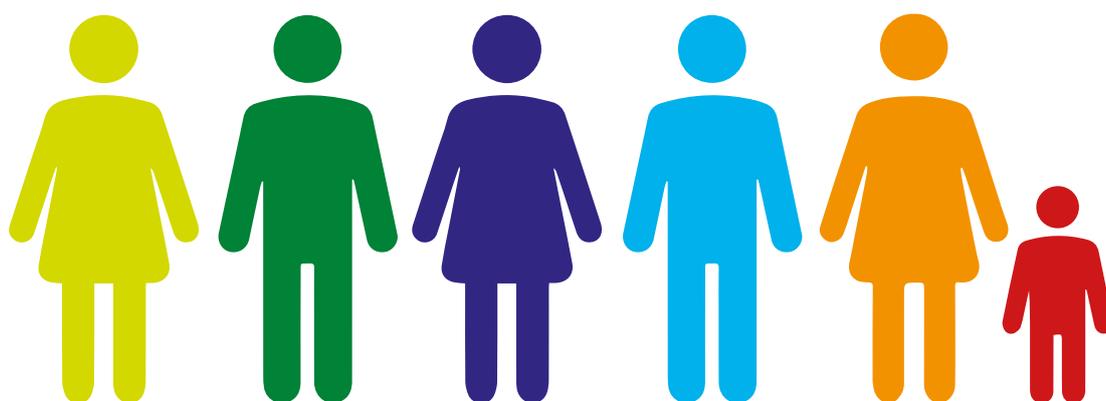


Monitoring mental health
and suicide prevention reform

Fifth National Mental Health *and* Suicide Prevention Plan 2020

Technical Report



Australian Government
National Mental Health Commission

This publication is the technical supplement to the third progress report in a series of annual Fifth Plan progress reports. A complete list of the National Mental Health Commission's publications is available from our website.

About this report

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Introduction

The *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) establishes a national approach for collaborative government action to improve the provision of integrated mental health and related services in Australia.

The Fifth Plan is underpinned by 8 priority areas and 32 actions that are designed to improve the transparency, accountability, efficiency and effectiveness of Australia's mental health system. The Fifth Plan actions are detailed in the *Fifth National Mental Health and Suicide Prevention Plan Implementation Plan* (Implementation Plan). The 8 priority areas of the Fifth Plan are:

Priority Area 1:

Achieving integrated regional planning and service delivery

Priority Area 2:

Effective suicide prevention

Priority Area 3:

Coordinating treatment and supports for people with severe and complex mental illness

Priority Area 4:

Improving Aboriginal and Torres Strait Islander mental health and suicide prevention

Priority Area 5:

Improving the physical health of people living with mental illness and reducing early mortality

Priority Area 6:

Reducing stigma and discrimination

Priority Area 7:

Making safety and quality central to mental health service delivery

Priority Area 8:

Ensuring that the enablers of effective system performance and system improvement are in place.

The Fifth Plan also identifies 24 performance indicators that are designed to collectively measure the health and wellbeing of Australians and the performance of the mental health system for the life of the Fifth Plan and into the future.

Reporting on the progress of mental health reform is essential in order to know whether the commitments in the Fifth Plan are being met and are making a difference. The National Mental Health Commission (the Commission) has been given responsibility for delivering an annual report to health ministers on the implementation progress of the Fifth Plan actions and performance against the identified indicators.

The *Fifth National Mental Health and Suicide Prevention Plan, 2020: Progress Report 3* (2020 Progress Report) is the third annual report. It outlines the progress achieved against the Fifth Plan Implementation Plan as at 30 June 2020, and presents the available performance indicators.

To inform our reporting on implementation progress, the Commission conducts an implementation progress survey of key stakeholders. This Technical Report provides a methodological overview of the development and administration of the implementation progress survey for the 2020 Progress Report. It also describes the rationale, caveats and key reporting information for each performance indicator in the report.

Performance indicators

Performance indicators are measures that concisely describe a system and guide continuous improvement efforts.

The Fifth Plan identifies a set of 24 performance indicators that are designed to collectively measure the health and wellbeing of Australians, and the performance of the mental health system for the life of the Fifth Plan and beyond. With this long-term monitoring in mind, the performance indicators include broad measures of the health status of the population and measures of the process of mental health care, rather than measures that closely align with the priority areas or actions under the Fifth Plan.

Where possible, the indicators include data at both a national level and allow performance to be reported for different age groups, for gender categories, and for Aboriginal and Torres Strait Islander peoples.

The Fifth Plan indicator set includes indicators that can currently be measured (Box 1), as well as indicators that require various amounts of development before they will be available for reporting ([Appendix A](#)). Under Action v of the Fifth Plan, the Mental Health Information Strategy Standing Committee (MHISSC) has responsibility for identifying data sources and developing methodologies for the 24 performance indicators identified in the Fifth Plan. The MHISSC has completed this work for 18 of the 24 indicators, and data on these indicators was included in the 2020 Progress Report.

The timeline for completion of the remaining indicators is difficult to gauge, as they cannot be constructed from established data collections. The MHISSC is investigating solutions for these indicators and they will be included in the Fifth Plan 2021 final report if they become available.

