigma and discrimination. • MHPC will engage with consumers and carers, professional bodies, workforce accreditation bodies, mental health commissions, service providers and other key stakeholders on the development and implementation of training programs. • MHPC will engage with other AHMAC Principal Committees on the approach to implementing training programs for the health workforce.	AHMAC (progress reported by the MHPC)	Completed by mid-2021.	n/a	Progressing through other reforms	Through the National Mental Health and Suicide Prevention Plan announced as part of the 2021–22 Budget the Australian Government is investing: • $1.0 million for initiatives to reduce the stigma associated with seeking mental health care among health practitioners, and promote mental health as a preferred career option • $1.9 million to improve the awareness and skillset of the health workforce to appropriately respond to Aboriginal and Torres Strait Islander mental health issues In addition, the Commission has been tasked with developing a National Stigma and Discrimination Reduction Strategy. This strategy will recommend short-, medium- and long-term actions to reduce self, public and structural stigma and discrimination across various settings, including in the health and mental health systems. The Government is continuing to work in partnership with state and territory governments to develop a 10-year National Mental Health Workforce Strategy, which will consider the quality, supply, distribution and structure of the mental health workforce. The strategy will provide options to attract, train, maximise, support and retain the mental health workforce required to meet the current and future demands of the mental health system, including planning for and managing demand and surge capacity. The strategy is expected to be finalised in early 2022, and is being informed by advice from an independent taskforce, feedback from state and territory governments and broader public consultation. The independent taskforce provided their final advice to the Australian Government in March 2022.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
19.2	• responding proactively and providing leadership when stigma or discrimination is seen	• MHPC will seek advice from the Expert Advisory Group about where national responses and leadership are needed to support stigma and discrimination reduction in the health workforce.	MHPC	Completed by mid-2018.	n/a	Progressing through other reforms	See response to Action 19.1.
19.3	• empowering consumers and carers to speak about the impacts of stigma and discrimination	• MHPC will seek advice from the Expert Advisory Group about approaches for reducing stigma and discrimination in the health workforce by empowering consumers and carers to speak about the impacts of stigma and discrimination.	MHPC	Completed by mid-2018.	n/a	Progressing through other reforms	See response to Action 19.1.
20	Governments will ensure that the Peer Workforce Development Guidelines to be developed in Priority Area 8: • create role delineations for peer workers that provide opportunities for meaningful contact with consumers and carers and grassroots based advocacy; and • identify effective anti-stigma interventions with the health workforce.	• Refer to Action 29 for implementation approach.	MHPC	Commence mid-2018. Completed 2021.	n/a	Completed and moved to ongoing administrative activities.	The Commission launched the National Lived Experience (Peer) Workforce Development Guidelines on 9 December 2021. The guidelines are primarily intended to inform decision-makers, including employers and funding bodies, and to support change across the mental health sector by improving understanding of the benefits of the lived experience workforce and by supporting employers to assess their local readiness and prioritise activities that support successful implementation.
Priority Area 7: Making safety and quality central to mental health service delivery							
21.1	Governments will develop a National Mental Health Safety and Quality Framework to guide delivery of the full range of health and support services required by people living with mental illness. The Framework will describe the national agenda and work program for safety and	• SQPSC will work with the Australian Commission for Safety and Quality in Health Care (ACSQHC) to update the National Safety Priorities in Mental Health.	SQPSC	Commence 2018. Completed 2021.	n/a	Closed	Phase 1 of the project to update the 2005 statement of National Safety Priorities in Mental Health was completed by Queensland in December 2020. The draft updated statement was submitted to the SQPSC to consider Phase 2: finalising the priorities as a national document. With the rationalisation of the health advisory committees established under COAG, Phase 2 of the project did not progress.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	quality over the next five years, and will include: • identifying new and emerging national safety and quality priorities, and updating the 2005 statement of National Safety Priorities in Mental Health.						At its final meeting on 26 February 2021, SQPSC agreed to provide the draft safety priorities to the Chair of the Health Chief Executives Forum (Secretary, NSW Health). On 30 March 2021, the Chair of SQPSC, Dr Murray Wright, wrote to the Chair of the Health Chief Executives Forum with the following update in relation to Action 21.1: Updated National Quality and Safety Priorities in Mental Health, Phase One, has been circulated to all jurisdictions and is attached for consideration. Phase One of the project is based on Queensland consultations only, as the unresolved 2020–21 AHMAC funding bid means the project has been unable to proceed to Phase Two, involving national consultations.
21.2	• a revised national mental health performance framework to support reporting on performance and quality across all mental health service sectors	MHISSC will revise the National Mental Health Performance Framework in line with: • development of the National Mental Health Safety and Quality Framework. • amalgamation of the National Health Performance Framework and Performance and Accountability Framework being undertaken by AHMAC. • the updated National Standards for Mental Health Services (NSMHS) being developed by the Australian Commission on Safety and Quality in Health Care	MHISSC	Commence 2019. Completed 2020.	n/a	Completed	This action was reported as 'completed' in the Fifth Plan 2019 progress report.
21.3	• a guide for consumers and carers that outlines how they can participate in all aspects of what is undertaken within a mental health service so that their role in ongoing safety and quality initiatives is strengthened	• The NMHC will progress the development of a consumer and carer guide. • The NMHC will consult with the National Mental Health Consumer and Carer Forum and SQPSC on the development of the guide.	SQPSC	Commence 2018. Completed 2020.	n/a	Completed	The Mental Health Safety and Quality Engagement Guide is available on the Commission's website. Feedback from the Project Advisory Committee and the SQPSC strengthened the final document, ensuring it is practical, targeted and accessible for its intended audience.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
21.4	• a process for revising the National Standards for Mental Health Services that accounts for interfaces with other relevant standards such as the National Disability Standards	• SQPSC will work with ACSQHC to develop a suitable process for revising the National Standards for Mental Health Services.	SQPSC	Commenced 2019. Completed 2021	n/a	Progressing through business-as-usual activities	The Action 21.4 Working Group recommended to the SQPSC on 24 July 2020 that the process developed under Action 21.4 should be initiated after the finalisation of Action 22, to ensure that the mental health supplement to the NSQHS is included in the standards mapping work and to inform stakeholder consultations. The Office of the Chief Psychiatrist in South Australia recommends that further work on the process developed under Action 21.4 be held in abeyance until Action 22 is completed.
21.5	• coverage of all relevant service delivery sectors.	• SQPSC will develop an approach to ensuring all relevant service delivery sectors are covered by the Framework.	SQPSC	Commence 2018. Completed 2020.	n/a	Completed	Actions under this priority are inclusive of relevant service delivery sectors.
22	Governments will develop a mental health supplement to the NSQHS Standards (2nd ed.) which will align the NSQHS Standards and the NSMHS. • The NSQHS Standards (2nd ed.) and its mental health supplement will guide implementation of the Standards for all mental health services in public and private hospitals and community services provided by local health networks to ensure a single set of standards for these services. • The NSMHS will be maintained as the authoritative reference point on quality mental health care for continuing use by those organisations not subject to the NSQHS Standards.	• SQPSC to work with the ACSQHC to develop a mental health supplement to the NSQHS Standards (2nd ed).	SQPSC	Commence 2019. Completed 2021.	n/a	Progressing through business-as-usual activities	In 2021, the ACSQHC Chief Executive Officer and the SQPSC Chair agreed that ACSQHC would lead this project. The ACSQHC established an advisory group to support the project, chaired by Dr Peggy Brown AO, comprising representatives from consumer and carer organisations, peak bodies, state and territory departments, PHNs and community-managed organisations. Preliminary consultations were held with key stakeholders. The outcomes of this process led the ACSQHC to determine that it would develop 2 separate resources to meet the requirements of Action 22 of the Fifth Plan, and the needs of stakeholders. The first resource is the NSQHS Standards User Guide for Acute and Community Mental Health Services, for mental health services subject to the Australian Health Service Safety and Quality Accreditation (AHSSQA) scheme. This builds on the map of the NSQHS Standards with the National Standards for Mental Health Services that the ACSQHC released in 2018, which demonstrates the alignment between the 2 sets of standards. A draft version of the user guide was circulated for national consultation with service providers subject to the AHSSQA scheme in the second quarter of 2021. The consultation draft was revised to reflect stakeholder feedback and reviewed by the project advisory group. The user guide will be released in the second half of 2022.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
							The second resource is the National Safety and Quality Mental Health Standards for Community-Managed Organisations (NSQMH Standards for CMOs), for mental health services that are not subject to the AHSSQA scheme. The ACSQHC conducted 2 rounds of national consultation on the NSQMH Standards for CMOs, co-sponsored by the Commission. Each national consultation comprised interactive webinars, online focus groups and the opportunity to provide written submissions. In the first round, the ACSQHC developed a consultation paper and provided an opportunity for stakeholders to determine what they would like included in the standards. Building on this information, the ACSQHC then developed the NSQMH Standards for CMOs and circulated a draft version in the second round of consultation. This version was revised to reflect stakeholder feedback and reviewed by the project advisory group. It will be presented to the ACSQHC Board for endorsement in June 2022. The ACSQHC will work with stakeholders to develop resources to support the implementation of the NSQMH Standards for CMOs.
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. Efforts should be made to ensure groups that are historically poorly represented in these surveys such as Aboriginal and Torres Strait Islander peoples are properly represented and that survey tools are appropriately adapted to allow for this.	• MHISSC will lead work with the AIHW to pool consumer and carer experiences of care data nationally, to develop performance indicators of consumer and carer experience, and to report these indicators annually at the lowest level of geography possible. • MHISSC will lead the work required to develop a primary care version of the Your Experience of Service survey (YES) survey tool.	MHISSC	Commence 2018. Completed 2021.	n/a	Progressing through business-as-usual activities	This work has moved to ongoing administrative activities and is being progressed by the AIHW. Data from the Your Experience of Service survey is currently being published by 3 states on the AIHW website.
24	Governments will develop an updated statement on National Mental Health Information Priorities for information developments over the next ten years.	• MHISSC will develop a 3rd edition of the National Mental Health Information Priorities, in consultation with consumers and carers, service providers, the NMHC, relevant professional organisations,	MHISSC	Published by December 2018	June 2020	Completed	This action was reported as ‘completed’ in the Fifth Plan 2020 progress report.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
		governments, PHNs and other relevant bodies.					
25	Governments will ensure service delivery systems monitor the safety and quality of their services and make information on service quality performance publicly available.	• Commonwealth-funded services will have safety and quality monitoring and public reporting mechanisms. • State and territory-funded services have safety and quality monitoring and public reporting.	MHISSC (formerly SQPSC)	Completed end 2021	n/a	Progressing through business-as-usual activities	This work has moved to ongoing administrative activities.
26	Governments will improve consistency across jurisdictions in mental health legislation. This will be based on an understanding of their impacts on consumer and carers, and consistent with the 1 July 2016 United Nations Human Rights Council Resolution on Mental Health and Human Rights and the 2006 Convention on the Rights of Persons with Disabilities.	• All governments, through SQPSC, will continue to work together to develop effective working relations within existing legislative provisions.	MHPC	Commence 2017 and ongoing	n/a	Progressing through business-as-usual activities	Work on this action is being progressed and led by Queensland Health which is leading the National Mutual Recognition Project to develop a national legislative scheme for the mutual recognition of civil mental health orders. As part of this project, Queensland Health manages the National Mutual Recognition Interjurisdictional Project Steering Committee, of which the Australian Government Department of Health and Aged Care is a member. A model Bill has been provided to the New South Wales Parliamentary Counsel's Office for drafting.
27	Governments will make accessible the WHO QualityRights guidance and training tools to build awareness amongst consumers and carers, community managed organisations and other health services of consumer rights under the Convention on the Rights of People with Disabilities.	• 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. • The Commonwealth and states/territories will request their funded organisations utilise the guidance and training tools.	All jurisdictions (formerly SQPSC)	Commence 2018 and ongoing	n/a		A national status rating is not possible, as states are implementing this action independently. See status ratings and context for each jurisdiction below.
			Australian Government Department of Health			Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report.
			New South Wales—NSW Health			Completed	The WHO QualityRights guidance and training tools are included as a key resource in the New South Wales Strategic Framework and Workforce Plan for Mental Health 2018–2022. NSW Health ensures the principles of trauma-informed care are incorporated when updating and reviewing mental health policy and guidance.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
			New South Wales—Mental Health Commission			Progressing through business-as-usual activities	A key function of the Mental Health Commission of New South Wales is to amplify and advocate for the voice of people with lived experience of mental health issues and caring and kinship groups to be central to mental health reforms. This critical pillar of reform is articulated in the Mental Health Commission of New South Wales' Living Well in Focus 2020–2024: Strategic Plan for Community Recovery, Mental Health and Wellbeing in New South Wales, which was tabled in Parliament in November 2020. This strategic plan includes key priority areas for whole-of-government reform, and has 24 recommended actions. A stocktake of the work underway and planned by government agencies to implement the 24 actions was released late last year, and is available on the Mental Health Commission of New South Wales website. The Mental Health Commission of New South Wales will continue to monitor this progress and reinforce messages that build awareness of consumer rights for people with lived experience of mental health issues, their carers and kinship groups.
			Victoria—Department of Health and Human Services			Progressing through other reforms	An extensive program of work to promote and protect the human rights of mental health consumers was recommended by the Royal Commission into Victoria's Mental Health System, and is currently underway.
			Queensland—Department of Health			Progressing through business-as-usual activities	Queensland Health is currently exploring how the WHO QualityRights guidance and training tools can most appropriately be promoted across Queensland Health-delivered and funded mental health alcohol and other drugs services. The guidance aligns with the provisions of the *Mental Health Act 2016* and therefore promotion of the training tools will increase awareness of consumer rights through administration of the Act.
			South Australia—SA Health			Progressing through business-as-usual activities	In July 2021, the SA Health Human Rights and Coercion Reduction Committee was established to oversee measures that promote the Principles of the Convention on the Rights of Persons with Disabilities and a Human Rights analysis to support the development of new models of care for new services. Consideration of the WHO QualityRights tool kit will be considered in the coming year. The Human Rights and Coercion Reduction Committee is made up of people with lived experience (consumers and

