Case Studies

PHNs and stepped care

"Thinking nationally, acting locally represents a new mental health and suicide prevention system architecture. It puts people first and ensures they are engaged effectively in mental health system design, development and delivery."

Dr Peggy Brown, Chief Executive Officer, National Mental Health Commission

The following case study on the Western Australian Primary Health Alliance is an example of how joint partnerships in planning go beyond health to provide coordinated care for people with mental illness.

Case study: Applying an Outcome Based Commissioning framework

Western Australia has established a unique Primary Health Network (PHN) operating model, with the Western Australia Primary Health Alliance (WAPHA) responsible for operating all three of Western Australia’s PHNs. This presents a distinct opportunity to better coordinate care and establish innovative partnerships at the state and local level.

Another unique aspect of mental health in Western Australia is that the WA Mental Health Commission (WAMHC) holds a contractual relationship with the WA Department of Health to commission services. As a result, both WAMHC and WAPHA are exploring opportunities to establish a co-commissioning model. Through this model, they will be able to commission a full continuum of care to ensure no gaps in services exist.

WAPHA applies an Outcome Based Commissioning (OBC) framework to determine the work it will commission. OBC means that health care services are paid based on the achievement of the outcomes that are important to the people using the service. WAPHA’s OBC framework is designed to improve the experience of the individual and achieve cost-efficiencies. The approach aims to drive value through the key principles shown in the figure below.

How does an outcome based approach drive value across the system?

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
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<tr>
<td>Working with stakeholders to define outcomes that matter</td>
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<tr>
<td>Incentivising efficiency through different payment mechanisms</td>
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<tr>
<td>Removing barriers to produce greater value</td>
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<tr>
<td>Aligning provider commissioner and public goals</td>
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<tr>
<td>Incentivising providers to innovate to deliver high-value patient outcomes</td>
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</table>
Key principles of the Outcome Based Commissioning framework

To ensure WAPHA can apply its OBC approach, it has established a dataset in partnership with Curtin University to collect and analyse health data to support decision making. A single dataset for primary health care in Western Australia is expected to drive economies of scale and support PHN efficiency.

This case study illustrates how one PHN is using their regional needs analysis to implement mental health reform action, especially for vulnerable populations.

Case study: The missing middle and the challenge of primary mental health reform

A key part of recent Australian Government reforms to mental health was to place Primary Health Networks (PHNs) at the forefront of community mental health system design. All PHNs are required to develop a detailed mental health needs assessment. The aim of this is to develop a strong foundation from which to build a tailored response to regional mental health needs.

**Western Sydney Primary Health Network (WSPHN)** is a PHN based in Blacktown, New South Wales, that has demonstrated a strong interest in pursuing mental health reform. As part of its regional needs analysis, WSPHN considered national and regional trends in mental health expenditure using Medicare data from the Australian Government’s Better Access initiative. This analysis showed that the WSPHN is below the average national per capita spending under the **Better Access initiative**. It also found that the highest use of the initiative is, in fact, in the region’s wealthiest areas, and that the program is not getting to the people who need it most. Emergency department attendances continue to grow and place increased pressure on hospital admissions.

The following diagram shows WSPHN’s conceptualisation of the challenge of mental health reform across a continuum of need based on work undertaken with Synergia.

<table>
<thead>
<tr>
<th>General Population 80%</th>
<th>Mild 10–14%</th>
<th>Moderate 4–7%</th>
<th>Severe 2–3%</th>
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<tbody>
<tr>
<td><strong>% Access</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild Psychological distress</td>
<td>21% of people engaging with MH services</td>
<td>Lower intensity support</td>
<td></td>
</tr>
<tr>
<td><strong>Mild/Moderate</strong></td>
<td>Diagnosable condition</td>
<td>Relatively uncomplicated</td>
<td>Flexible mix of support</td>
</tr>
<tr>
<td><strong>Missing Middle</strong></td>
<td>Complex</td>
<td>Co-occurring</td>
<td></td>
</tr>
<tr>
<td>Federal funding</td>
<td>State funding</td>
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**Looking across the funding continuum, from Australian Government– to state-funded services, WSPHN reports rising access rates for people with mild psychological distress and relatively uncomplicated mild–moderate mental illness. However, access levels are low for the vulnerable populations, who suffer combinations of moderate and complex mental illness, drug and alcohol issues, comorbid physical conditions and other social issues. This group has become known as the ‘missing middle’.**

People in the missing middle have more complex needs than generally provided by unidimensional psychological support, yet are not considered ‘severe enough’ for constrained state mental health services. People in the missing middle are at risk of falling through the silos and divides of our health system.

WSPHN’s analysis led to their contention that many hospital presentations could be prevented with well organised community mental health care. WHSPN has therefore proposed an alternative approach based on the development of three key tools: person-centred design, use of a general practice–supported stepped care system approach, and shifting funding to more efficient and effective upstream services and supports. WHSPN’s mental health strategy aims to increase access to, and address inequalities of, services. To achieve this, they have set specific targets based on the number of general practitioners referring people to the Access to Allied Psychological Services program and the Mental Health Nurse Incentive Program, the response times by providers, and the establishment of financial management systems that allow control and visibility of the cost of service and management of funds.
WSPHN’s ‘quadruple’ aim

WSPHN aims to drive mental health reform in primary care towards a system that meets four aims:

- improve population mental health and physical health outcomes
- better experience of mental health care and support for people
- better satisfaction for clinical partners, especially general practitioners, their practice team and the local network of providers
- improve value for money while meeting the needs of mental health consumers.

The focus of WSPHN’s direction for mental health reform is the development of a ‘person-centred medical home’, with an integrated response to physical and mental health needs. This will rely on team-based care approaches and the development of a broader ‘neighbourhood’ that is connected and integrated.

It is early days for PHN planning in relation to mental health. WSPHN has focused on articulating the problem and some solutions in an innovative way. Critical to its thinking is the need to build a strong coalition of support among local general practitioners and health providers to work together to develop a new approach to mental health challenges.

References

1. The Better Access initiative enables Medicare-funded access to a range of talking therapies, such as cognitive behavioural therapy, to allied health professionals, particularly psychologists. Available at: [www.health.gov.au/mentalhealth-betteraccess](http://www.health.gov.au/mentalhealth-betteraccess)

There are some good examples in Australia that have successfully linked primary health care and community services, such as Neami National, as illustrated in the following case study.