Box 1: Available performance indicators, by area of monitoring

Reported performance indicators	
Monitoring health and wellbeing of Australians	Monitoring performance of the mental health system
PI 1: Children who are developmentally vulnerable	PI 13: Mental health consumer experience of service
PI 2: Long-term health conditions in people with mental illness	PI 14: Change in mental health consumers' clinical outcomes
PI 3: Tobacco and other drug use in adolescents and adults with mental illness	PI 15: Population access to clinical mental health care
PI 6: Prevalence of mental illness	PI 16: Post-discharge community mental health care
PI 7: Adults with very high levels of psychological distress	PI 17: Mental health readmissions to hospital
PI 9: Social participation in adults with mental illness	PI 18: Mental health consumer and carer workers
PI 10: Adults with mental illness in employment, education or training	PI 22: Seclusion rate
PI 11: Adult carers of people with mental illness in employment	PI 23: Involuntary hospital treatment
PI 19: Suicide rate	
PI 24: Experience of discrimination in adults with mental illness	

Limitations of performance indicators

As a result of differences in the collection schedules of the data sources required to report on the Fifth Plan indicators, the data used in the 2020 Progress Report vary in the number of years of data available and the time periods they cover. Some data sources are annually collected administrative data and have more years of data available, while others are national surveys that are collected less frequently, resulting in fewer years of data being available. Some data sources do not currently have sufficient data to show trends over time.

The Fifth Plan performance indicators describe the status of the health and wellbeing of Australians and the performance of the mental health system.

Where sufficient time series data is available, performance indicators can measure whether there have been improvements in health, wellbeing or system performance. However, performance indicators are unable to provide information on 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.

In addition to these general limitations, each performance indicator has several caveats that should be considered when interpreting the data. The next section describes these caveats, along with the rationale and key Fifth Plan reporting information for each indicator.

Detailed descriptions of performance indicators

Performance Indicator 1

Children who are developmentally vulnerable

What does this indicator measure?

This indicator measures the percentage of children who meet the criteria for developmentally vulnerable in the Australian Early Development Census (AEDC).

This indicator can be disaggregated by sex, Indigenous status, state and territory, remoteness area, and socio-economic disadvantage categories.

Higher proportions of children who are developmentally vulnerable suggest a greater need for support targeted at the early years of life.

Why is it important?

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.

Caveats

Data on developmental vulnerability cannot indicate the cause of the developmental vulnerability, whether it relates to the child's mental health, or whether the child has previously received or is currently receiving additional supports for their vulnerability.

AEDC scores are based on data from all children who participate in the AEDC and take into account variations in the age of children in their first year of schooling.

AEDC scores are categorised into 3 groups:

- developmentally vulnerable: scores ranked in the lowest 10%
- developmentally at risk: scores ranked between 10% and 25%
- developmentally on track: scores ranked between 25% and 100%.

Only children who are categorised as developmentally vulnerable are in scope for this indicator.

Scores on the AEDC are teacher-rated.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2019 Progress Report. The data source for this indicator is collected approximately every 3 years and was most recently collected in 2018. Updated data for this indicator may not become available during the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See table PI 1.1 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 2

Long-term health conditions in people with mental illness

What does this indicator measure?

This indicator measures the percentage of people with mental illness who have another long-term health condition. Higher incidence of long-term health conditions in people with mental illness suggests poorer physical health.

'Another long-term health condition' is defined as 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 (COPD; Bronchitis, emphysema).

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

Why is it important?

The prevalence of long-term health conditions in people with mental illness is a measure of their physical health. Equality in health is a basic human right for all Australians. However, it is well known that people living in our community with mental illness have poorer physical health than those without mental illness.ⁱ

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

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

Caveats

Data on the co-morbidity of physical and mental health conditions provides an indication of the current health status of people with mental illness, but cannot indicate the cause of any differences in physical health. The available data does not support analysis of differences in the physical health of people with different types of mental illness.

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

All ages are in scope for this indicator.

Reporting under the Fifth Plan

This indicator was first published for the general population in the Fifth Plan 2018 Progress Report and updated data was published in the 2019 Progress Report. Data for Aboriginal and Torres Strait Islander peoples was published for the first time in the 2020 Progress Report.

Source data for this indicator is published approximately every 3 years and was most recently conducted in 2017–18 for the general population and 2018–19 for Aboriginal and Torres Strait Islander peoples, so updated data may not become available during the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 2.1, PI 2.2, PI 2.3 and PI 2.4 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 3

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

What does this indicator measure?

This indicator measures the percentage of adolescents and adults with mental illness who report the use of licit and illicit drugs. Higher proportions of adolescents and adults who use tobacco and other drugs suggests poorer health.

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

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

Why is it important?

Tobacco and other drug use in adolescents and adults with mental illness is a proxy measure for their physical health.

There is a strong association between illicit drug use and mental illness. However, it can be difficult to determine to what degree drug use causes mental illness, and to what degree mental illness gives rise to drug use, often in the context of self-medication.ⁱⁱⁱ

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

People with mental illness have higher rates of tobacco use than other Australians.^{iv} In Australia, lung cancer is responsible for a reduction in life expectancy of 6 years. Tobacco use is responsible for 80% of lung cancer burden.^v

Caveats

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.