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
							carers), legal professionals, medical representatives, public advocacy and children and young people representatives. Of significance, the committee approved a Decision-Making Capacity Factsheet for the medical profession, and in 2022 will prepare a similar resource for people with lived experience. In addition, work will start on developing a Human Rights analysis tool that will support the development of models of care for all new commissioned services, with a focus on best practice, personalised care and reduction in restrictive practices. In April 2022, the SA Health Strategic Mental Health Quality Improvement Committee and the SA Health Human Rights and Coercion Reduction Committee were provided with the WHO QualityRights toolkit for comment and feedback. In late 2021, the Office of the Chief Psychiatrist's Lived Experience Advisory Group used the WHO QualityRights tool as a reference to update the Chief Psychiatrists Inspection protocol for lived experience inspections.
			Western Australia—Department of Health and Mental Health Commission			Completed	This action was reported as 'completed' in the Fifth Plan 2020 progress report.
			Tasmania Department of Health			Progressing through business-as-usual activities	As noted in the 2019 Fifth Plan progress report, implementation of the WHO QualityRights Guide was considered to be cost prohibitive by the Mental Health Principal Committee in 2018, with exploration of comparable training options the responsibility of individual jurisdictions. Tasmania's *Mental Health Act 2013* requires people exercising responsibilities under it to have regard for the Mental Health Service Delivery principles set out in Schedule 1 of the Act. These principles are closely aligned with the Convention on the Rights of Persons with Disabilities. A review of the Act completed in 2020 has considered education and training opportunities, including training to support clinicians and others who are required to exercise responsibilities under the Act, with a focus on the Mental Health Service Delivery Principles. This work is led by the Office of the Chief Psychiatrist.

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
			Northern Territory—Department of Health			Completed	The Northern Territory Department of Health engages with clients to increase consumer awareness about their rights and responsibilities throughout the patient journey, and has created sector awareness of the WHO QualityRights guidance and training tools. Various Department of Health policies and procedures incorporate the WHO QualityRights guidance and training tools.
			Australian Capital Territory—ACT Health Directorate			Progressing through business-as-usual activities	Accessibility and implementation of the WHO QualityRights guidance and training tools pertaining to mental health will be considered as part of recontracting, new commissioning and the recommissioning of non-government providers of mental health services starting in early 2022.
			Australian Capital Territory – Office for Mental Health and Wellbeing			Not applicable	The Office for Mental Health and Wellbeing does not directly commission mental health services in the Australian Capital Territory. The ACT Health Directorate have this area of responsibility.
Priority 8: Ensuring that the enablers of effective system performance and system improvement are in place							
28	Governments will request the National Mental Health Commission to work in collaboration with the National Health and Medical Research Council, 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 NMHC will lead the development of a research strategy in collaboration with the NHMRC, consumers and carers, states and territories, research funding bodies and prominent researchers.	MHPC	Commence mid-2018. Completed 2021.	n/a	Completed	The Commission has finalised the National Mental Health Research Strategy. The strategy provides the principles to guide and support decision-makers (funders and researchers) in improving the mental health research system, and outlines the actions for system reform that will ensure mental health research enables and reflects the significant reforms occurring in the mental health system.
29	Governments will develop Peer Workforce Development Guidelines consistent with the recommendation made by the National Mental Health Commission's 2014 National Review of Mental Health	• The NMHC will lead the development of Peer Workforce Development Guidelines. • The NMHC will consult with all governments, mental health commissions, consumers and carers and the mental health	MHPC	Commence mid-2018. Completed 2021.	n/a	Completed	The Commission launched the National Lived Experience (Peer) Workforce Development Guidelines (Guidelines) on 1 December 2021. The guidelines aim to inform decision-makers, including employers and funding bodies and to support change across the mental health sector by improving understanding of the benefits of the lived experience workforce and by supporting employers to