Case study: Embedding person-centred care in community mental health

Neami National is a community mental health service supporting people living with mental illness to improve their health and live independently. Neami provides services in diverse communities in Western Australia, Queensland, South Australia, Victoria and New South Wales, ranging from the inner city to regional communities, including Dubbo, Broken Hill and Cairns. Neami has delivered a range of community mental health support services for more than 25 years. From humble beginnings in the suburbs of Melbourne, Neami now has 800 staff supporting more than 7000 people in local communities across Australia.

Neami’s span of service provision (shown below) gives an indication of the breadth of the challenge of providing effective mental health care in the community.

<table>
<thead>
<tr>
<th><strong>Housing and Supported Accommodation Initiative</strong></th>
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<tr>
<td>Neami delivers 10 HASI services across New South Wales and five similar supported accommodation services in South Australia. It provides a range of early intervention, crisis respite, housing and other services in five locations in South Australia.</td>
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<table>
<thead>
<tr>
<th><strong>Day to Day Living in the Community and Personal Helpers and Mentors Program</strong></th>
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<tr>
<td>These programs offer psychosocial support to people, making it easier for them to live in the community. Neami provides these programs in New South Wales, Victoria, Queensland and Western Australia.</td>
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<table>
<thead>
<tr>
<th><strong>Way2Home Assertive Outreach Service</strong></th>
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<tr>
<td>This service aims to connect homeless people with enduring accommodation and other supports. It operates in inner-city Sydney, with the service site located in Darlinghurst.</td>
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<thead>
<tr>
<th><strong>Prevention and Recovery Care (PARC) Service</strong></th>
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<tr>
<td>This involves short-term care in the community, to either prevent a person needing admission to hospital or, on their discharge, to facilitate their return home. Neami offers PARC services in Barwon and Preston in Victoria. Neami also provides sub-acute services similar to PARC in Dubbo and Broken Hill (NSW), Joondalup (WA) and Cairns (Qld).</td>
</tr>
</tbody>
</table>

| **Aboriginal and Torres Strait Islander Intensive Outreach** |
Neami uses an evidence-based framework for service delivery practice. The Collaborative Recovery Model was developed over a number of years at the University of Wollongong and was adopted as a whole-of-organisation practice framework by Neami National in 2009. The model is consistent with the values of the recovery movement and meets the Australian Government's criteria for a recovery-oriented practice.

To ensure its services are positively engaging with clients, Neami recently undertook a research project titled ‘An exploration of the application of the Collaborative Recovery Model (CRM) within Neami National’. The aim of the study was to determine whether the model was being implemented as intended, and whether delivery of the model is seen by staff and clients to be useful and beneficial in supporting recovery and wellbeing.

Key findings were as follows:

- Almost 90 per cent of clients hold the key practices within the CRM as being either ‘important’ or ‘very important’ towards supporting their recovery.
- More than 80 per cent of clients rated these practices as being applied in the ‘usually’ to ‘always’ range.
- More than 90 per cent of clients rated the sessions with their key worker as being ‘helpful towards assisting their personal recovery’.

The Mental Illness Fellowship Victoria’s Doorway Housing and Support Program (Doorway) is an example of a model of support that breaks down traditional program boundaries of mental health, housing and economic participation.

**Case study: Bringing together mental health, housing and economic participation**

The Doorway program run by Wellways (previously called Mental Illness Fellowship) Victoria is unique because it provides integrated mental health and housing support services through a single agency. The Housing and Recovery Worker (H&RW) role embodies this, integrating two roles that historically have been separate. There is an explicit focus on combating social isolation, and increasing economic participation, client confidence and choice. The whole-of-life focus aims to support sustainability of outcomes achieved and security for participants when they leave the program.

The key program features are detailed below.

### Housing support

H&RWs work with participants to choose and sustain rental accommodation. Participants contribute 30 per cent of personal income and all build tenancy management skills. Doorway subsidises payments for the first 18 months.

### Coordinated care

H&RWs meet with participants (weekly for at least 4 months) and coordinate the integrated support team. Core team includes family members, friends and Area Mental Health Service case managers. Broader teams can also include employment and other health support services.
Doorway has demonstrated a positive impact on both individuals and the health and housing systems.

This model has proven that, given the opportunity to enter the rental market and with the right support, people with mental illness can create homes, build lives for themselves in their communities, and improve their health and wellbeing. Evaluation of the pilot program demonstrated a range of health, housing, social and economic benefits, detailed below:

From the 12 months before to the 12 months after

- Estimated hospital admissions decreased from 20 to 6
- Average time in bed-based clinical mental health services per person/year decreased from 20 to 12
- Emergency Department presentations decreased from 93 to 63
- Engaged in paid or unpaid work increased from 16 per cent to 27 per cent
- 1 in 3 participants improved to the point of their being discharged from their Area Mental Health Service
- Most participants reported feeling more independent, having greater levels of self-respect and pride, and reconnection with family and friends
- Government savings estimated at $11,050 in avoided costs per person/year through reduced use of bed-based mental and ambulatory mental health services, presentations to emergency departments and hospital admissions

References

Early intervention can be implemented through a broad range of people and settings, including schools, colleges, universities, workplaces, housing and other community services, and through police and emergency services. The Prevention First Framework developed by the Hunter Institute of Mental Health provides a useful approach to identifying the different prevention and early intervention actions needed in mental health.

Case study: Achieving prevention and early intervention in mental health
The Hunter Institute of Mental Health's Prevention First Framework is a resource designed for policy makers, governments, health and mental health workers and other sectors that have responsibility for preventing mental ill-health and promoting mental health and wellbeing. The Framework builds on existing Australian models and policies and is designed to aid planning and monitoring of prevention activities and to help translate policy into action.

Prevention First identifies seven areas for action to achieve prevention and early intervention in mental health. Action areas are not mutually exclusive. The Framework provides examples of strategies that align with each of the seven action areas:

- actions to prevent the onset of mental ill-health in the whole community or groups in the community
- actions to prevent the onset of mental ill-health in groups at higher risk
- actions to intervene early and reduce the duration and severity of mental ill-health for groups or individuals at high risk and/or showing early signs of mental ill-health
- actions to reduce the duration and severity of mental ill-health for people experiencing an episode of mental illness
- actions to reduce the ongoing impact of mental ill-health on individuals recovering from a diagnosed mental illness
- actions to promote mental health and wellbeing in individuals experiencing or recovering from a diagnosed mental illness
- actions to promote mental health and wellbeing in the whole community or groups in the community

The Prevention First Framework, illustrated below, outlines the target population groups, the focus of activity, the movement of interventions across population and individual levels, and the focus on all people being supported to achieve and maintain optimal mental health regardless of an individual's mental health status.