This data includes people aged 14 and over.

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

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report and updated in the 2020 Progress Report. Source data for this indicator is collected approximately every 3 years and was most recently collected in 2019. It is unlikely that updated data will become available during the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 3.1, PI 3.2, PI 3.3, PI 3.4, and PI 3.5 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 6

Prevalence of mental illness

What does this indicator measure?

This indicator measures the percentage of people who experienced mental illness in the previous 12 months. Lower prevalence rates suggest higher levels of mental health and wellbeing.

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

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

Why is it important?

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

Caveats

Mental illness varies in severity and duration. Prevalence data quantifies how much of the community is affected by mental illness in any given year, but does not reflect variations in the extent to which individuals are impacted by their mental illness.

Data for different components of this indicator is sourced from 3 different surveys. Data from the 3 surveys cannot be compared to 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. The surveys that are the data source for this indicator did not contain a large enough sample of Aboriginal and Torres Strait Islander peoples to produce a reliable national estimate. A comparable survey of Aboriginal and Torres Strait Islander peoples' mental health is not currently available.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report. Estimates of the prevalence of common mental illnesses in adults were most recently published in 2007, child and adolescent prevalence estimates were most recently collected in 2013–14 and prevalence estimates for psychotic disorders were most recently published in 2010. Although a survey to collect updated data for the estimates of common mental illnesses in adults is in the early stages of development, it is not clear if the child and adolescent mental illness or psychotic disorders data will be updated during the life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 6.1, PI 6.2, PI 6.3, PI 6.4, PI 6.5, and PI 6.6 in the accompanying Excel workbook for the most recent data available for this indicator.

Performance Indicator 7

Adults with very high levels of psychological distress

What does this indicator measure?

This indicator measures the percentage of adults with very high levels of psychological distress. Psychological distress is derived from the Kessler Psychological Distress Scale. Higher proportions of Australians with very high levels of psychological distress suggests lower levels of wellbeing.

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

Why is it important?

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

Caveats

Data 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.

Data includes people aged 18 and over.

Data is age standardised to the 2001 Estimated Resident Population.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report, and updated data for both Indigenous and non-Indigenous Australians was published in the 2019 Progress Report. Psychological distress data for non-Indigenous Australians is published approximately every 3 years, and data for Indigenous Australians is published approximately every 4 years, so additional data may not become available during the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 7.1, PI 7.2, PI 7.3 and PI 7.4 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 9

Social participation in adults with mental illness

What does this indicator measure?

This indicator measures the percentage of adults with mental illness who report social participation. Higher proportions of adults with a mental illness who report social participation suggest that more people with mental illness have a contributing life.

This indicator can be disaggregated by age group, sex, remoteness areas and Indigenous status.

To ensure the data are as culturally appropriate as possible and due to differences in the available data sources, social participation is defined and calculated differently between Indigenous and non-Indigenous people for the purposes of this performance indicator.

For non-Indigenous people, social participation includes participating in social groups, community groups, or civic or political groups, attending a sporting event as a spectator, attending cultural venues or events, or having a say within the general community on issues important to the respondent, within the last 12 months.

For Indigenous people, social participation includes participating in community or special interest groups, attending cultural venues or events, attending a sporting event, participating in Aboriginal or Torres Strait Islander cultural activities or ceremonies or feeling like you have a say within the general community on issues that are important to you.

Why is it important?

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 a range of community activities and contribute to the community are important factors in recovery from mental illness.

Caveats

The similarities between people with and without mental illness reported in this indicator do not align with reports that people with mental illness experience high levels of social exclusion, including reduced participation in day-to-day activities. However, the data for this indicator cannot be disaggregated by mental illness type or severity, so cannot reflect any variation in experience that may exist between these sub-groups. Further investigation is required to determine whether the data accurately reflects the experience of people with all types and severity levels of mental illness.

Although the data estimates the social participation of people with mental illness, it cannot indicate whether social participation for people with mental illness aligns with the social participation they want or their satisfaction with their social participation.

Data includes people aged 15 and over.

Experience of mental illness is self-reported.

Data for Aboriginal and Torres Strait Islander peoples and non-Indigenous people is not directly comparable.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2019 Progress Report. Source data for this indicator are collected approximately every 4 years, and was most recently collected in 2014. Updated data may become available during the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 9.1, PI 9.2 and PI 9.3 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 10

Adults with mental illness in employment, education or training

What does this indicator measure?

This indicator measures the percentage of adults with mental illness who are in employment, education or training. Higher proportions of people with mental illness in employment, education or training suggest that more people with mental illness are being supported to live a contributing life.

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

'In education and training' includes people who indicated that they are currently studying for a qualification and people aged 15–19 who indicated that they are attending secondary school.

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

Why is it important?

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

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

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

Caveats

Estimates of the proportion of people with mental illness who are in employment, education or training cannot indicate whether people are being adequately supported to maintain their employment, education or training for the long-term.

Experience of mental illness is collected by self-report.

'In education' is defined as being both enrolled and currently participating in a course. People who had enrolled but not commenced, and people undertaking hobby or recreational courses are not included.