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	Programmes and Services, and the commitment made at Action 20.	sector on development of the guidelines.					assess their local readiness and prioritise activities that support successful implementation.
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.	• MHISSC will continue development of data sources to monitor the growth of the national peer workforce in public sector mental health services. • MHISSC will also identify opportunities for reporting of employment of peer workers in the non-government sector, including PHNs.	MHISSC	Commence mid-2018 and ongoing	n/a	Completed	Completed.
31	Governments will use the outputs from the NMHSPF, and other relevant data, to develop a Workforce Development Program that will guide strategies to address future workforce supply requirements and drive recruitment and retention of skilled staff.	• The Commonwealth will manage contractual arrangements with an expert provider to obtain outputs from the NMHSPF to inform the development of this activity. • MHPC will agree on the scope of the Workforce Development Program and will consult with relevant AHMAC committees on the approach to ensure alignment with broader health workforce policy arrangements.	AHMAC (progress reported by the MHPC)	Commence early-2018. Completed 2022.	n/a	Progressing through business-as-usual activities	The Workforce Development Program is contingent on the National Mental Health Workforce Strategy being completed.
32	Governments will develop a National Digital Mental Health Framework in collaboration with the National Digital Health Agency that will include: • an analysis of available research on new technology driven platforms that are already operational; • an analysis of interoperability	• MHPC will agree the approach to development of the Framework. • The Commonwealth, in collaboration with the National Digital Health Agency, will engage a suitably qualified provider to scope the requirements of a national digital mental health framework through a comprehensive consultation process, including with the Aboriginal and Torres Strait	AHMAC (progress reported by the MHPC)	Commence mid-2018. Framework completed 2020.		Progressing through business-as-usual activities	The Australian Government Department of Health and Aged Care engaged PwC Australia to develop the National Digital Mental Health Framework. Significant stakeholder consultation has been done to inform the drafting of the framework. A Digital Mental Health Framework Advisory Group was established to provide guidance and advice on the project. Membership was informed by the MHPC. The final framework has been submitted to the Australian Government Department of Health and Aged Care, and will be publicly released shortly. The framework will

Action	Action description	Roles	Coordination point or nominated respondent	Milestone date in implementation plan	Amended completion date (if applicable)	Status	Context for ratings
	considerations relevant to future data developments; • cohesive guidance on the structure of digital mental health help services; • recommendations on the development of new digital service delivery platforms; • actions for addressing access to new digital service delivery platforms for people from culturally and linguistically diverse communities and others who have limited engagement with these platforms; • clinical governance mechanism for e-mental health services that builds appropriate safety and quality mechanisms into service delivery and provides for links into traditional face-to-face services; and • workforce development priorities to improve access to digital services.	Islander Mental Health and Suicide Prevention Subcommittee. • States and territories to contribute to Commonwealth consultation and development of the framework.					support engagement on the redesign of the Australian Government Digital Mental Health Program. The ACSQHC partnered with service users, consumers, carers, families, clinicians, service providers and technical experts to develop the National Safety and Quality Digital Mental Health Standards. The standards were officially released on 30 November 2020. The standards aim to improve the quality of digital mental health service provision, and to protect service users and their support people from harm. The 3 standards include 59 actions related to clinical and technical aspects of digital mental health services. They describe the level of care and the safeguards that a digital mental health service should provide.

Appendix B: Case studies

Priority Area 1: Achieving integrated regional planning and service delivery

Adopting common assessment and referral in Tasmania

Recognising the need for a standardised approach to understanding the needs of people presenting for mental health support, Primary Health Tasmania became early adopters of the Australian Government Department of Health and Aged Care's Initial Assessment and Referral Decision Support Tool (IAR-DST). This work relates to Action 2.6 and Action 2.7 of the Fifth Plan, and is a key reform direction in Rethink 2020, Tasmania's joint regional mental health plan. The adoption and use of the IAR-DST across the mental health sector, and not just with Primary Health Network (PHN)-commissioned services, is a priority in Rethink 2020 and has been agreed by the Department of Health Tasmania.

Between April and November 2021, Primary Health Tasmania led a working group with representatives from Department of Health Tasmania, Tasmanian Health Service (local hospital network), community service providers and general practitioners (GPs) to localise the IAR-DST for Tasmanian users. The working group reviewed key considerations for adoption in Tasmania, such as local service mapping, referral processes, workforce requirements, clinical governance, and solutions including digital tools needed to support seamless referral.

With input from this working group, a Tasmanian IAR-DST webform has been developed which:

- captures referrer and consumer details
- incorporates the IAR-DST with the provision for clinicians to use their judgement to override
- includes a service directory with local services categorised by the IAR level of care
- incorporates a Mental Health Treatment Plan for general practitioners using this tool.

The Tasmanian IAR-DST webform is currently being piloted with self-nominated Primary Health Tasmania-commissioned services and GPs. Evaluation and learnings from these trials will inform system-wide adoption in Tasmania, which will enable efficient and appropriate referrals across the mental health care system, as well as support step-down referrals from public health services.

Developing a unique statewide commitment to reform

The Western Australian Foundational Plan for Mental Health, Alcohol and Other Drug Services, and Suicide Prevention (the Foundational Plan) was finalised in early 2021, and recognises that PHNs and Local Hospital Networks (LHN) (Health Service Providers in Western Australia) provide the core architecture to support system integration at the regional level.

The Foundational Plan is a simple pragmatic document that considers the confluence of service provision commissioned and delivered by the Western Australian Mental Health Commission, health service providers, and the Western Australian Primary Health Alliance, by seeking ways of developing and enhancing access to care across the broader Western Australian healthcare system to:

- reduce fragmentation and duplication
- address shared priorities, including opportunities for joint planning and commissioning
- integrate pathways for people with mental illness and/or alcohol and other drug issues within the current health system.

Despite business-as-usual challenges arising due to the COVID-19 pandemic, the Foundational Plan has been a truly collaborative process that involved extensive stakeholder engagement and consultation, including workshop participation, content input and reviews by each Western Australian health service provider, the Mental Health Commission and a range of peak bodies.

The Foundational Plan has been endorsed by the Western Australian Primary Health Alliance 's Chief Executive Officer, the Chief Executives of Western Australia's 5 health service providers and the Western Australian Mental Health Commissioner. This statewide commitment is unique to Western Australia and provides a tangible example of PHN–LHN cooperation, recently identified as a system deficit within the Productivity Commission Inquiry Report into Mental Health (2020).

The recently negotiated bilateral schedule (signed in April 2022) between the Australian Government and Western Australian Government under the new National Mental Health and Suicide Prevention Agreement, specifies that the Western Australian Joint Regional Mental Health Plan (that is, the Foundational Plan) and the Western Australian Mental Health and Other Drug Services Plan 2015–2025 are the foundational tools to inform collaborative decision-making.

Moving Moments

Moving Moments is founded on a framework of care aimed at reducing the disproportionate impact of social isolation experienced by older persons, the effects of which are vast and extend across a variety of health domains.

The Department of Communities, Disability Services and Seniors (2020) projects that Queensland's population of people aged 65 years and older will double between 2019 and 2049. By way of supporting this population and preparing for its future growth, the Central Queensland, Wide Bay, Sunshine Coast PHN, in partnership with Lutheran Services, commissioned the delivery of Moving Moments in Caloundra, Hervey Bay and Biloela, and supported the program's formal evaluation by Griffith University to inform future planning.

Moving Moments and the commissioning process through which it was implemented align with a combination of priorities set out in the Fifth Plan, particularly Priority Area 1. In addressing an emerging and increasingly accentuated area of need, the PHN, Lutheran Services and many other community stakeholders enabled the operationalisation of an innovative, collaborative and cost-effective program, and set a firm foundation for this region's commitment to older persons' health and wellbeing into the future.

The Moving Moments' final evaluation report (2022) found that '… participants noted dramatic changes in their motivation and desire to be engaged. Participants noted the variety of opportunities and experiences as significant. All (100%) of the participants reported changes in their mood and motivation'.[3]

Planning for wellbeing

In 2018, Brisbane North PHN and Metro North Health launched Planning for Wellbeing, the joint regional plan for mental health, suicide prevention and alcohol and other drugs. Implementation of Planning for Wellbeing has been led by multi-stakeholder partnership groups in the areas of lived experience leadership, children and young people, suicide prevention, severe mental illness, psychological services and alcohol and other drugs.

This was supplemented by short-term task-focused action groups on carers, mental wellbeing, culturally and linguistic diverse communities, older people and LGBTQIA+ communities. All activity related to Planning for Wellbeing is coordinated by the Strategic Coordination Group, consisting of lived experience and carer representatives, mental health and alcohol and other drugs non-governmental organisation peak bodies, the Institute for Urban Indigenous Health, Queensland Health, Metro North Hospital and Health Service and Brisbane North PHN.

In 2020, a review and refresh of Planning for Wellbeing was initiated by the Strategic Coordination Group. Each partnership/action group was asked to review their section of the regional plan to check whether needs had changed, progress was achieved in meeting the objectives and implementing the actions, and whether future actions were still relevant. A refreshed plan was published at the end of 2020, extending the life of the plan to 2025.

Planning for Wellbeing has its own website (www.planningforwellbeing.org.au) which lists all of the objectives and actions in the plan, and publicly reports on their progress. The site also highlights stories of success and achievement in implementation.

To prepare for the next stage of developing a comprehensive regional plan and co-commissioning arrangements, Brisbane North PHN and Metro North Hospital and Health Service have co-funded a coordinator position for 2 years. The coordinator will support the implementation and reporting of the current plan, oversee the development of the new comprehensive plan and work with the PHN and Hospital and Health Service (and potentially other funders) to develop co-commissioning models.