**The Prevention First Framework**

![Diagram of the Prevention First Framework](image)

**References**


**Suicide Prevention**

"Suicide is not only about those who are gone. It’s about those who have survived and why … We need to know why people choose life at that moment when they are in their deepest despair, when they are in that existential crisis; when they have decided to take their own lives, but then choose not to."
The way forward is to hear their stories, to explore the factors that contributed to them choosing life. How did they move through the experience? Was it a sudden act of kindness, was it community connection, was it family, was it their religious or spiritual beliefs, or was it some other support or inexplicable thing that made a difference? I believe that the answers and solutions lie there.”

Áine Tierney, Australian Advisory Group on Suicide Prevention

"Communities have a key role to play in suicide prevention. There is a virtuous circle: stronger communities, stronger people, flourishing communities, flourishing people."

Lucy Brogden, National Mental Health Commissioner

The case study below is an example of a resource that has helped build local capacity in suicide prevention and responding to crises.

Case study: Building community capacity

The Communities Matter toolkit is a set of resources that helps communities to build their community capacity – particularly within small towns – to respond to crises and engage in community-driven suicide prevention initiatives. The toolkit is based on the principle that suicide prevention is everyone’s business. It is designed to be a ‘one-stop shop’ for tools and resources, and to provide key contacts to help communities to develop local suicide action plans. The toolkit also contains information to help communities evaluate their progress.

The Communities Matter toolkit is a partnership between the NSW Mental Health Commission and Suicide Prevention Australia. The toolkit was released as a booklet in late 2014 and piloted in two small communities. Based on feedback received, the online toolkit was developed and launched in October 2015.
Indicative tool - networking with others

Work-in-progress checklist

- Has the action group registered with Suicide Prevention Australia?
- Has information from Suicide Prevention Australia been used in community activities?

Information you should keep

- Feedback from action group members
- Self-assessment on how Suicide Prevention Australia information has been applied in the community
- Records on community involvement in national action, e.g. World Suicide Prevention Day

The toolkit website has links to real-life examples of positive community action by existing suicide prevention groups, including action plans, group memberships and Facebook pages. This feature is particularly valuable because it promotes sharing of expertise and ‘lessons learned’, and provides communities with tangible examples of what can be achieved.

Between November 2015 and February 2016, the new toolkit website has had 1450 visitors (with an average of 70 per cent new visitors), 3342 page views and 556 downloads. Most users are Australian, but there has also been international website traffic, including from the United States, Russia, Canada, New Zealand and the United Kingdom.

At this stage, the impact the toolkit is having has not been evaluated. However, its approach is consistent with studies that have shown that communities produce better mental health outcomes through individual empowerment, cohesion and a sense of belonging, resilience to overcome challenging situations, leadership and access to resources.

References

The following case study gives an example of a program designed to address the period immediately following a suicide attempt. Research indicates that a history of suicide attempt is one of the strongest risk factors for completed suicide, and that within 9 years of an individual attempting suicide, 3–12 per cent of those individuals will have died by suicide\(^1\). The period following a suicide attempt is a critical time for high-quality care and ensuring people have the necessary support. Interventions immediately after an attempt can provide much-needed treatment and support to individuals, families and communities. However, the care provided during this period is often inconsistent, is not based on current evidence and is constrained by the service provider’s personal attitudes towards suicidal behaviour.\(^2\)

Case study: Ensuring postdischarge care continues after a suicide attempt

The Care After a Suicide Attempt (CAASA) project was commissioned by the National Mental Health Commission as a comprehensive study of individual’s experiences with the health system after a suicide attempt, and to find out what works to reduce the risk of future attempts. This project establishes the knowledge base and priority areas that will help develop effective interventions to prevent repeat suicide attempts and, consequently, suicide deaths. The diagram below provides a summary of the project, including the methodology, findings and, most importantly, seven reform priorities to strengthen support for individuals following a suicide attempt.

**Methodology**

- Literature review
- Online survey (n=192)
- Interviews (n=38)
- Date linkage project (service utilisation)
- Data review
- Target study with Indigenous Australians delayed

**Understanding the current state review and consultation findings**

- Low levels of satisfaction with health care services - particularly with emergency departments and at discharge.
- Staff attitudes are variable, with many demonstrating a lack of knowledge about suicide.
- Complex needs are not well catered to.
- One-third of people presenting to hospital following a suicide attempt receive no mental health follow-up.
- Of those who do receive follow-up, for 59 per cent this is only one 30-minute session.
- Current data collection approaches do not effectively capture a substantial proportion of attempts.

**Reform priorities**

- Treatment at the time that responds to psychological distress as well as physical injury.
- An integrated approach to improving care after a suicide attempt.
- Combined clinical and non-clinical models of care.
- Coordinated support (i.e. case worker) to facilitate service use.
- Use of technology and e-mental health strategies - integrated into referral systems.
- Data and monitoring of service performance.
- Support for caregivers.
References


There are a number of programs that aim to reduce stigma and discrimination surrounding suicide in men – particularly those in isolated environments, including male-dominated workplaces – who are more likely than women to die from suicide. For example, Mates in Construction, Mates in Mining and the Ripple Effect are effective suicide prevention programs for men in the construction, mining and farming industries, respectively. These programs all employ a peer-to-peer approach to reducing stigma and discrimination surrounding suicide. Research published in the past two decades has demonstrated that peer programs can have statistically significant effects on attitudes, norms, knowledge, behaviours, and health and achievement outcomes.

Case study: Targeted suicide prevention, and stigma and discrimination reduction programs for men – Mates in Construction, Mates in Mining and the Ripple Effect

Mates in Construction is a multi-model prevention and early intervention program. Mates in Construction trains employees in the construction industry on how to:
- identify poor mental health and wellbeing in themselves and their peers
- seek help for themselves or a mate in need
- provide face-to-face intervention for those contemplating suicide
Mates in Construction compliments on-site training by posting field officers to sites who:
- undertake case management for employees with poor mental health
- provide ongoing site support
- attend site events to answer queries and provide information and direction
Mates in Mining is in its early phases and adopts the Mates in Construction approach at Australian mine sites.