Data is limited to people aged 15–64.

Data for Aboriginal and Torres Strait Islander peoples and non-Indigenous people is not directly comparable.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report, and updated data was published in the 2019 Progress Report. Source data for this indicator are collected approximately every 3 years for non-Indigenous people and approximately every 4 years for Aboriginal and Torres Strait Islander peoples. It is unclear if updated data will become available during the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 10.1, PI 10.2 and PI 10.3 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 11

Adult carers of people with mental illness in employment

What does this indicator measure?

This indicator measures the percentage of adult carers of people with mental illness, who are in employment. Higher proportions of carers of people with mental illness in employment suggest that more carers are being supported to live a contributing life.

This indicator can be disaggregated by age, sex and carer status.

Why is it important?

A well-integrated, effective and sustainable mental health system for people with severe and complex mental illness also supports carers and their participation in employment.^{vi}

Caveats

Employment data for carers of people with mental illness cannot indicate whether the carers are satisfied with their level or type of employment.

A carer is defined as a person who provides ongoing unpaid assistance, in terms of help or supervision, to a person with a disability. Both primary and other carers are in scope for this indicator.

Data is available for people aged 15–64 years and living in the same household as the recipient of care.

'In employment' includes people who work both part-time and full-time.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2019 Progress Report. Source data for this indicator is collected approximately every 3 years and was most recently collected in 2018. It is not clear if updated data will become available during the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See table PI 11.1 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 13

Mental health consumer experience of service

What does this indicator measure?

This indicator measures the percentage of mental health consumers with an experience of service score equal to or higher than 80 using the Your Experience of Service (YES) survey. Higher proportions of consumers with a positive experience of service suggest a higher-performing mental health system.

This indicator is disaggregated by age group, Indigenous status, mental health service delivery setting and involuntary treatment status.

Why is it important?

Consumer experiences of care from mental health services are vital to inform ongoing quality improvement efforts.

Caveats

A significant proportion of people with mental illness choose not to access mental health services and supports. Data on the experiences of mental health consumers cannot indicate whether existing services would be rated positively by these people.

Under this indicator, a mental health consumer is defined as a person who uses or has used a public mental health service and has responded to the YES survey.

Individual consumers may have completed the YES survey more than once in the reporting year.

Reporting under the Fifth Plan

This indicator was published for the first time in the Fifth Plan 2019 Progress Report and updated in the 2020 Progress Report. Source data for this indicator is collected annually, and was most recently collected in 2018–19. Updates to this indicator are expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 13.1, PI 13.2 and PI 13.3 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 14

Change in mental health consumers' clinical outcomes

What does this indicator measure?

This indicator measures the proportion of mental health-related episodes of care where:

- significant improvement
- significant deterioration
- no significant change

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

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

Why is it important?

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

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

Caveats

Data on mental health consumers' clinical outcomes cannot indicate why consumers' clinical symptoms improved, deteriorated or had no significant change.

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

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report and updated data was published in the 2019 Progress Report and 2020 Progress Report. Source data for this indicator is collected annually and was most recently collected in 2018–19. Updated data is expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See table PI 14.1 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 15

Population access to clinical mental health care

What does this indicator measure?

This indicator measures the percentage of the population receiving clinical mental health services. If the prevalence of mental illness is stable (see PI 6), then higher proportions of people accessing clinical mental health care suggest less unmet need.

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

Why is it important?

Measuring population treatment rates against what is known about the distribution of mental illness in the community gives a broad estimate of unmet need. The issue of unmet need has become prominent since the National Survey of Mental Health and Wellbeing indicated that a majority of people affected by a mental disorder do not receive treatment.^{vii}

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

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

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

Caveats

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.

This indicator is calculated separately for public, private, and combined Medicare Benefits Schedule and Department of Veterans' Affairs data.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report and updated data was published in the 2019 Progress Report. Source data for this indicator is collected annually, and was most recently collected in 2018–19. Updated data is expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 15.1, PI 15.2, PI 15.3 and PI 15.4 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 16

Post-discharge community mental health care

What does this indicator measure?

This indicator measures the 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. Higher proportions of people who access community mental health care following their discharge from hospital suggest a more effective mental health system.

This indicator can be disaggregated by age group, sex, socio-economic disadvantage group, remoteness, and Indigenous status. This indicator can also be disaggregated by whether the client or the client and/or carer participated in the community mental health contact.

Why is it important?

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

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

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

Caveats

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

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 if 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.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report, and updated data was published in the 2019 Progress Report and 2020 Progress Report. Source data for this indicator is collected annually and was most recently collected in 2018–19. Updated data is expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 16.1 and PI 16.2 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 17

Mental health readmissions to hospital

What does this indicator measure?

This indicator measures the percentage of in-scope overnight separations from state 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. This is also known as rapid readmission. Higher rates of rapid readmission suggest that less effective care is being provided by the mental health system.

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

Why is it important?

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

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

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

Caveats

Rapid readmission may point to deficiencies in the functioning of the mental health system. However, readmission data cannot indicate where the deficiency exists.