Reducing the impact of suicide by ensuring a coordinated and timely response

As a result of several suicide deaths of young people over a short period in 2018, Murrumbidgee PHN led a collaboration with relevant local organisations to develop a whole-of-region approach to suicide prevention and aftercare. Now known as the Murrumbidgee Suicide Prevention and Aftercare Collaborative, it includes local service providers, local, state and Australian government and agencies, and non-government organisations. Together, these organisations identify gaps and opportunities to work as one health system and guide activities to build community capacity and awareness around suicide prevention and aftercare supports.

An early output was the Murrumbidgee Suicide Event and Critical Incident Communications and Response Protocol, a framework guiding suicide and critical incident responses. Central to this framework is the Murrumbidgee Local Response Group, comprised of Murrumbidgee PHN, Murrumbidgee Local Health District, Wellways, New South Wales Police and New South Wales Ambulance, which is tasked with responding to a suicide event or critical incident.

The Murrumbidgee Local Response Group ensures a coordinated and timely response to suicide events and other critical incidents for people and communities who are directly impacted, and improves community capacity to minimise risk of contagion. Each response is unique and consists of various strategies and actions such as:

- liaising with state and national bodies to provide information sessions and education
- increasing and geo-targeting social media messaging
- monitoring media for stigma and risks
- ensuring culturally appropriate practical supports are available.

More recently, a suicide prevention and self-care guide for the region's first responders was developed, with useful tools and tips to guide first-responder engagement with a bereaved family and community, and support their personal wellbeing and safety. Ongoing activities under the collaborative's Priority Action Plan include suicide prevention training—including Mindframe and Question, Persuade, and Refer—and ongoing promotion and use of region-wide resources and plans.

Priority Area 2: Effective suicide prevention

Blacktown Safe Space

Western Sydney PHN recognises the need for community-based services that provide specialist mental health support in a welcoming and non-clinical setting. Suicide prevention is a complex area requiring a holistic approach that goes beyond clinical treatment. Peer workers with lived experience give people confidence the service truly understands their challenges.

Western Sydney PHN commissioned Blacktown Safe Space, operated by Stride, as the first of its kind in New South Wales. Safe Space is equipped with sensory rooms and staffed by peer workers, support workers and mental health specialists. In the past 12 months, Safe Space has supported 207 visitors through 483 occasions of service. This success has helped secure the rollout of additional Safe Space houses across New South Wales and Queensland.

Lorna[4] is 18 years old and visited Safe Space experiencing high levels of distress and strong, intrusive thoughts of suicide. She was struggling with self-harm and had a history of suicide attempts due to extensive childhood trauma, scoring 100/100 on the Subjective Units of Distress Scale.

When Lorna arrived at Safe Space, she was withdrawn and non-communicative. A staff member sat with her until she felt comfortable speaking. Slowly, Lorna shared her struggles and how previous trauma was impacting her life. Through conversation, the worker helped explore and validate her feelings. Lorna shared

[3] Cartmel J and Vince K, 2022; *Moving Moments Final Evaluation Report*, Griffith University: Brisbane.
[4] Name changed to protect the identity of this client.

some personal poetry and things she does to keep safe, and the worker helped her create a safety plan. She left the centre feeling supported and with lowered distress levels.

During the 72-hour follow-up call, Lorna was proud to share that she had not engaged in self-harm since her visit. Lorna has continued to send updates of how many days she has been free from self-harm and photos of things she has done to maintain her wellbeing.

Mateship Matters

Brisbane North PHN partnered with Mates in Construction through the National Suicide Prevention Trial to develop the Mateship Matters program. Mateship Matters provides an educational program to sports clubs to help members recognise the signs of suicidal distress and highlight how they can help, or how they can access referral support tools and resources. Community members (such as coaches or peers) who participate in the program become a key connector and often referral point between individuals seeking the support to services available. The unique sporting environment and intergenerational dynamic have been key to the program's success.

The Mateship Matters training modules are delivered by MATES field officers and all sessions feature group discussions to encourage a sense of mateship and mutual support. Field officers are available to carry out informal club visits (in addition to formal training) and offer postvention support in the event of a critical incident. A critical incident may be a suicide, but it also encompasses broader struggles and challenges that impact a club's community (for example, illness or accidents). Participants of the Mateship Matters program are informed that they, and their family members, have access to a 24/7 MATES telephone support line should they wish to engage with a MATES case manager.

Providing 'connector' training for community members through trial program activities has provided support for individuals to help them recognise the signs of suicidal distress, highlight how they can help and provide referral support tools for an at-risk individual and community members who may need support.

Over the trial period, evaluation of the Mateship Matters program found that it had a positive and significant influence on participants' suicide-related knowledge, attitudes, and behaviours. There were improvements across every dimension measured by the survey (knowledge, willingness and confidence to offer help, as well as seek help), but the largest improvement was observed for the knowledge and confidence items.

Improving post-emergency department and hospital follow-up of people who have attempted suicide

Adelaide PHN and the South Australian Government collaborated to improve follow-up of people who have attempted suicide in the Central Adelaide LHN region by co-commissioning The Way Back Support Service (TWBSS). This service is a Beyond Blue designed suicide prevention program targeting people discharged from hospital after attempting suicide, or who are experiencing suicidal crisis and at imminent risk of a suicide attempt.

It delivers non-clinical care, providing practical psychosocial support for up to 3 months by support coordinators to help people stay safe and connected with their support networks and existing community and health services. The service has recently been enhanced through the introduction of a dedicated position to support Aboriginal and Torres Strait Islander peoples. A key component of the model is a social work position within partnering hospitals to assist with the assessment and referral process to The Way Back Support Service coordinators who then contact the person within 24 hours.

At the time of reporting, the program had received more than 350 referrals from hospitals and community mental health teams. The program is helping to bridge the service gap and reduce the re-hospitalisation rate in the community.

Supporting pharmacies to prevent suicide

Primary Health Tasmania, through the National Suicide Prevention Trial, is working with pharmacies to look at ways of supporting community pharmacists in suicide prevention.

The Pharmacy Project is helping community pharmacists to play a meaningful role in suicide prevention by building their confidence and skills to respond to people in distress and at risk of suicide. It is a collaboration between the Black Dog Institute, the Tasmanian branch of the Pharmaceutical Society of Australia, the Tasmanian Pharmacy Guild of Australia and Curtin University.

To date, more than 80 pharmacists from about 160 community pharmacies in Tasmania have undertaken evidence-based suicide prevention training and have gained access to additional resources that will help them identify signs of suicidal behaviour among their customers.

The first stage of the project involved a literature review and co-design workshops with pharmacists, which helped identify 3 priority action areas:

- advanced suicide prevention training for pharmacists
- localised health pathways
- means restriction.

A customised educational program for pharmacists was co-created and piloted in 2019. Due to COVID-19 restrictions, an online version of the training was developed and rolled out in 2020–21. In parallel, the project team worked to develop dedicated accompanying materials for use in community pharmacies, including encouraging the use of Tasmanian HealthPathways.

A survey about means restriction is being conducted across Tasmania, alongside targeted interviews to understand the role pharmacists currently play in restricting the means used for suicide, in the case of pharmacies 'staged supply'. Staged supply aims to reduce risk of prescribed medication overdose by limiting medication quantities for patients identified as being at risk of suicide. This part of the project aims to create a comprehensive picture of how staged supply works in pharmacies across Tasmania, and identify challenges and areas for improvement in the care provided to people in crisis.

'The training upskilled us to be able to help people and refer them on to their GP, [as well as] services like Black Dog Institute, Beyond Blue and Lifeline. It really increased our skills and confidence in talking to people that appear to be distressed.' Serena Hayward, owner, Mews Pharmacy.

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

Addressing complex mental health and psychosocial needs for children, young people and their families in Brisbane South

In 2020, Brisbane South PHN undertook a scoping study, in partnership with Metro South Hospital and Health Service Child and Youth Mental Health Service, to understand the mental health and wellbeing needs of children, young people and their families in the Logan region of Brisbane South. This study identified significant service gaps for children (under 12 years) with complex mental health needs, and highlighted that the psychosocial health needs of vulnerable children (7 to 17 years), their families and carers were not being addressed adequately.

A service response to address this identified gap for children and young people experiencing complex mental health difficulties, too severe to be managed by primary mental health services yet not severe enough to meet the criteria for tertiary services, was needed. In response, Brisbane South PHN implemented a pilot project aimed at addressing the complex psychological vulnerabilities experienced by children and young people.

The Commonwealth Psychosocial Support Program for children and young people pilot project started in 2021 across multiple communities in the Logan region, focusing on the delivery of holistic early intervention capacity building for children, young people and their families and community.

During the first full year of the program (1 January to 31 December 2021), 286 children and young people accessed the service, with 4,151 service contacts delivered. This is a significant reach into the community, providing improved access to psychosocial supports for children, young people and their families, and resulting in better outcomes including improved self-esteem, confidence, emotional regulation, communication and ability to understand feelings and emotions. The program evaluation also noted increased school engagement and attendance, and improved family routines and communication.

During the implementation of the pilot, the Commonwealth Psychosocial Support Program worked closely with key partners across the service system to embed an integrated response that included referral pathways between services including the Child and Youth Mental Health Service, local schools and other community organisations.