The Ripple Effect is an online intervention investigating what works to reduce the self-stigma and perceived stigma among males in the farming community, aged 30-64 years, who have been affected by suicide in some way - through themselves, or through someone they know.
The Ripple Effect was launched in mid-2016. It provides:
- the opportunity for farmers to anonymously share experiences in a peer-supported environment
- encouragement for a positive cycle to disrupt self-stigma and perceived stigma, and reduce the stigma surrounding suicide overall
- the opportunity to increase knowledge and literacy about the experience of suicide (challenging suicide myths and framing the experience in a way that recognises the farming culture, facilitating help-seeking where required).

References


Aboriginal and Torres Strait Islander social and emotional wellbeing
"The mental health of Aboriginal and Torres Strait Islander people needs to be addressed through the concept of social and emotional wellbeing. This concept understands the self as connected to the domains of the mind and emotions, body, family and kinship, community, culture, country, and spirituality. A consideration of historical trauma and the current social determinants of health inequality needs to also inform any intervention or program."

Professor Pat Dudgeon, National Mental Health Commissioner

A significant development in mental health has been the renewed call by Aboriginal and Torres Strait Islander people for linking mental health, social and emotional wellbeing, suicide prevention and substance misuse services through the Gayaa Dhuwi (Proud Spirit) Declaration. The declaration helps guide culturally appropriate and locally responsive healing, empowerment and leadership programs.

Case study: The Gayaa Dhuwi (Proud Spirit) Declaration

The Gayaa Dhuwi Declaration was developed by the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH). Developed as a companion declaration to the Wharerātā Declaration, its aim is to achieve the highest attainable standard of mental health outcomes for Aboriginal and Torres Strait Islander people. It emphasises the importance of recognising Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, and mental health and healing, and combining them with clinical perspectives.

Gayaa means happy, pleased and proud, and Dhuwi means spirit in the Yuwaalaraay and Gamilaraay languages of northwest New South Wales.

The Declaration sets out five key principles, with supporting information, for Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system. It is also the basis of assessing suicide prevention services and programs for Aboriginal and Torres Strait Islander people.

The Gayaa Dhuwi Declaration’s five key principles

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

By committing to the Declaration and working in partnership with Aboriginal and Torres Strait Islander communities, health and supporting services will be best placed to take a strengths-based approach. This means acknowledging that stronger connections to culture and Country build stronger individual and collective identities, self-esteem and resilience, which ultimately improves health outcomes.

At the launch of the Declaration, Professor Tom Calma AO said, ‘it’s time for action if the mental health of our peoples is to improve, and for our suicide rates to come down to at least the same as that of other Australians. We must cement Indigenous leadership as fundamental and non-negotiable in that response, and the Gayaa Dhuwi Declaration provides a framework for that.’

References


Aboriginal and Torres Strait Islander people can be at greater risk of developing mental illness and face greater barriers to accessing mental health care. In one of Australia’s most remote communities, the Miwatj Mental Health Program has successfully adopted a person-centred approach and a stepped care model of mental health care as illustrated in the case study below.

Case study: Remote community action

The Elcho Island Galiwin’ku community is one of the largest Aboriginal and Torres Strait Islander communities in the Northern Territory, with a population of approximately 2500. This is one of the most remote communities in Australia.
The Miwatj Mental Health Program is a Yolŋu-led program based in Galiwin'ku on Elcho Island and is administered by the Miwatj Health Aboriginal Corporation, a Yolŋu Community Controlled Health Organisation. The program is leading in the treatment and management of Aboriginal and Torres Strait Islander mental health. The mental health team works collaboratively with families and the community to provide tailored care to individuals living with a mental illness. The needs of individuals are diverse, as family violence, neglect of children and gambling addiction continue to be problems in the Galiwin'ku community. The program is an integral part of the community in Galiwin'ku, and the team’s outreach program allows people to be treated in their homes where they feel most connected and at ease. The concept of health in the Yolŋu culture involves not only the body, mind and spirit being in balance, but also a sense of equilibrium with family and community.

Within the Galiwin'ku community, the program administers health care services to between 250 and 400 Yolŋu residents. The program aims to enable all Yolŋu people to have their mental health needs met in a manner that is self-determined and culturally appropriate. To ensure this, members of the program in management, leadership and staff are Aboriginal and Torres Strait Islander community members.

The program operates under a stepped care approach, with the ultimate aim of allowing people to be cared for on Elcho Island and within the community. It aims to add value to existing psychiatric services by implementing a both-ways shared care model, with a view to enhancing the accessibility, cultural security and appropriateness of services provided to clients and their families. The following diagram illustrates the services the program provides.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>Person centred care</td>
<td>Mitwaji liaises with government psychiatric services to provide case management for Yolŋu people who have engaged with services and are returning to their community. Miwatj collaborates with government and non-government services to facilitate seamless service provision between different catchment areas.</td>
</tr>
<tr>
<td>Coordinated care</td>
<td>Mitwaji liaises with service providers across the region (in both the Miwatj clinic and NT Government clinic regions) to provide primary and secondary consultation for Yolŋu people already engaged with existing services, including drug and alcohol services, Community Correction services, Police and schools. Telehealth services are also provided to psychiatrists within the NT Department of Health.</td>
</tr>
<tr>
<td>Community outreach support</td>
<td>Miwatj provides a comprehensive multidisciplinary triage, assessment, and case management service for at risk and marginalised Yolŋu people in the community. This may include people with a co-morbid health condition, complex psychosocial issues, or those unable or unwilling to access mainstream services.</td>
</tr>
<tr>
<td>Inpatient support</td>
<td>Miwatj cooperates with the Inpatient Treating Team in Darwin to manage the care of returning clients. The The Miwatj Mental Health RN coordinator attends the unit in Darwin to visit Yolŋu people receiving acute, rehabilitation, or forensic mental health care. They provide enhanced cultural security and integrity in assessment and treatment where traditional beliefs are of particular relevance to the recovery of patients.</td>
</tr>
<tr>
<td>Mental health literacy</td>
<td>Miwatj provides mental health literacy education to the wider community, aimed at de-stigmatising mental illness for family and community members. It facilitates early recognition of mental health and encourages help seeking behaviour.</td>
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</table>
Miwatj plays an important role in life promotion, suicide prevention, suicide intervention and postvention in the community. The team is available 24 hours a day to assist families and communities with emergencies.