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report and updated data was published in the 2019 Progress Report and 2020 Progress Report. Source data for this indicator is collected annually and was most recently collected in 2018–19. Updated data is expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 17.1 and PI 17.2 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 18

Mental health consumer and carer workers

What does this indicator measure?

This indicator measures the proportion of staff employed in state and territory administered specialised mental health services who are mental health consumer workers and/or mental health carer workers. This is a proxy measure of the appropriateness of care, support and treatment. Higher rates of consumer and carer workers suggest a more responsive mental health system.

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

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

This indicator can be disaggregated by state and territory. Data is available separately for consumer and carer workers.

Why is it important?

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

Caveats

There are a range of roles for consumers and carers within mental health services, and models adopted by jurisdictions differ in their approach. Models include having consumers and carers in advisory roles on committees, working within clinical teams and directly with consumers and carers. The data on consumer and carer workers cannot indicate whether there are sufficient numbers of consumer and carer workers, or if the models adopted by jurisdictions achieve the optimal mix of roles.

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

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

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report, and updated data was published in the 2019 Progress Report. Source data for this indicator is collected annually and was most recently collected in 2018–19. Updated data is expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See table PI 18.1 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 19

Suicide rate

What does this indicator measure?

This indicator measures the number of suicides per 100,000 Australians. Higher suicide rates indicate poorer mental health and wellbeing.

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

Why is it important?

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 in Australia, and people with mental illness are at even greater risk.

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

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

Caveats

While the stable suicide data implies that the support available to individuals and communities has not improved their health and wellbeing in recent years, it is not possible to determine if the health and wellbeing of the community would have become worse in the absence of existing supports.

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report, and updated data was published in the 2019 Progress Report and 2020 Progress Report. Source data for this indicator is collected annually, and was most recently collected in 2019. Updated data is expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 19.1, PI 19.2 and PI 19.3 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 22

Seclusion rate

What does this indicator measure?

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

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

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

Why is it important?

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

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

Caveats

Seclusion rates may point to the existence of inadequacies in the functioning of the mental health care system, but they do not 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. As a result, data cannot be disaggregated for Aboriginal and Torres Strait Islander peoples.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report, and updated data was published in the 2019 Progress Report and 2020 Progress Report. Source data for this indicator is collected annually, and was most recently collected in 2019–20. Updated data is expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 22.1, PI 22.2 and PI 22.3 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 23a

Involuntary hospital treatment

What does this indicator measure?

This indicator measures the percentage of separations with specialised mental health care days that are involuntary. Higher rates of involuntary hospital treatment indicate that more consumers are experiencing restrictive and coercive practices in the mental health system.

This indicator can be disaggregated by age group, sex, Indigenous status, service target population and whether the unit is acute or non-acute.

Why is it important?

Involuntary care is a type of restrictive and coercive practice in which treatment for mental illness is provided without the person's consent.

All jurisdictions in Australia have legislation allowing people with mental illness to be treated involuntarily under certain conditions. This treatment may include medication and therapeutic interventions that are provided without the consent of the individual, either in hospital or in the community.

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.

Caveats

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. So while this indicator quantifies the proportion of public hospital separations with specialised mental health care that involved care that was provided without the individual's consent, it 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.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2019 Progress Report. Source data for this indicator is collected annually, and was most recently collected in 2018–19. Updated data is expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 23a.1 and PI23a.2 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 23b

Involuntary patient days

What does this indicator measure?

This indicator measures the percentage of admitted patient specialised mental health care patient days that are involuntary. Higher rates of involuntary hospital treatment indicate that more consumers are experiencing restrictive and coercive practices in the mental health system.

This indicator can be disaggregated by age group, sex, Indigenous status, service target population, and whether the unit is acute or non-acute.

Why is it important?

Involuntary care is a type of restrictive and coercive practice where treatment for mental illness is provided without the person's consent.

All jurisdictions in Australia have legislation allowing people with mental illness to be treated involuntarily under certain conditions. This treatment may include medication and therapeutic interventions that are provided without the consent of the individual, either in hospital or in the community.

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.

Caveats

While this indicator quantifies the proportion of public hospital patient days with specialised mental health care that involved care that was provided without the person's consent, it 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.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2019 Progress Report. Source data for this indicator is collected annually and was most recently collected in 2018–19. Updated data is expected annually for the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 23b.1 and PI 23b.2 in the accompanying Excel workbook for all data available for this indicator.

Performance Indicator 24

Experience of discrimination in adults with mental illness

What does this indicator measure?

This indicator measures the percentage of adults with mental illness who report the experience of discrimination. Higher proportions of people with mental illness who have experienced discrimination in the past 12 months suggest lower levels of wellbeing.

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

Why is it important?

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

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

Caveats

The data shows the proportion of people who have experienced one or more instances of discrimination in the past 12 months, but does not reflect the total number of instances of discrimination experienced, the severity of discriminatory events or the impact of the discrimination on the individual. The data also 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 and non-Indigenous people are not comparable. Due to data limitations, data for Aboriginal and Torres Strait Islander peoples include only their experience of discrimination related to their Aboriginal and Torres Strait Islander status.