The pilot continued to respond to the presenting community need and also evolved to address emerging needs being identified throughout implementation. Brisbane South PHN secured additional non-recurrent funding to incorporate clinical care and coordination into the program to address a significant clinical service support gap that was being highlighted for more than 70% of participants. The outcomes of the enhanced model are currently being evaluated, but initial findings indicate positive outcomes across both clinical and psychosocial measures.

Brisbane North PHN mental health integrated hubs

Facing consistent feedback about the impacts of service fragmentation on consumers, Brisbane North PHN undertook a detailed review process to improve services for people experiencing severe and complex mental health conditions.

Based on this review and co-design with consumers and carers, the PHN has reconceptualised its funding approach to provide alternatives to hospital care that offer holistic, integrated support. In 2019, 3 integrated service hubs were commissioned to act as a one-stop-shop for mental healthcare coordination, nursing, group psychological therapies, and psychosocial and physical health support.

The aim of the mental health hubs is to support people with severe mental illness to:

- live well in the community
- access integrated clinical and non-clinical services, matched to their level of need
- achieve their recovery goals.

The hubs provide a coordinated response with a no wrong door policy for people needing to access mental health supports within their community. Over the first 2 years, a comprehensive evaluation framework has been developed to monitor the impact of the integrated service model.

An evaluation report completed in November 2021 identified the following outcomes:

- More than 2,200 referrals have been received by the hubs, which resulted in 1,651 episodes of care and more than 38,000 service contacts.
- People with severe and complex mental illness accessing the hubs report positive experience and improved recovery outcomes.
- There were positive group-level changes in psychological distress and recovery over time.
- Service user-rated experience scores all exceeded the 85% satisfaction target set, except for the friends/family involvement, with 79% positive responses.
- The pooling of resources enables integration of clinical and non-clinical supports in one place; integration as part of the wider local service system remains challenging.

Brisbane North PHN will continue to partner with providers to improve and build on this integrated service model to achieve better supports for people with severe mental illness.

The Way Back Support Service, Western Sydney

Navigation of the mental health and community services sectors can be daunting for people, particularly during times of distress. Having a support person who is familiar with the system and has time to guide a consumer to the right services can provide a crucial aspect of care and treatment.

The Way Back Support Service is an aftercare service for people aged 15 years and over who have attempted suicide or experienced a suicidal crisis. The program is personalised to meet individual needs, and a support coordinator is responsible for maintaining contact with the client. They support clients to access holistic support, which includes emotional support services, safety planning, and access to various health professionals and services, including psychologists, mental health caseworkers, drug and alcohol rehabilitation services, and employment specialists. Last year, The Way Back Support Service received 454 referrals.

Juan[5] engaged with the service in May 2021 and was linked to WorkWell, an employment specialist service, where he was assisted in finding and securing a job. Juan got back in touch to share that he had just received a promotion and had bought his own home. He was extremely grateful for the support he received, and advised that he was doing really well.

Another client said, 'Being connected with The Way Back was the first time I've been connected to a service that has allowed me to feel heard, and which has provided support in a professional and conscientious way. I was always kept fully informed and provided with copies of documents which were sent to others; the communication was fantastic. I have a great deal of respect for The Way Back, previously I had lost all trust in the mental health system, but The Way Back has restored some of that trust and helped me to see I can continue.'

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

Aboriginal and Torres Strait Islander mental health and suicide prevention—The Yarning Circle Project

Brisbane North PHN partnered with Youth2Knowledge through the National Suicide Prevention Trial to deliver the Yarning Circle Project to schools across the Moreton Bay region. The Yarning Circle Project provides Aboriginal and Torres Strait Islander students with a safe place for young people to build strong connections to their culture and each other through attending a one-hour Yarning Circle facilitated by local Elders each week for 5 weeks. The facilitation of these groups helps build cultural identity and cultural pride and allows individuals to seek help confidentially and safely from Elders, or be pointed in the right direction for further assistance.

A primary objective of the program is to empower improved resilience in Indigenous youth. By providing positive cultural connection, students report an increased reason for living, greater pride in being Aboriginal and improved self-esteem.

A total of 192 young people attended the Yarning Circle Project sessions during the trial period. Evaluation questionnaires were received for 145 students:

- 51.7% (75) were male and 48.3% (70) were female.
- The mean participant age was 13.41 years (SD = 1.89).
- The majority of students identified as being Aboriginal (121; 83.4%), 5.5% (8) identified as Torres Strait Islander, and 10.3% (15) identified as both Aboriginal and Torres Strait Islander peoples.

The Yarning Circle Project has provided a safe system to self-empower individuals and build cultural pride within schools. In addition, Elders (and referrals by key school staff) are providing a community point of contact and assistance for those in need of care. Provision of culturally safe guidance and support is catering for the needs of these individual students.

Extensive engagement with students and teachers throughout the 5-week program has demonstrated significant improvements in students' self-esteem, reasons for living, connection to culture and community.

Reducing the impact of suicide in Darwin with Strengthening our Spirits

In 2016, Northern Territory PHN led the coordination and implementation of the Darwin National Suicide Prevention Trial. Darwin was chosen as one of 12 trial sites by the Australian Government to develop and implement a systems-based approach to suicide prevention at a local level for at-risk populations. Aboriginal and Torres Strait Islander peoples of greater Darwin were selected for the trial.

Northern Territory PHN engaged the Aboriginal and Torres Strait Islander community to inform and lead the design of an approach to suicide prevention that was culturally informed and responded to local needs and priorities. This led to the creation of the Strengthening our Spirits model. The model focuses on healing, building resilience and connection, and serves as a foundation for understanding where and how to intervene with suicide prevention activities.

The model incorporates the 4 elements, which depict the importance of balance between fire (spirit), land (mother), air (healing) and water (identity); when there is an imbalance in the elements, self-harm and suicide can occur.

This model has been instrumental in guiding Northern Territory PHN's commissioned activities for the Darwin region. Over a 5-year period, a total of 28 activities or projects have been commissioned in alignment with the Strengthening our Spirits model.

A recent evaluation of the National Suicide Prevention Trial in Darwin found the model to be a useful framework for social and emotional wellbeing that resonates with many providers. To build evidence about the model's effectiveness, Northern Territory PHN is committed to developing an outcomes framework and data collection tools. These could be used with providers beyond the greater Darwin region.

Marrin Weejali Aboriginal Corporation

More than 13,000 Aboriginal and Torres Strait Islander peoples live in Western Sydney, and there is significant need for holistic, community-focused and culturally-safe services. In response to this need, Western Sydney PHN commissioned Marrin Weejali, an Aboriginal community organisation providing culturally-appropriate alcohol, drug and non-acute mental health counselling, referral and advocacy services.

Marrin Weejali takes a personal, community-driven approach to identify the root causes of substance misuse and to help clients find healthy solutions to overcome their mental health issues. Over the past year, the program has supported 391 people.

Michael[6] was the victim of emotional and physical domestic violence, using ice as an escape. As the violence and drug use continued, Michael's 4 children were removed. 'That was the worst time in my life. I couldn't believe that as a father I had let my children down,' Michael said. Struggling to cope with the loss of his children and trapped in an abusive marriage, Michael spent $450 per day on drugs and became involved in criminal activity to support his habit.

Eventually, Michael had the strength to leave his wife and walk away from the abuse. He moved in with his mum and decided to seek help to stop using drugs. Michael had a limited number of people he could turn to, so he contacted Marrin Weejali for support. Marrin Weejali connected Michael to a dedicated

[5] Name changed to protect the identity of this client.
[6] Name changed to protect the identity of this client.

support worker and provided weekly counselling sessions to help him talk about his past without judgement. With the support to keep his life on track, Michael found a healthy relationship and a stable job. Marrin Weejali is also advocating for him to regain custody of his children.

'Thank you, Marrin Weejali, for all of your help, you all do an amazing job, and you helped save my life.'

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

Community Based Information System, physical health reporting

Community Based Information System is the information system used in South Australian mental health services. The data is used by mental health services in numerous ways, including informing progress against key performance indicators.

During the Southern Adelaide LHN physical health action plan workshops, access to meaningful data about physical health assessments for consumers was identified as a barrier to action.

The Community Based Information System information management team worked with clinicians to produce reports that the teams could easily run to indicate whether a person had a physical health assessment completed.

A timeframe of 6 months has been included in the reporting to alert the teams of consumers who are due for a physical health review. A function to include the request for collection of and uploading of physical health assessments completed by GPs was also included in the Community Based Information System physical health suite of screens and reports.

Work is continuing on updating the physical health assessment screen to include smoking, nutrition, alcohol use and physical activity data for consumers, providing a more holistic picture, and assisting in the national reporting datasets.

Metabolic health webpage update

SA Health has had a long-standing metabolic health webpage that was established in 2009. The page is public facing and accessible to consumers, clinicians and GPs.

During 2021, the webpage and resources were collaboratively reviewed with consumers, carers, clinicians and GPs to provide more updated, dedicated resources to consumers and clinical staff. The page was split into a consumer-focused page and a clinician-focused page.