Miwatj Health has reached a number of achievements. As a whole, Miwatj Health administered 55,575 episodes of care in 2013–14. The number of evacuations required from Elcho Island relating to a mental health instance has also reduced from on average one a week, to one every three months. Although Elcho Island used to experience clusters of suicides, there has not been a suicide in more than 2 years.

Miwatj uniquely also attends to the legal advocacy of its clients. It provides cross-sector support through collaborating with both the courts and the local police. Miwatj attends court sessions on behalf of clients to provide evidence of their mental health conditions and treatments.

Mental Health Services in Rural and Remote Areas program, reporting period 1 July 2014 to 30 June 2015.

References


The case studies below provide examples of current interventions that successfully focus on suicide prevention in Aboriginal and Torres Strait Islander communities.

Case study: National Empowerment Project, and ALIVE and Kicking Goals!

National Empowerment Project: Cultural, Social and Emotional Wellbeing Program – Queensland Mental Health Commission and University of Western Australia

Suicide is one of the most common causes of death among Aboriginal and Torres Strait Islander people, accounting for 1 in 19 Indigenous deaths. Those between the ages of 15 and 34 are at highest risk, with suicide accounting for nearly 1 in 3 deaths. Poverty and historical factors contribute to the suicide rate being, on average, twice as high as that for Australia’s non-Indigenous population.

High rates of distress experienced by individuals can have significant negative impacts for communities. This is particularly true in remote and isolated communities, and can be amplified by the interconnected nature of remote Aboriginal and Torres Strait Islander communities.

The National Empowerment Project (NEP) is an innovative Aboriginal and Torres Strait Islander–led program that works directly with communities. The aim of the program is to promote the positive social and emotional wellbeing and mental health of families and the community, to build resilience against challenging circumstances and events, and prevent psychological distress and suicide.

The NEP is founded on six guiding principles, which are shown in the circular image below.
The NEP Cultural, Social and Emotional Wellbeing Program (NEP CSEWB) was developed after extensive research and consultation in 11 communities across Australia to identify risk and protective factors influencing the social and emotional wellbeing and mental health of these communities; and potential responses to tackle these issues through a focus on individuals, families and communities. In this way, communities have been directly involved in leading program development, which ensures that the program is responsive to actual need.

The NEP CSEWB is currently being piloted in Kuranda and Cherbourg. It is still too early to attribute outcomes to the program; however, initial evaluations suggest that it is making a positive difference in the lives of individuals and families in Cherbourg and Kuranda. There is in-principle agreement for implementation and program delivery in more communities.

**ALIVE and Kicking Goals!**

Set in a unique part of Australia, ALIVE and Kicking Goals! (AKG) is a community-based, community-developed and community-driven suicide awareness and prevention program that is grounded in continual learning. AKG steps outside the traditional frames of risk factors and models of vulnerability. Rather, from the beginning, it has focused on enhancing protective factors within West Kimberley communities by working to de-stigmatise, open a discourse around depression and suicidality, and encourage positive help-seeking. The program is offered to young people throughout the West Kimberley region of Western Australia.

- AKG is a youth suicide prevention project that uses football and peer education to help identify suicide risk and develop prevention strategies within a culturally appropriate environment.
- The program aims to develop young Aboriginal peer educators to share their knowledge, enabling them to support other young Aboriginal and Torres Strait Islander people to access support services.
- It is a grass roots initiative to educate, inspire and model alternatives to suicide through supporting positive relationships and life choices.
The program was primarily targeted at young Aboriginal and Torres Strait Islander men, and a female peer educator had been included to engage young women in the community on mental health and wellbeing issues and recently the development of the AKG women’s DVD.

It operates in a range of settings across schools, prisons and community settings across the West Kimberley region.

AKG is one of the few suicide prevention programs in the Kimberley region that is wholly owned by an Aboriginal and Torres Strait Islander community.

An independent evaluation of the AKG project reflects positive outcomes. An important aspect of the program’s success was that the community owned and led the program from its inception. The program has been flexible in its delivery, and has used social media in its advertising strategy, referral pathways and communication with the community. The evaluation indicated several opportunities to further develop the program, such as a program designed specifically for younger children.

References


Digital mental health

"Mental health can be radically transformed by new technologies. The Australian Government has made a clear commitment to e-mental health in response to the Commission’s Review. Now we need to put this in action."

Ian Hickie, National Mental Health Commissioner

An opportunity exists to support an integrated person-centred digital mental health system, through rapid translation of digital research into practice, and through policy that promotes innovative research and development in digital mental health. The following case study illustrates how digital mental health can support an integrated person-centred mental health system and improve people’s health and wellbeing.

Case study: Including users in the design of digital services that work for them

Project Synergy is an example of a participatory design approach to developing evidence-based online mental health promotion, intervention and treatment. At each stage of the design process, young people had the opportunity to provide input about their experiences and feedback about the proposed interventions. This resulted in an e-mental health ecosystem of care for Australia’s young people, incorporating complementary Young and Well Cooperative Research Centre (CRC) products, certified apps and web-based interventions, underpinned by a set of sector standards, digital interfaces and integrated technologies.

The Young and Well CRC developed an innovative methodologies guide. Participatory design of evidence-based online youth mental health promotion, intervention and treatment, which presents a framework and tools for youth engagement and participation, where young people contribute as co-designers of interventions. Although the guide focuses on the design phase of the process, the involvement and influence of users can extend into other phases, including how the problem is identified and defined, and how the intervention is evaluated.

The guide highlights that for people to be meaningfully involved in the development of digital solutions, they must be:

- fully informed about the topic or project
- provided with opportunities to participate that are not tokenistic
- listened to and their feedback used to inform the project
- aware of the expectations, which must be set at the start of an activity
supported during their engagement and participation by staff that are available to answer questions and assist when problems arise

resourced to participate – for example, through skills development, increased knowledge and/or support. Although this work has been designed for young people, the principles of participatory design in achieving digital solutions that meet peoples’ needs can be applied across different cohorts of the Australian population.

References


E-mental health initiatives are gaining traction as a cost-effective and accessible mechanism to immediately boost the capacity of the mental health system. The following case study demonstrates interventions designed to help young people.