Data for 2014 included people aged 18 years and older and data for 2019 included people aged 15 years and over.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report, with selected updated data available in the 2020 Progress Report. Source data for this indicator is published approximately every 4 years. A full set of data was most recently published in 2014 and a full updated set of data is expected in 2023. Updated data may not become available during the remaining life of the Fifth Plan.

More information about the data source and calculation methodology for this indicator can be found on the Metadata Online Registry. See tables PI 24.1, PI 24.2, PI 24.3 and PI 24.4 in the accompanying Excel workbook for all data available for this indicator.

Implementation progress survey methodology

Surveyed stakeholders

To determine the progress of implementing the Fifth Plan as at 30 June 2020, the Commission surveyed stakeholders listed as the Coordination Point of each action or – where a Coordination Point is not identified – the identified lead for the action (Box 2). A matrix showing the actions each stakeholder was asked to provide an update on is in [Appendix B](#).

Implementation progress survey process

The implementation progress survey questions and timeframes are informed by advice from the Commission's Fifth Plan Technical Advisory Group (FPTAG). The FPTAG includes representatives from each state and territory government, the Australian Government Department of Health, the Australian Institute of Health and Welfare, the Safety and Quality Partnership Standing Committee, the Suicide Prevention Project Reference Group, the Mental Health Information Strategy Standing Committee, and the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group. The FPTAG also includes consumer and carer representatives.

In 2020, each stakeholder was emailed a Microsoft Excel table with the actions they have responsibility for. The table showed the:

- action number and description
- role description
- name of the Coordination Point or identified responder
- milestone dates, as written in the Implementation Plan, and any known amendments to the Implementation Plan milestone dates
- response fields.

In addition to providing their status updates, stakeholders were encouraged to review the milestone dates listed in the table and provide updates as necessary.

The implementation progress survey asked respondents to rate the implementation status of their actions, as at 30 June 2020, on a 4-point scale. These ratings indicate whether actions are progressing according to the milestone date in the Implementation Plan, or an agreed revised timeline.

Box 2: Surveyed stakeholders

The Commission surveyed the following stakeholders about the implementation status of actions where they are either named as the Coordination Point or are leading implementation of the action:

- the Australian Health Ministers Advisory Council (response provided by the Mental Health Principal Committee on behalf of the Australian Health Ministers Advisory Council)
- the Mental Health Principal Committee
- the National Mental Health Service Planning Framework Steering Committee
- the Mental Health Information Strategy Standing Committee
- the Safety and Quality Partnership Standing Committee
- the Australian Government Department of Health
- state and territory departments of health
- state mental health commissions
- the National Mental Health Commission

The 4 points of the status rating scale are:

Yet to commence: there has been no activity to achieve this action to date.

Commenced – not on track: implementation activities have commenced but progress has stalled or been delayed.

Commenced – on track: the action is progressing as expected and will be completed by either the milestone date listed in the Implementation Plan or the amended completion date listed in the status update table. This rating can also be used if the Implementation Plan does not have a milestone date listed, and the action is progressing as reasonably expected.

Completed: the action has been completed, and no further work is required.

Respondents were also asked to provide relevant context and information about why each status rating was given. If an action was rated as 'yet to commence' or 'commenced – not on track' respondents were asked to provide reasons for the delay.

Respondents providing updates on behalf of a committee were required to provide a single agreed response about progress of actions on behalf of the committee, rather than one response per committee member.

For actions with all governments and/or mental health commissions as the Coordination Point (Actions 14 and 27), the Commission requested that each government and/or mental health commission provide a rating and description for implementation within their jurisdiction (rather than a state or territory perspective on the national implementation of the action). Where responsibility for these actions is shared between the state mental health commission and department of health, departments of health and state mental health commissions were encouraged to liaise with each other to come to an agreed position before submitting their updates to the Commission. However, it was at the stakeholder's discretion whether to submit a single consolidated response on behalf of their government, or separate responses for each organisation.

Responses to the implementation progress survey

Implementation progress surveys were distributed to stakeholders on 21 September 2020. Responses were due to be returned to the Commission on 16 October 2020.

Most stakeholders provided responses to the implementation progress survey. The National Mental Health Service Planning Framework Steering Committee and the South Australian Department for Health and Wellbeing (SA Health) were unable to provide a status update.

Wellbeing SA indicated that due to a change in organisational scope and focus, they no longer have responsibility for implementing Fifth Plan actions as a state mental health commission. As such, it did not provide a status update for the 2020 Progress Report.

For Actions 14 and 27, where all governments and mental health commissions are identified as Coordination Point, the departments of health and mental health commissions of Western Australia and the Australian Capital Territory provided consolidated responses on behalf of their respective governments, whereas these agencies in Queensland and New South Wales responded separately.

Reporting

The combination of implementation status ratings and descriptions form the basis of the 2020 Progress Report. The 2020 Progress Report primarily focuses on actions rated as 'commenced – not on track' and 'yet to commence'. These actions require additional attention to ensure the effective implementation of the Fifth Plan.