The webpage and the 'It's not just about your head' campaign was relaunched across the state with accompanying posters provided to all SA Health mental health services, hospitals, non-government organisations and Aboriginal Community Health Services. Screen savers were included on the SA Health computers and internal TV monitors across hospitals to raise the awareness of the importance of looking after physical health and connecting with a GP.

Clinicians, GPs, consumers and carers are encouraged to use the webpages and its resources to assist in physical health discussions.

Mental Health GP Liaison Group and webpage

In 2019, the SA Health Mental Health GP Liaison group was formed, consisting of mental health clinicians from LHNs, GPs in GP integration officer positions with SA Health, the Adelaide PHN representative, drug and alcohol services clinicians and the SA Health communications officer.

The group aimed to:

- connect all people and teams with a GP liaison focus across SA Health together
- improve mental health teams' connection to GPs
- improve the physical health of mental health consumers
- improve the access and awareness of GPs for mental health services.

During 2020, the group developed a Mental Health GP Shared Care webpage, a one-stop-shop for GPs to access mental health resources, support and information. The GP liaison GPs met with the LHN community mental health teams to help forge collaborative links to GP practices and build programs and communication.

In 2021, the focus of the group moved to providing collaborative education to GPs and mental health medical staff, to run forums for shared case presentation and help GPs with mental health management and mental health medical staff with physical health management. This work continued into 2022.

Southern Area LHN Equally Well Physical Health Action Plan

In 2021, the Office of the Chief Psychiatrist and the LHN GP Liaison Integration Officer assisted the Southern Area LHN mental health teams to develop a physical health action plan for mental health services. The plan aims to improve the awareness of the importance of monitoring physical health in both staff and consumers, and to increase access to physical health assessments.

A series of workshops were held with consumer, medical, nursing, safety and quality representatives, facilitated by the Office of the Chief Psychiatrist Advanced Nurse Consultant and the LHN GP Liaison Integration Officer.

The Equally Well Action Plan template was used to create the Southern Area LHN Physical Health Action Plan with a more detailed implementation plan developed for endorsement. Action plan checkpoint meetings are held every 3 months to monitor progress. Through the workshops, access and availability in terms of data collection were identified as areas for development at a statewide level, and referred to the information and data management groups for assistance. This resulted in more usable reports being available to teams about the physical health of mental health consumers.

This initiative is ongoing and being implemented across the other LHNs.

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

Building cross sector workforce capability to improve mental health outcomes of people with borderline personality disorder

Through a joint planning process, Brisbane South PHN and Metro South Hospital and Health Service identified a significant gap in service access and clinical intervention for people diagnosed with borderline personality disorder. Services across the care continuum (primary–tertiary) in Brisbane South reported increases of people with borderline personality disorder presenting for support, and providers identified low levels of capacity, capability and confidence to provide the necessary evidence-based treatments. The emergency department, therefore, had become one of the main pathways for people with borderline personality disorder presenting and re-presenting in crisis.

In response to this gap, Metro South Hospital and Health Service and Brisbane South PHN identified the need to build cross-sector workforce capability to enable increased access to timely and evidence-informed interventions for people with borderline personality disorder.

Using a partnership approach, Metro South Hospital and Health Service and Brisbane South PHN designed and embedded a Dialectical Behaviour Therapy (DBT) Cross-Sector Workforce Capability Framework and Implementation Plan across the region. The model provided collaborative cross-sector training based on core competencies, along with support and mentoring for providers across:

- the hospital and health services
- private providers
- PHN-commissioned and other funded mental health suicide prevention and alcohol and other drugs service providers
- general practice.

The project resulted in a sustainable model of workforce development using a capability matrix-guided purposeful training based on individuals' roles and levels of dialectical behaviour therapy capability. Reflective communities of practice were also established to provide support, mentoring and ongoing development of the sector to continue to develop the cross-sector response.

This joint approach has resulted in a significant increase in providers' self-rated knowledge, competency and confidence in providing dialectical behaviour therapy-informed support for people with borderline personality disorder across the region. This has resulted in increased service access and individual and group-based treatment for people, regardless of what point of the service system they accessed. It has improved mental health and wellbeing outcomes for people with borderline personality disorder.

It is anticipated that, as the workforce capability increases, people will receive the level of dialectical behaviour therapy intervention and support they require. This enhanced access to treatment will result in further reductions in hospital presentations.

Stocktake report: National PHN Mental Health Lived Experience Engagement Network

In 2018, the Department of Health supported the establishment of the National Mental Health Lived Experience Engagement Network (MHLEEN). The network aims to:

- embed lived experience engagement in the commissioning of primary mental health services
- promote and build the peer workforce
- have a national network of PHNs and other stakeholders working together to ensure 'nothing about us without us'.

Key achievements during this reporting period included in the annual stocktake report of PHNs engagement and workforce development activities include demonstrated increases in activity since the 2018 stocktake report.

Some highlights from the 2021 report show an increase in PHNs:

- having policies and procedures and access to guidelines for engagement activities, including sitting fees, terms of reference, correspondence, mailing lists and engagement templates and tools
- using a specific engagement framework and/or model
- having KPIs around lived experience engagement in their tendering and reporting requirements
- including people with a lived experience on tender assessment panels and lived experience researchers, educators, trainers and consultants
- having either created an identified lived experience role within their PHNs and/or engaged lived experience consultants
- all having at least some commissioned services requiring lived experience or peer workers

PHNs were also asked to provide case studies of co-design activities in the annual stocktake report. Compared with 2018, the level and quality of engagement has demonstrated major improvements in deeper and authentic engagement activities. These have been showcased at several international and national conferences during this reporting period.

National Lived Experience Advocacy Delegates (LEADers) independent advisory group to MHLEEN

In 2020–21, the MHLEEN developed an independent advisory group of lived experience leaders known as the Lived Experience Advocacy Delegates Advisory Group. National Lived Experience Advocacy Delegates (LEADers) work with their local PHNs (80% of PHNs to date).

A register has now been established, which provides information, including where LEADers have specialist expertise in a particular area (for example, suicide prevention, child and youth). LEADers are a diverse group and have various roles, including:

- PHN community advisory committees as required by the Department of Health
- other mental health, alcohol and other drug-specific governance committees, such as regional plans
- priority group committees, such as child and youth, suicide prevention, alcohol and other drugs
- consumer or carer consultant to the PHN

- project-specific committees, such as safe spaces, headspace
- lived experience/peer workers in commissioned services
- volunteers in local mental health services.

The Lived Experience Advocacy Delegates Advisory Group has met monthly since April 2021. Included in the terms of reference, the group's key functions are to:

- build a collective and independent voice and advisory group to support the work of MHLEEN
- provide support to people with a lived experience to actively participate in mental health reforms
- provide an opportunity to have regular updates on state/territory and national work underway
- provide advice on emerging issues faced by people with a lived experience (consumers and/or carers)
- have opportunities to advocate on primary mental health issues
- disseminate information and updates to local networks and groups.

The advisory group has provided advice to MHLEEN and PHNs on:

- how PHNs can improve their engagement activities by aiming for authentic co-design processes, supporting and/or establishing local and regional networks with communities, and promoting lived experience employment and consultancy
- what capacity building is needed for people with a lived experience to enable authentic participation.

More recently, members have co-presented best-practice case studies at several international and national conferences and forums.

Embedding lived experience into the commissioning of primary mental health services

The MHLEEN has a membership from the 31 PHNs and other key national stakeholders. It aims to:

- embed consumer and carer engagement in the co-design throughout the commissioning of primary mental health services
- promote and support the employment of peer workers as part of multi-disciplinary teams
- maintain a national network of PHNs and other key stakeholders to support the coordination and collaboration of person-centred recovery-focused primary mental health care.

In 2021, a national stocktake report was undertaken to gather and analyse data and information on PHN engagement activities and lived experience workforce development.

Compared with the benchmark survey undertaken in 2018, PHNs have demonstrated an increase of having lived experience leaders and expertise at the governance and regional planning activities, including participation in tender development and assessment panels, specialist partnership groups and commissioning services that have peer workers involved.

Internally, there has been further development of good practice policies and procedures using co-designed guidelines for engagement and workforce development. There has also been an increase in PHNs creating identified lived experience positions within the PHN and/or engaging lived experience consultants to work with the PHN and commissioned services.

Co-producing lived experience leadership resources

During 2021, the National Mental Health Consumer and Carer Forum (NMHCCF) and the MHLEEN entered a formal partnership and collaboration to co-design a suite of Lived Experience Leadership projects. These projects aim to build the capacity of people with a lived experience—including carers, family and kin—and the sector and system, to embed engagement authentically in design, implementation and evaluation of services.

Lived experience co-production and leadership has become an increasingly significant feature of the contemporary mental health policy environment. Currently, multiple organisations and many individuals provide lived experience (consumers, carers and peer workers) input into an array of research, policy, programmatic and practice initiatives.

However, the sector lacks co-production maturity, and the lived experience workforce is fragmented, is variable in quality and lacks a clear understanding of what constitutes lived experience expertise in a system-design sense. Governments, public mental health services and community managed services also lack co-production capabilities.

Three projects are being undertaken to consolidate and promote existing initiatives and resources to support effective growth of mental health lived experience voices and leadership. They are:

- the establishment a central national repository of mental health consumer and carer leadership-related knowledge and initiatives to be included on the NMHCCF website
- the co-design of a Mental Health Lived Experience Governance Framework and Toolkit to guide identified priority organisations and jurisdictions when engaging with people with lived experience
- review of formal lived experience leadership education and training.