Case study: Easy-to-access tools for young people – ReachOut Breath and ReachOut WorryTime

In 2015, ReachOut Australia launched two free mobile apps to help young people independently manage anxiety and stress: ReachOut Breathe and ReachOut WorryTime. These two apps are part of the Toolbox, developed in collaboration with the Young and Well Cooperative Research Centre. The Toolbox is an online collection of more than 50 apps endorsed by mental health professionals, and reviewed and rated by young people (less than 25 years old) according to the newly developed Mobile Application Rating Scale.

ReachOut Breathe

uses visuals to help users slow down their heart rate through their breathing. This aims to increase feelings of calmness and reduce physical symptoms of stress and anxiety.

ReachOut Breathe is one of the world’s first wellbeing apps. Settings can be customised for individuals, and it is accessible from both Apple Watch and iPhone.

ReachOut WorryTime

helps to manage anxiety by confining worry to a specific time each day. WorryTime helps users to feel more in control of anxiety and stress, and develop a regular method of dealing with day-to-day worries. It is designed for young people aged 12 and above, and is available for Apple and Android phones.

Both ReachOut apps have been developed from evidence-based psychological therapies. From June to December 2015, the apps were downloaded more than 28,000 times.

ReachOut Breathe has a user rating of 4+ stars on the Apple App Store. User testing found the app easy to use, attractive in design and functional. Similarly, user testing of ReachOut WorryTime found that both young people and professionals rated the app 4 out of 5 stars. Users found the app easy to use, and effective in helping them describe and hence manage worries. A randomised controlled study of WorryTime’s effectiveness was completed in 2016.

References


This case study demonstrates the evidence-based approach behind an e-mental health application for young people.

Case study: Evidence-based e-mental health in action

MoodGYM is an innovative, interactive web-based program designed to prevent depression in young people that:

- has more than 850,000 registered users worldwide
- teaches the principles of cognitive behaviour therapy, and demonstrates the relationship between thoughts and emotions
• works through dealing with stress and relationship break-ups
• teaches relaxation techniques.

Published research trials found MoodGYM to be effective in reducing depressive and anxiety symptoms in users. The studies examined MoodGYM:

• in a range of settings (e.g. schools, universities, Lifeline, NHS Choices online)
• across the mental health care spectrum (e.g. from prevention to treatment)
• in different age groups (e.g. adults, adolescents)
• in a range of population groups (e.g. students, primary health care patients, community users)
• in different countries
• with and without guidance.

Studies suggest that MoodGYM is a viable option for those who cannot access face-to-face therapy, and for those waiting for traditional services. There is also demonstrated cost-effectiveness of translating MoodGYM, which currently operates in five languages.

The National Institute for Mental Health Research’s e-hub consists of several other programs:

• e-couch provides self-help programs for depression, general anxiety and social anxiety, using strategies drawn from cognitive behavioural and interpersonal therapies, relaxation and physical activity. New programs for separation and divorce, and loss and bereavement are also available.

• Bluepages provides information on treatments for depression based on the most recent scientific evidence, as well as symptom quizzes and relaxation downloads, and links to other helpful resources.

• Beacon provides consumer and research reviews and rankings of online e-health programs for mental and physical health disorders.

These programs are all free of charge to end users because of support from the Australian Government Department of Health. These programs have undergone numerous evaluations, and e-couch has been evaluated in a number of randomised controlled trials (RCTs). One RCT showed that the e-couch depression program yielded a greater reduction in depressive symptoms, with the combination of e-couch and an online support group showing longer-term positive outcomes for participants. The e-couch depression program has demonstrated effectiveness in the reduction of depressive symptoms in people aged 45 years or more with a history of, or risks for, cardiovascular disease, compared with an attention placebo control.

Severe and complex mental illness
Physical and mental health are mutually integral in protecting, promoting and achieving overall wellbeing. The Commission welcomes greater focus on addressing the physical health of people with mental illness, particularly for people with serious mental illness, and has developed a National Consensus Statement on the Physical Health of People Living with Mental Illness, which will be available in 2017.

Case study: Equally Well Consensus Statement on improving the physical health of people living with mental illness in Australia

The interaction of mental illness with other chronic diseases is one of the biggest challenges to public health systems in Australia. Three out of every five (60 per cent) people living with mental illness have a co-existing physical illness. This is compared with 12 per cent in the general population. They are three times more likely to have a cardiovascular or respiratory disease, twice as likely to have diabetes or be overweight, and six times more likely to have dental problems. Studies in Australia and other developed nations indicate that people living with mental illness are more likely to die prematurely, and their life expectancy is shortened by up to 30 per cent. There is evidence this life expectancy gap is widening. However, poor health in people living with a mental illness is not inevitable, and research has shown effective care and support enables people living with mental illness to lead a contributing life.

The Equally Well Consensus Statement (Equally Well) has been developed by the National Mental Health Commission following extensive consultation with key stakeholders across the mental health sector. Interested stakeholders came together from across Australia representing consumers and carers, and the non-government and government sectors to address the extremely poor physical health outcomes for people with a mental illness who are dying between 10 and 32 years earlier than the general population.

An approach was developed by these stakeholders to improve the physical health and wellbeing of people living with mental illness. All shared a common vision of people living with mental illness receiving the same access to holistic, person-centred mental and physical health care as the rest of the population, thereby improving their quality and length of life.

Implementation of Equally Well has the potential to see significant improvement at the primary health care – acute care interface. It aims to reduce variation in care, address the often siloed approach to treatment and care, and improve service effectiveness and efficiency and health outcomes for people with lived experience, their families and support people.

The Commission will issue a national call for organisations to formally pledge their commitment to Equally Well and to act in their areas of influence to make changes towards improving the physical health of people living with mental illness. Organisations will be encouraged to circulate it through their networks. The statement will be accessible on a dedicated website that includes additional information and resources.

Vision

People living with a mental health illness will have the same life expectancy, quality of life and access to quality health care as the general population.

Essential elements needed to address the physical health needs of people living with a mental illness

1. **A holistic, person centred approach** - People living with mental illness, their families and other support people will be empowered to be active partners in planning their care. They will be equipped with the tools and knowledge to advocate for and co-design quality health care.

2. **Effective promotion, prevention and early intervention** - Proactively facilitating early detection and intervention, thereby reducing avoidable physical illness. Services will focus on promoting a healthy lifestyle and providing psychosocial supports which contribute to overall wellbeing.

3. **Equity of access to all services** - improved and more equal access, without discrimination, to health services, housing, education, employment, community participation and a safe environment.

4. **Improved quality of care** - Mental health services will ensure physical health checks are an integral part of care provision. Health and mental health workers understand their role in integrated care.