To present summary statistics about how many actions and sub-actions are in each status category, the Commission counted all numbered and unnumbered actions and sub-actions of the Fifth Plan. The Fifth Plan formally has 32 actions, many of which are divided into numbered sub-actions. One action (Action 8) has 2 distinct, but un-numbered parts, with different implementation timelines. Because of the different implementation timelines, the Commission decided to count these 2 parts as separate sub-actions. Actions 14 and 27, cannot produce a single aggregate status rating, because the identified Coordination Points are all governments and mental health commissions, and all governments, respectively. Although progress against Actions 14 and 27 is reported separately for each jurisdiction, these 2 actions are counted as a single action for the purpose of producing a denominator for calculating summary statistics. With these considerations, the Commission reports the status of a total of 66 actions and sub-actions.

Differences between the 2019 and 2020 implementation progress surveys

As the annual Fifth Plan Progress Report continues to evolve, the Commission makes corresponding changes to the implementation progress survey and survey process.

There were 2 key changes between the 2019 and 2020 implementation progress survey:

- For actions where Coordination Points are identified, Implementers were not asked to provide status updates.
- Unlike previous years, detailed questions about barriers, enablers and case studies were not included.

In 2019, implementation progress surveys were sent to both Coordination Points (stakeholders listed as the 'Coordination Point' of each action in the Fifth Plan Implementation Plan) and Implementers (stakeholders mentioned in the 'Roles' description of the Implementation Plan as contributing to the implementation of the action) for action status updates. With the aim of producing a more streamlined, reader-friendly progress report, in 2020, only Coordination Points or the stakeholder nominated as responsible for leading the implementation of the action were surveyed. As a result, Primary Health Networks or their state equivalent were not surveyed directly in 2020. The Mental Health Expert Reference Panel, the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group, and the Suicide Prevention Project Reference Group were also not surveyed directly in 2020.

In 2019, respondents were asked to provide detailed information in the following areas, in addition to their status updates:

- significant achievements, barriers or enablers encountered while implementing actions
- how consumers and carers were engaged throughout the implementation of actions
- case studies of successful or innovative initiatives.

In 2020, respondents were asked to provide only a context for the status rating assigned, including a brief description of any significant achievements or barriers to implementing the actions.

Despite the new streamlined format adopted for the 2020 Progress Report, the implementation status of actions and the information collected about the context of these ratings remain broadly comparable to the 2019 Progress Report.

Appendices

Appendix A

Reporting status of the *Fifth National Mental Health and Suicide Prevention Plan* performance indicators

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Appendix B

2020 Action Update Responder Matrix

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Appendix A

Reporting status of the *Fifth National Mental Health and Suicide Prevention Plan* performance indicators

Related Fifth Plan priority area(s)	Reporting status			
	Included in 2018 report	Included in 2019 report	Included in 2020 report	Not available for reporting
PI 1: Children who are developmentally vulnerable Nil		✓	✓	
PI 2: Long-term health conditions in people with mental illness 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.	✓	✓	✓	
PI 3: Tobacco and other drug use in adolescents and adults with 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.	✓	✓	✓	
PI 4: Avoidable hospitalisations for physical illness in people with mental illness Priority Area 5: Improving the physical health of people living with mental illness and reducing early mortality.				✓
PI 5: Mortality gap for people with mental illness 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 7: Making safety and quality central to mental health service delivery.				✓
PI 6: Prevalence of mental illness 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.	✓	✓	✓	
PI 7: Adults with very high levels of psychological distress Priority Area 1: Achieving integrated regional planning and service delivery	✓	✓	✓	

Appendix A

Reporting status of the *Fifth National Mental Health and Suicide Prevention Plan* performance indicators

Related Fifth Plan priority area(s)	Reporting status			
	Included in 2018 report	Included in 2019 report	Included in 2020 report	Not available for reporting
PI 8: Connectedness and meaning in life Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness Priority Area 6: Reducing stigma and discrimination				✓
PI 9: Social participation in adults with mental illness Priority Area 1: Achieving integrated regional planning and service delivery Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness		✓	✓	
PI 10: Adults with mental illness in employment, education or training Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness	✓	✓	✓	
PI 11: Adult carers of people with mental illness in employment Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness		✓	✓	
PI 12: Proportion of mental health consumers in suitable housing Priority Area 6: Reducing stigma and discrimination Priority Area 8: Ensuring that the enablers of effective system performance and system improvement are in place				✓
PI 13: Mental health consumer experience of service Priority Area 1: Achieving integrated regional planning and service delivery 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 6: Reducing stigma and discrimination Priority Area 7: Making safety and quality central to mental health service delivery		✓	✓	
PI 14: Change in mental health consumers' clinical outcomes Priority Area 1: Achieving integrated regional planning and service delivery 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 7: Making safety and quality central to mental health service delivery	✓	✓	✓	
PI 15: Population access to clinical mental health care Priority Area 1: Achieving integrated regional planning and service delivery Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention	✓	✓	✓	

Appendix A

Reporting status of the *Fifth National Mental Health and Suicide Prevention Plan* performance indicators