The projects each have a 50:50 representatives from both NMHCCF and MHLEEN on the project steering groups and investment. They are due for completion and launch in 2022.

Let's LEAD: Transformational leadership for emerging lived experience leaders

The NMHCCF and the MHLEEN have partnered with the Yale University Program for Recovery and Community Health to support up to 15 emerging leaders with a lived experience of recovery of mental ill health to participate in the LET(s)LEAD Academy, a transformational leadership development program.

Candidates were selected through an expression of interest process and have personal lived experience of mental health issues and recovery. They will be making positive changes in their community or sector or are interested in transformational change.

The virtual course—facilitated by instructors from the Program for Recovery and Community Health and guest facilitators throughout Australia—ran from February 2022 to November 2022. The first phase of the course consists of 10-weekly online seminars that cover concepts such as developing a personal vision, transformational change, appreciative inquiry, strategy and change management.

In the second phase of the course, participants will be matched with the mentorship of a community leader nationally or internationally according to a self-chosen piece of work contributing to the lived experience sector.

It is intended that, after course completion, participants will provide lived experience transformational leadership within their organisation and within the mental health lived experience (peer) workforce sector within Australia. All tuition fees will be paid by NMHCCF and MHLEEN. The first cohort will be graduating in October 2022. A second cohort is planned in 2022 to focus on carers, family and kin emerging leaders.

Appendix C: Overview of Fifth Plan performance indicators

Indicator	Description	Importance	Limitations	Frequency	Last reported
PI 1: Children who are developmentally vulnerable	Percentage of children who meet the criteria for developmentally vulnerable in the Australian Early Development Census (AEDC) (lowest 10% of scores).	Early learning skills, such as the ability to use language, solve problems and communicate with others, help children to reach their full potential. Children who display poor early learning skills are likely to fall further behind, so early detection and intervention are important to children's longer-term outcomes.	Scores on the AEDC are teacher-rated. Data on developmental vulnerability cannot indicate the cause of the developmental vulnerability, whether or not it relates to the child's mental health, or whether or not the child has previously received or is currently receiving additional supports for their vulnerability.	About every 3 years	• 2021
PI 2: Long-term health conditions in people with mental illness	Percentage of people with mental illness who have another long-term health condition which has lasted 6 months or more, or is expected to last 6 months or more.	Numerous studies have shown people living with mental illness are more likely to die early, most often due to physical illnesses.	Based on self-reported cases of asthma, arthritis, cancer, diseases of the circulatory system, diabetes mellitus, back problems, chronic obstructive pulmonary disease (bronchitis, emphysema). The data cannot indicate the cause of any differences in physical health, and does not support analysis of differences in the physical health of people with different types of mental illness.	About every 3 years	• 2020–21 for the general population • 2018–19 for Aboriginal and Torres Strait Islander peoples
PI 3: Tobacco and other drug use in adolescents and adults with mental illness	Percentage of adolescents and adults (14 years and over) with mental illness who report the use of licit and illicit drugs, including alcohol and tobacco.	There is a strong association between illicit drug use and mental illness, but it is difficult to determine the degree to which one causes the other. Both licit and illicit drug use contribute to poorer health outcomes and decreased life expectancy for people with mental illness in Australia.	Data on pharmaceuticals that are used appropriately for their medical purpose is not included in this indicator. Prevalence of tobacco and other drug use cannot indicate the extent to which the potential poor health outcomes associated with substance use have actually occurred. 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.	About every 3 years	• 2019
PI 4: Avoidable hospitalisations for physical illness in people with mental illness (indicator not reported)	Number and proportion of people with a mental illness who have been hospitalised for an avoidable physical illness in the previous 12 months.	Numerous studies have shown people living with mental illness are more likely to die early, most often due to physical illnesses.	Data systems can only identify consumers in touch with state and territory community mental health services and will not include people with a mental illness who receive services through primary care or private providers.		n/a
PI 5: Mortality gap for people with mental illness (indicator not reported)	Average life expectancy for a person with mental illness compared with the life expectancy of all Australians.	Numerous studies have shown people living with mental illness are more likely to die early, most often due to physical illnesses.	Data systems can only identify consumers in touch with state and territory mental health services and will not include people with a mental illness who receive services through primary care or private providers.		n/a

Indicator	Description	Importance	Limitations	Frequency	Last reported
PI 6: Prevalence of mental illness	Percentage of people who experienced mental illness in the previous 12 months.	Differences in prevalence of mental illness by age and sex are important considerations for policy development and service planning. Prevalence rates also provide a high-level indication of the mental health of Australians.	Prevalence data quantifies how much of the community is affected by mental illness in any given year, but does not reflect variations in severity or duration. Data for different components of this indicator is sourced from 3 different surveys, and cannot be compared with each other. Data for people experiencing psychotic illness only includes people who are in contact with specialised mental health services. Equivalent data is not available for Aboriginal and Torres Strait Islander peoples.	Infrequent—a new National Study of Mental Health and Wellbeing started in 2020–21. Comprehensive national estimates for 2020–21, including lifetime and 12-month prevalence of mental health disorders were released in July 2022.	• 2007 for common mental illnesses in adults • 2013–14 for child and adolescent: • 2010 for psychotic disorders
PI 7: Adults with very high levels of psychological distress	Percentage of adults (18 years and over) with very high levels of psychological distress. Psychological distress is derived from the Kessler Psychological Distress Scale.	Very high levels of psychological distress may signify a need for professional help, and provide an estimate of the need for mental health services.	Data on psychological distress quantifies non-specific psychological distress, based on questions about negative emotional states. The data does not provide an indication of the individual's or the community's ability to cope with psychological distress, or the supports they may require to cope more effectively.	Non-Indigenous Australians: about every 3 years Aboriginal and Torres Strait Islander peoples: about every 4 years	• 2017–18
PI 8: Connectedness and meaning in life (indicator not reported)	Proportion of mental health consumers reporting connectedness and meaning in life.	Connectedness and meaning in life influence mental health and wellbeing and are important factors in recovery from mental illness. This indicator may give an indication of the effectiveness of treatment and supports, as well as the impact of stigma.	Sufficient data is not currently available to support reporting of a national indicator.		n/a
PI 9: Social participation in adults with mental illness	Percentage of adults (aged 15 years and over) with mental illness who report social participation.	People affected by mental illness experience high levels of social exclusion, including reduced social participation in day-to-day community activities. Maximising opportunities to participate in various community activities and contribute to the community are important factors in recovery from mental illness.	Data for this indicator cannot be broken down by mental illness type or severity, and may not accurately reflect the experience of people with all types and severity of mental illness. The data cannot indicate whether social participation of people with mental illness aligns with the social participation they want or their satisfaction with their social participation. Experience of mental illness is self-reported. Data for Aboriginal and Torres Strait Islander peoples and non-Indigenous people is not directly comparable.	No future iteration is currently scheduled	• 2014
PI 10: Adults with mental illness in employment, education or training	Percentage of adults (aged 15–64 years) with mental illness who are in employment, education or training.	People with mental illness are over-represented in national unemployment statistics, and untreated mental illness is a major contributor to lost economic productivity. Employment rates for people affected by mental illness can be improved substantially, leading to better health outcomes.	Experience of mental illness is collected by self-report. Data for this indicator cannot indicate whether or not people are being adequately supported to maintain their employment, education or training for the long-term. Data for Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians is not directly comparable.	Non-Indigenous Australians: about every 3 years Aboriginal and Torres Strait Islander peoples: about every 4 years	• 2020–21 for the general population • 2018–19 for Aboriginal and Torres Strait Islander peoples