5. **Care coordination and regional integration** - National leadership and regional coordination to ensure integrated care across the health, mental health and social services sectors. Establishing effective e-health solutions to enable both quality care and care coordination.

6. **Monitoring progress towards improved physical health and wellbeing** - Development of targets and indicators to measure progress, with information and research systems than enable monitoring, accountability and improvement.

This case study shows how an organisation has embedded a holistic and person-centred approach to mental health and wellbeing in their business to protect and promote mental wellbeing, and empower people to seek support when they need it.

Case study: Promoting equality and opportunity for people with disability and mental illness

Encompass Community Services is a not-for-profit organisation, committed to promoting equality and opportunity for people with a disability or mental illness, or for those who are disadvantaged. More than 30 per cent of the staff at Encompass have a disability or mental illness. Both staff and clients identified a need for services that were not easily available to them and have developed many of the services offered by Encompass.

Services and programs offered by Encompass include:

- supported accommodation
- employment services
- training (as a registered training organisation)
• respite services for those with disabilities
• a life skills and independent living program
• discount furniture and preloved business clothing
• business enterprises to build skills and create opportunities for participants
• the Paddock – horticulture therapy.

In one initiative – the Urban Farm Project – Encompass enabled clients with mental illness to be employed as part of the Encompass ‘Job Jump’ initiative. Clients were employed for 8 hours a week for 6 months, at full award wages, to develop and work on a self-sustainable vegetable garden. The project was executed by staff skilled in the benefits of horticulture therapy and mental health, and provided access to lived experience of employment.

Working together in a team environment, the clients gained work experience, developed their capacity for work, learned new skills and applied them practically, complementing and promoting social inclusion. Furthermore, a non-discriminatory work environment was created where clients were able to focus on their capabilities. Ownership of the project was encouraged through their ideas and physical achievements.

Of the 20 people who participated, 3 were able to transition into sustainable employment. This initiative was developed to add value to the client’s participation and to encourage formal qualifications in Certificate II Horticulture Production as a means to gain further employment. The project thus enabled community engagement and social inclusion within the wider community for the clients involved.

The Urban Farm project is set to continue with the planned build of an Agri-business Centre of Excellence, to provide increased training opportunities for jobs in the growing agri-business sector. Encompass is working with other community organisations and agri-businesses to address regional disadvantage, by providing supported pathways in this sector.

Youth and children

"We need to shift the focus from downstream to upstream services – from income support and crisis responses, to early intervention, prevention and support for recovery-based community services, stable housing and participation in employment, education and training."

Professor Allan Fels, Chair, National Mental Health Commission

The following case study is an example of an early intervention program that integrates services to support disadvantaged children and families.

Case study: Supporting development pathways

Challis Parenting and Early Learning Centre (CPELC) supports development pathways for children under the age of four. The program approaches a common goal in a unique way, and operates in some of the most disadvantaged metropolitan communities in New South Wales and Western Australia. Each of these communities has a higher-than-average Aboriginal and Torres Strait Islander population.

The CPELC is an early-years integrated services intervention program. It provides parents and families with comprehensive, family-centred case management across a range of essential health, education and social services. The following diagram outlines what the CPELC offers.

| Available as an early intervention/prevention program for children living within the Challis community Primary school catchment (school boundary). |
| Provides programmes for children 0-3 years and support programmes and services for their parents/guardians. |
Operates as a service hub and provides case management support.

Integrates a range of services to create a streamlined source of support for children and families, including child health services, psychology services, parenting groups, playgroups and kindergarten.

The CPELC model has demonstrated significant local improvements for children in one of Western Australia’s most disadvantaged metropolitan communities. Literacy indicators suggest that children attending CPELC in pre-primary school outperform other Western Australian students in school readiness, and improvements in school readiness and teaching effectiveness have lifted from below to above the state average during the life of the program. Acknowledging the success of the model, the Western Australia Government has now committed $50 million to rolling out 16 similar centres across the state.

References


The following case study is an initiative that brings together the health and education sectors, and builds the capacity of those working in early childhood and school settings to better support children and young people with or at risk of mental illness.

Case study: School and place-based early intervention program

Doctor on Campus (DOC) is a mental health early intervention program for secondary schools operating at Victor Harbor High School in South Australia. It brings together local school and health services to support the individual student. The figure below summarises how the DOC program operates, and identifies reasons for its success. During the 10-year life of the program, DOC has attended to the mental health needs of more than 300 students from the local area. Participating doctors, psychologists, counsellors, students and their families all verify the substantial benefits of the program.
Why it works

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<td>Confidential</td>
<td>Overcomes stigma</td>
<td>Teen friendly processes</td>
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References


The case studies below are designed to improve wellbeing and prevent mental illness among young people.

Case study: Promotion of positive mental health and early intervention

It is essential that positive mental health is promoted. Psychoeducational and psychological interventions designed to increase protective factors can reduce rates of incident depression by 20–25 per cent over 1–2 years. In Australia, there are several programs that aim to improve wellbeing and prevent or reduce the impact of mental illness among young people.
### KidsMatter

KidsMatter is a similar initiative to MindMatters – but focuses on primary schools and early childhood education.

It offers programs, tools and resources on children’s mental health for primary schools, early childhood centres, parents and the wider community.

KidsMatter is funded by the Australian Government and has been rolled out to 2000 schools across the country.

KidsMatter was evaluated in 2009 and 2012. In 2012 the evaluation found KidsMatter:

- Had positive effects on children’s wellbeing
- Provided opportunities to raise staff awareness
- Provided staff with common language to promote communication
- Observed impacts varied in size and were not evident in all aspects.

### MindMatters

MindMatters is a mental health initiative for schools with secondary students and aims to improve the mental health and wellbeing of young people with a focus on promotion, prevention and early intervention.

MindMatters is a blended learning framework, funded by the Australian Government Department of Health. It includes over 20 online modules, resources and face to face support provided by Principals Australia Institute to help schools develop a mental health strategy and support ongoing implementation.

The MindMatters mental health framework is built around four key components:

1. Positive School Community
2. Student skills for resilience
3. Parent and families
4. Support for students experiencing mental health difficulties

MindMatters is being implemented in over 1100 schools across Australia.

### Smiling Mind

Smiling Mind is a free web-based app for children, adolescents and adults. It is a meditation tool for phones, computers and other devices.