Related Fifth Plan priority area(s)	Reporting status			
	Included in 2018 report	Included in 2019 report	Included in 2020 report	Not available for reporting
PI 16: Post-discharge community mental health care 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: Making safety and quality central to mental health service delivery	✓	✓	✓	
PI 17: Mental health readmissions to hospital Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention	✓	✓	✓	
PI 18: Mental health consumer and carer workers Priority Area 8: Ensuring that the enablers of effective system performance and system improvement are in place	✓	✓	✓	
PI 19: Suicide rate Priority Area 1: Achieving integrated regional planning and service delivery Priority Area 2: Effective suicide prevention Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention	✓	✓	✓	
PI 20: Suicide of people in inpatient mental health units Priority Area 2: Effective suicide prevention				✓
PI 21: Rates of follow-up after suicide attempt/self-harm Priority Area 1: Achieving integrated regional planning and service delivery Priority Area 2: Effective suicide prevention Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention Priority Area 7: Making safety and quality central to mental health service delivery				✓
PI 22: Seclusion rate Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness Priority Area 7: Making safety and quality central to mental health service delivery	✓	✓	✓	
PI 23: Involuntary hospital treatment PI 23a: Involuntary hospital treatment (separations) PI 23b: Involuntary patient days 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		✓	✓	
PI 24: Experience of discrimination in adults with mental illness Priority Area 6: Reducing stigma and discrimination	✓	✓	✓	

Appendix B

2020 Action Update Responder Matrix

Action	MHPC	NMHSPF SC	MHISSC	AHMAC	SQPSC	DoH	S & T	MHC	NMHC
Governance									
i	✓								
ii	✓								
iii	✓								
iv				✓					
Measuring and reporting on change									
v	✓								
vi				✓					
vii			✓						
Priority Area 1									
1.1	✓								
1.2	✓								
1.3		✓							
1.4		✓							
1.5			✓						
2.1				✓					
2.2				✓					
2.3	✓								
2.4	✓								
2.5	✓								
2.6	✓								
2.7	✓								
2.8	✓								
Priority Area 2									
3	✓								
4	✓								
5	✓								

Appendix B

2020 Action Update Responder Matrix

Action	MHPC	NMHSPF SC	MHISSC	AHMAC	SQPSC	DoH	S & T	MHC	NMHC
Priority Area 3									
6	✓								
7						✓			
8	✓								
9						✓			
Priority Area 4									
10	✓								
11	✓								
12.1	✓								
12.2	✓								
12.3	✓								
12.4	✓								
13.1	✓								
13.2			✓						
13.3	✓								
13.4			✓						
13.5			✓						
Priority Area 5									
14						✓	✓	✓	✓
15	✓								
16	✓								
16.1	✓								
16.2	✓								
16.3	✓								
17			✓						

Appendix B

2020 Action Update Responder Matrix

Action	MHPC	NMHSPF SC	MHISSC	AHMAC	SQPSC	DoH	S & T	MHC	NMHC
Priority Area 6									
18	✓								
19.1				✓					
19.2	✓								
19.3	✓								
20	✓								
Priority Area 7									
21.1					✓				
21.2			✓						
21.3					✓				
21.4					✓				
21.5					✓				
22					✓				
23			✓						
24			✓						
25			✓						
26	✓								
27						✓	✓	✓	
Priority Area 8									
28	✓								
29	✓								
30			✓						
31				✓					
32				✓					

- MHPC** Mental Health Principal Committee
- NMHSPF SC** National Mental Health Service Planning Framework Steering Committee
- MHISSC** Mental Health Information Strategy Standing Committee
- AHMAC** Australian Health Ministers' Advisory Council
- SQPSC** Safety and Quality Partnership Standing Committee
- DoH** Australian Government Department of Health
- S & T** state and territory governments
- MHC** state mental health commission
- NMHC** National Mental Health Commission

Glossary

Ambulatory mental health care

Ambulatory mental health care is 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

Community mental health care refers to 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.

Coordination Point

A Coordination Point is the stakeholder named in the *Fifth National Mental Health and Suicide Prevention Plan Implementation Plan* as having responsibility for coordinating the implementation of the action.

Developmentally vulnerable

Developmentally vulnerable is defined as 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

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

Implementer

An Implementer is the stakeholder named under 'Roles' for each action in the *Fifth National Mental Health and Suicide Prevention Plan Implementation Plan*.

Long-term health condition

A long-term health condition is defined as 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 (COPD; Bronchitis, emphysema).

Mental health carer workers

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

Mental health consumer workers

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

Overnight separations

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

Psychological distress

Psychological distress is measured using the Kessler psychological distress scale. The scale consists of questions about non-specific psychological distress. It seeks to measure the level of current anxiety and depressive symptoms a person may have experienced in the 4 weeks prior to interview.

Glossary

Residential mental health care services

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

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

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

Seclusion

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

Separation

Separation is the term used to refer to 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

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

Acronyms and abbreviations

2018 Progress Report *Fifth National Mental Health and Suicide Prevention Plan, 2018: Progress Report*

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*

AEDC Australian Early Development Census

Fifth Plan *Fifth National Mental Health and Suicide Prevention Plan*

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

MHISSC Mental Health Information Strategy Standing Committee

MHPC Mental Health Principal Committee

NMHC National Mental Health Commission

NMHSPF National Mental Health Service Planning Framework

SQPSC Safety and Quality Partnership Standing Committee

YES survey Your Experience of Service survey

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