Indicator	Description	Importance	Limitations	Frequency	Last reported
PI 11: Adult carers of people with mental illness in employment	Percentage of adult carers (aged 15–64 years) of people with mental illness, who are in employment and living in the same household.	Higher proportions of carers of people with mental illness in employment suggest that more carers are being supported to live a contributing life.	Includes full-time and part-time employment. Data cannot indicate whether carers are satisfied with their level or type of employment.	About every 3 years	• 2018
PI 12: Proportion of mental health consumers in suitable housing (indicator not reported)	Proportion of people using mental health services who report having suitable housing.	Many people living with mental illness interface with health care, social care, housing and other services. Poor integration between mental health services and other services can result in vulnerable people being caught in cycles of prolonged illness and dependence.	Sufficient data is not currently available to support reporting of a national indicator.		n/a
PI 13: Mental health consumer experience of service	Percentage of mental health consumers with an experience of service score equal to or higher than 80 using the Your Experience of Service survey.	Consumer experiences of care from mental health services are vital to inform ongoing quality improvement efforts.	Individual consumers may have completed the Your Experience of Service survey more than once in the reporting year. Data on the experiences of mental health consumers cannot indicate whether existing services would be rated positively by people with mental illness who choose not to access mental health services and supports.	Annually	• 2019–20
PI 14: Change in mental health consumers' clinical outcomes	Proportion of mental health-related episodes of care where significant improvement, significant deterioration or no significant change was identified between baseline and follow-up of completed outcome measures.	Routine mental health outcome measurement provides the opportunity to monitor the effectiveness of mental health services across jurisdictions to assist with service benchmarking and quality improvement.	Data on mental health consumers' clinical outcomes cannot indicate why consumers' clinical symptoms improved, deteriorated or had no significant change. Data cannot currently be broken down for Aboriginal and Torres Strait Islander peoples.	Annually	• 2019–20
PI 15: Population access to clinical mental health care	Percentage of the population receiving clinical mental health services.	The National Survey of Mental Health and Wellbeing indicated the majority of people affected by a mental disorder do not receive treatment. Measuring population treatment rates against what is known about the distribution of mental illness in the community gives a broad estimate of unmet need.	Service access data cannot indicate whether people are accessing the right services to meet their needs. The data also cannot indicate the proportion of people who might benefit from accessing clinical mental health care who do not access care, or their reasons for not accessing care.	Annually	• 2020–21 for the general population • 2019–20 for Aboriginal and Torres Strait Islander peoples
PI 16: Post-discharge community mental health care	Percentage of separations from state or territory public acute admitted patient mental health care service units for which a community mental health service contact was recorded in the 7 days following that separation.	Research indicates consumers have increased vulnerability immediately following discharge, including higher risk for suicide. 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.	For this indicator, only direct contact with the consumer constitutes a 'post-discharge follow-up'. However, a growing body of evidence suggests follow-up with the consumers' carer represents best practice for some cohorts. Data on post-discharge community mental health care cannot indicate why some people do not access community mental health care following their discharge from hospital, or whether they have accessed other forms of support following their discharge from hospital. This measure does not consider variations in intensity or frequency of service contacts following separation from hospital.	Annually	• 2019–20

Indicator	Description	Importance	Limitations	Frequency	Last reported
PI 17: Mental health readmissions to hospital	Percentage of in-scope overnight separations from state or 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.	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.	Due to data limitations, no distinction is made between planned and unplanned readmissions. Readmission data cannot indicate where in the mental health system a deficiency exists.	Annually	• 2019–20
PI 18: Mental health consumer and carer workers	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.	Consumer and carer involvement in the planning and delivery of mental health helps to adequately represent the views of consumers and carers, advocate on their behalf, and promote the development of consumer responsive services.	Jurisdictions differ in their approaches to consumer and carer employment in mental health services, from advisory roles to working within clinical teams or directly with consumers and carers. Data on consumer and carer workers cannot indicate whether there are sufficient numbers of consumer and carer workers, or whether the models adopted by jurisdictions achieve the optimal mix of roles. The data does not include Indigenous status or the number of consumer and carer workers employed in the community.	Annually	• 2019–20
PI 19: Suicide rate	Number of suicides per 100,000 Australians.	Suicide rates provide a high-level indication of community mental health and wellbeing. Suicide is the leading cause of death among people aged 15-44 years in Australia, and people with mental illness are at even greater risk.	Due to the process of suicide death investigation and registration, data is 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. The data cannot indicate the effectiveness of existing supports.	Annually	• 2020
PI 20: Suicide of people in inpatient mental health units (indicator not reported)	Number of suicides that occur in admitted patient specialised mental health services.	Although rare, suicide deaths in inpatient mental health units may point to inadequacies in the system and risks to the safety of consumers receiving mental health care.	Data is only available for public hospitals.		n/a
PI 21: Rates of follow-up after suicide attempt/self-harm (indicator not reported)	Proportion of presentations to hospital for which there was a follow-up in the community within an appropriate period.	A previous suicide attempt is the most reliable predictor of a subsequent death by suicide.	Data systems can only identify consumers in touch with state and territory mental health services, and cannot currently identify people who receive follow-up care through primary care or private providers.		n/a
PI 22: Seclusion rate	Number of seclusion events (confinement of a consumer or patient) per 1,000 patient days within public acute admitted patient specialised mental health service units.	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 data cannot indicate specifically where the inadequacies exist. 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 or patients.	Annually	• 2020–21

Indicator	Description	Importance	Limitations	Frequency	Last reported
PI 23a: Involuntary hospital treatment	Percentage of separations with specialised mental health care days that are involuntary.	As involuntary care is considered a type of restrictive practice, monitoring involuntary care is an important component of understanding and reducing the use of restrictive practices in Australian public hospitals.	A separation is coded as involuntary if the person has received involuntary treatment at any time during their admission. However, not all people remain involuntary for the full period of their admission to hospital. This data cannot indicate what type or how much care was provided without consent. Data from this indicator should be interpreted in conjunction with data from PI 23b: Involuntary patient days.	Annually	• 2019–20
PI 23b: Involuntary patient days	Percentage of admitted patient specialised mental health care patient days that are involuntary.	As involuntary care is considered a type of restrictive practice, monitoring involuntary care is an important component of understanding and reducing the use of restrictive practices in Australian public hospitals.	This indicator cannot indicate what type of care was provided without consent. Data from this indicator should be interpreted in conjunction with data from PI 23a: Involuntary hospital treatment.	Annually	• 2019–20
PI 24: Experience of discrimination in adults with mental illness	Percentage of adults with mental illness who report the experience of discrimination.	Discrimination against people with mental illness can increase feelings of isolation and create barriers to seeking help.	The data shows the proportion of people who experienced one or more instances of discrimination in the previous 12 months, but not the total number of instances of discrimination, the severity or the impact on the individual. The data cannot determine whether the discrimination was the result of the person's mental illness. Experience of mental illness is collected by self-report. Data for Aboriginal and Torres Strait Islander peoples only includes discrimination related to Aboriginal and Torres Strait Islander status, and is not comparable with data on non-Indigenous Australians. Data for 2014 includes people aged 18 years and over, and data for 2019 includes people aged 15 years and over.	About every 4 years, next full update expected in 2023	• 2014 • 2020 data is available for experience of discrimination in adults with mental illness by sex (Table PI 24.4)

Glossary

Ambulatory mental health care

Mental health care provided to hospital patients who are not admitted to 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.

Community mental health care

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

Consumers and carers

Has been used throughout the Fifth Plan final progress report to maintain consistency across the terminology used by the Fifth Plan itself, and all subsequent progress reports. Language in relation to these descriptors is evolving and remains contested, with different terms used in differing context by different groups.

Coordination point

The stakeholder named in the Fifth Plan implementation plan as having responsibility for coordinating the implementation of the action.

Developmentally vulnerable

Children with an Australian Early Development Census (AEDC) domain score in the lowest 10% of scores, based on data from all children who participated in the AEDC, taking into account age variations in the population of children in their first year of schooling.

Illicit drugs

Illegal drugs, drugs and volatile substances used illicitly, and pharmaceuticals used for non-medical purposes.

Lived experience of mental ill health

A current or previous experience of mental ill health, trauma or distress. For Aboriginal and Torres Strait Islander peoples, a lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.

Lived or living experience of caring/being a carer

A current or previous experience of being an unpaid carer or support person for someone experiencing mental ill health, trauma or distress.

Long-term health condition

Any of the following conditions, which has lasted 6 months or more, or is expected to last 6 months or more:

- asthma
- arthritis
- cancer
- diseases of the circulatory system
- diabetes mellitus
- back problems
- chronic obstructive pulmonary disease (bronchitis, emphysema).

Postvention

An intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers).

Psychological distress

Measured using 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 4 weeks before interview.

Seclusion

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

Separation

An 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

Services 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.

Acronyms and abbreviations

2018 progress report Fifth National Mental Health and Suicide Prevention Plan 2018: Progress report 1

2019 progress report Fifth National Mental Health and Suicide Prevention Plan 2019: Progress report 2

2020 progress report Fifth National Mental Health and Suicide Prevention Plan 2020: Progress report 3

ACCHS Aboriginal Community Controlled Health Service

ACSQHC Australian Commission on Safety and Quality in Health Care

AEDC Australian Early Development Census

AHMAC Australian Health Ministers' Advisory Council

AHSSQA Australian Health Service Safety and Quality Accreditation

AIHW Australian Institute of Health and Welfare

COAG Council of Australian Governments

Fifth Plan Fifth National Mental Health and Suicide Prevention Plan

FTE full-time equivalent

GP general practitioner

IAR-DST Initial Assessment and Referral Decision Support Tool

implementation plan Fifth National Mental Health and Suicide Prevention Plan Implementation Plan

KPI key performance indicator

LEADers National Lived Experience Advocacy Delegates

LHN Local Health Networks

MHISSC Mental Health Information Strategy Standing Committee

MHLEEN National Mental Health Lived Experience Engagement Network

MHPC Mental Health Principal Committee

National Agreement National Mental Health and Suicide Prevention Agreement

NDIS National Disability Insurance Scheme

NMHC National Mental Health Commission

NMHCCF National Mental Health Consumer and Carer Forum

NMHSPF National Mental Health Service Planning Framework

NSMHS National Standards for Mental Health Services

NSQHS Standards National Safety and Quality Health Service Standards

NSQMH Standards for CMOs National Safety and Quality Mental Health Standards for Community-Managed Organisations

NSW Health New South Wales Ministry of Health

PHN Primary Health Network

PI performance indicator

SA Health South Australian Department for Health and Wellbeing

SQPSC Safety and Quality Partnership Standing Committee

WHO World Health Organization