The app provides age-specific mindfulness meditations that are tailored for different age groups – from age seven to age 22. There are also meditations for adults.

Smiling Mind also offers mindfulness programs for sport and business, and free tools for teachers and facilitators to run their own programs.

Studies show mindfulness programs like these have positive impacts:

- Reduced stress and incidence of mental health issues
- Increase resilience
- Improved life satisfaction and wellbeing
- Improved concentration and cognition.

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A 2005 evaluation of the MindMatters Program run by the Hunter Institute found that the program resulted in a decrease in bullying, increased self-esteem and stronger connections within schools. A further evaluation is currently being conducted by the Australian Council for Educational Research.

Research examining the effectiveness of wellbeing interventions with children and youth is limited. However, a study of a mindfulness education program in Canada showed significant increases in optimism and improvements in social competent behaviours. Although the evidence on the benefits of mindfulness is growing, it is important to ensure there is strong evidence of the positive impacts of mindfulness programs before they are translated into policy.
References


7. McCartney M. Mindful of mindfulness. BMJ. 2006;352;i839.

Monitoring and reporting

"If we are to encourage contributing lives, we need to develop and apply comprehensive measures of outcomes across the service systems."

Rob Knowles, National Mental Health Commissioner

"Consumer and carer involvement in designing outcome measures and reporting will ensure that these are meaningful to both individuals and programme evaluation."

National Mental Health Commission

Greater insights into the characteristics of people using mental health services and prescription medications were made possible by the Commission’s work with the Australian Bureau of Statistics on the 2011 Mental Health Services-Census Integrated Dataset. This case study demonstrates how linked data can expand and improve evidence based policy and planning in mental health, without compromising the privacy of individuals.

Case study: Data linkage

The Mental Health Services-Census Data Integration project brings together, for the first time, the breadth of the 2011 Census data with administrative information on people accessing subsidised mental health-related Medicare Benefits Schedule (MBS) services and Pharmaceutical Benefits Scheme (PBS) prescription medication.

This project was initiated on behalf of the National Mental Health Commission (the Commission) to inform the National Review of Mental Health Services and Programmes (the Review). Through funding provided by the Commission, a partnership between the Commission, the Australian Bureau of Statistics (ABS) and the Australian Government Department of Health developed this new integrated dataset to address key policy needs.

Integrating a selected subset of data items from the MBS, PBS and the 2011 Census has greatly increased the power of the data to support analyses of the circumstances and characteristics of people experiencing mental ill-health as they interact with the health care system.

This new Mental Health Services-Census Integrated Dataset not only provides the Commission with additional information which supported the Review, it has also expanded the suite of existing mental health data sources.

At the completion of the linkage process:

- 1,072,284 person-records (69.6 per cent) of the 1,540,836 person-records on the MBS dataset were linked to the 2011 Census
- 1,669,278 person-records (70.9 per cent) of the 2,354,118 person-records on the PBS dataset were linked to the 2011 Census

"This project demonstrates the innovation that can be achieved in mental health planning when agencies are able to work outside their usual mandates. The result of this partnership, and use of the linked data with Censusu, will enable better delivery of services in Australia, targeting those most in need."

Dr Peggy Brown, CEO, National Mental Health Commission

In October 2014, the ABS released the first analysis from the integrated dataset. This provided information such as labour force participation and educational attainment of those accessing mental health-related MBS and PBS services. These types of data help to shape future policy and services.
A second analysis was released in early 2016, which focused in more detail on the individual types of service use (e.g. consultations with psychologists) and medicines (e.g. antidepressants), in conjunction with the number of mental health-related consultations and prescriptions Australians accessed in 2011. Combinations of types of treatments were also considered, and logistic regression modelling was used to identify the likelihood of a person transitioning from services to medicines and vice versa.

In the Integrated Dataset, the 2011 Census provides insight into a range of sociodemographic characteristics including age, sex, remoteness, socioeconomic disadvantage, household income, labour force status, educational attainment and others. Further analyses of the Mental Health-Census Integrated Dataset are being undertaken on behalf of a range of stakeholders. The ABS is the custodian of the dataset.

This data linkage project presents a new opportunity to analyse longitudinal data and better understand the patient journey. The project provides an expanded and improved evidence base for policy and planning in mental health, without compromising the privacy of individuals.

In the future, there is potential to link this integrated mental health related dataset with other administrative datasets, such as hospital data to build a more complete picture of the consumer journey, including hospital inpatient, ambulatory treatments and outcomes.

References


The following case studies show how information on consumer and carer outcomes is being collected through two new surveys. The surveys enable consumer and carer feedback to be directly and systematically collected, collated and analysed, so services can better understand their clients and make informed improvements to service quality.

Case study: Measuring experiences of mental health services

Your Experiences of Service survey

Finalised in 2015, the Your Experiences of Service (YES) survey involved extensive consumer and carer involvement in its development, and is based on the recovery principles outlined in the 2010 National Mental Health Standards.

The YES survey includes open-ended questions so that a consumer can make their own individual comments about their experience of service. The survey has been translated and is available in 21 community languages. Those organisations that are licensed to use the survey can add additional questions specific to their own service environments. The YES survey is being used in New South Wales, Queensland and Victorian public mental health services, and is being piloted in other jurisdictions before further rollout. A version of the survey suitable for use in community-managed organisations has also been developed and will be made available once finalised.

The results of the YES survey are anonymous, but can be collated and reported to organisations to support quality improvement activities, with a view to enhancing the consumer’s experience of service provision. By using a nationally consistent measure, organisations can be benchmarked, allowing identification of best practice and its dissemination across the mental health sector. The YES survey can be accessed on the Australian Institute of Health and Welfare website.
Mental Health Carer Experience Survey

Following a review of national and international literature to identify existing measures of carers’ experiences of care, the Australian Mental Health Outcomes and Classification Network (AMHOCN) coordinated the development of a national tool that can support mental health services to monitor and improve carer experience as part of an evidence-informed quality improvement program.

The Mental Health Carer Experience Survey (MH-CES) comprises 37 items encompassing concepts that underpin several key criteria identified in Standard 7 (Carers) of the 2010 National Standards for Mental Health Services. Additional questions can also be added to the MH-CES to gather information specific to a particular organisation or service. The MH-CES has just been made available to the mental health sector and can be accessed from the AMHOCN website. As implementation occurs, further work will be undertaken to facilitate reporting of the MH-CES across the sector.

References