Monitoring mental health and suicide prevention reform

Fifth National Mental Health and Suicide Prevention Plan, 2019

Progress Report 2

Australian Government
National Mental Health Commission

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- the Fifth Plan Technical Advisory Group, for their expertise and advice throughout the planning process for this implementation progress report.
- the survey respondents whose feedback informed this progress report, namely the Australian Government Department of Health, the state and territory government health departments, the Primary Health Networks, the state mental health commissions, and the subcommittees of the Council of Australian Governments Health Council.
- the Australian Institute of Health and Welfare and the Australian Bureau of Statistics, for providing data to report against the performance indicators.

About this Report

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Foreword

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. Endorsed by the Council of Australian Governments (COAG) Health Council in August 2017, the Fifth Plan has now completed its second year of implementation.

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

The inaugural Fifth Plan implementation progress report (2018 Progress Report) was presented to the COAG Health Council in October 2018. I am proud to present the second report on implementation progress, the *Fifth National Mental Health and Suicide Prevention Plan, 2019: Progress Report 2* (2019 Progress Report).

The 2019 Progress Report outlines progress achieved by stakeholders against each of the Fifth Plan's 32 actions as at 30 June 2019. The report also includes performance indicators designed to collectively provide a picture of how Australia's mental health system is performing. This year, the NMHC is pleased to present five additional performance indicators that were unavailable in 2018.

As reported by stakeholders, the majority of actions appear to be progressing on schedule. Although some priority areas appear to have progressed further than others, the NMHC is encouraged by the ongoing efforts of all involved in implementing the actions of the Fifth Plan, and the continued engagement by all stakeholders with consumers and carers.

There is more to measuring progress than simply reporting on the status of actions. The NMHC is interested in understanding how the completion of Fifth Plan actions is changing mental health and suicide prevention planning, delivery and evaluation. Now that governance arrangements are in place and the milestones of some actions have been achieved, the NMHC can seek to understand and measure the outcomes of these actions starting in 2020.

Outcomes will also continue to be assessed from the perspectives of consumers and carers, via the NMHC's annual consumer and carer report. The *Fifth National Mental Health and Suicide Prevention Plan, 2019: The consumer and carer perspective,* published in September 2019 presents baseline data on the experiences of consumers and carers as they access the mental health system. The NMHC will use this baseline to track progress and measure change from the perspective of consumers and carers over the coming years.

In seeking to understand the experiences of consumers and carers in conjunction with monitoring the progress of the Fifth Plan's implementation, the NMHC can measure progress and, ultimately, determine whether the Fifth Plan has been successful in achieving its objectives.

Thank you to all the stakeholders who are working together to implement actions under the Fifth Plan – the Australian Government, state and territory governments, Primary Health Networks and Australian Health Ministers' Advisory Council committees – for their valuable contributions to this report. It is through the sustained and collaborative efforts of stakeholders that improvements in mental health and suicide prevention in Australia will be realised.

Christine Morgan
CEO of the NMHC

Executive Summary

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) builds on the foundations of previous reform efforts and establishes a national approach for collaborative government action to improve the provision of integrated mental health and related services in Australia. To achieve this, the Fifth Plan identifies eight priority areas and 32 actions that are designed to improve the transparency, accountability, efficiency and effectiveness of the Australian mental health system. Ultimately, the Fifth Plan aims to improve the lives of people living with a mental illness and the lives of their families, carers and communities.

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 (NMHC) has been given responsibility for delivering an annual report on the implementation progress of the Fifth Plan actions and performance against the identified indicators. The first of these reports, the *Fifth National Mental Health and Suicide Prevention Plan, 2018: Progress Report* (2018 Progress Report) was delivered to the Council of Australian Governments (COAG) Health Council in October 2018 and described the progress made towards the implementation of the Fifth Plan actions in its first year.

As part of its reporting role, the NMHC also sought to understand whether implementation of the Fifth Plan has had an impact on how consumers and carers experience mental health care. The NMHC conducted a national survey to capture the experiences of consumers and carers and published the *Fifth National Mental Health and Suicide Prevention Plan, 2019: The consumer and carer perspective* (2019 Consumer and Carer Report) in September 2019. The report established a baseline against which the performance of the Fifth Plan can be measured in terms of its impact on consumers and carers. It provides the unique perspectives of consumers and carers as they interact with a system while it undergoes reform.

By monitoring the progress of the work of stakeholders responsible for implementing the Fifth Plan, as well as seeking feedback from consumers and carers across Australia, the NMHC aims to gain a broader understanding of whether this reform is meeting its objectives. Monitoring the implementation progress of the Fifth Plan is also critical for identifying barriers, challenges and significant system changes that may impede progress or impact.

This report is the second in a series that will be produced annually over the life of the Fifth Plan. It outlines the progress achieved against the Fifth National Mental Health and Suicide Prevention Plan Implementation Plan (Implementation Plan) as at 30 June 2019, and presents the available performance indicators that are designed to collectively provide a picture of how Australia's mental health system is performing. Compared with the 2018 Progress Report, this year's report presents a more thorough and detailed analysis of progress. This is a result of more activities commencing in the second year of the Fifth Plan's implementation, in addition to a more targeted implementation progress survey process.

Monitoring and reporting on progress

To determine the progress of the implementation of the Fifth Plan, the NMHC surveyed the stakeholders named in the Implementation Plan that are responsible for delivering actions. These stakeholders included the Australian Government Department of Health, state and territory departments of health, national and state mental health commissions, Primary Health Networks (PHNs) and subcommittees of the COAG Health Council. Stakeholders were asked questions based on their specific role in the implementation of the eight priority areas and 32 actions.

For most actions in the Implementation Plan a stakeholder is named as a Coordination Point. The Coordination Point of each action was required to rate the progress of the action as at 30 June 2019. Progress was measured on a 4-point scale:

- Yet to commence
- Commenced – not on track
- Commenced – on track
- Completed.

These ratings indicate whether actions are progressing according to the milestone date stipulated in the Implementation Plan. In addition to rating progress, Coordination Points and Implementers were asked to describe activity towards the implementation of each action. Implementers are the stakeholders named under 'roles' for each action in the Implementation Plan. The combination of ratings and descriptions form the basis of this report.

The implementation progress reported by the NMHC is based on the responses provided by stakeholders and has not been independently verified. The NMHC has used stakeholder responses to describe the implementation progress of each action without further interpretation. In some instances, the NMHC has suggested points for consideration on the basis of these descriptions – particularly for actions where progress is yet to commence. In addition, many stakeholders other than those named in the Fifth Plan have an important role in the mental health system. The *Fifth National Mental Health and Suicide Prevention Plan, 2019: Progress Report* (2019 Progress Report) does not capture these stakeholder activities or perspectives.

Implementation progress

Overall, the implementation progress of the majority of actions across the Implementation Plan has been reported as 'commenced – on track'. However, some areas have not progressed as scheduled in the Implementation Plan.

The status of each of the Fifth Plan's 32 actions as at 30 June 2019 is presented in the table in Appendix A. A summary of progress against actions in each priority area of the Fifth Plan detailed in the Implementation Plan is provided below.

Governance

The majority of actions in the governance section were reported as 'commenced – on track', and most of the required governance arrangements have been established.

The NMHC understands that a working group to lead the review and renewal of the National Mental Health Policy has recently been established by the Mental Health Principle Committee (MHPC). The review was due to commence in January 2018, for completion in December 2020. It is understood that work on the review will commence once membership of the working group has been agreed, taking into account ongoing reform activities.

Changes to the leadership of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group (ATSIMHSPPRG) appear to have significantly affected the group's ability to implement the actions under Priority Area 4. It is expected that the work of the ATSIMHSPPRG can now be progressed without further delay as the group's composition and focus of actions have been finalised.

Measuring and reporting on change

The majority of actions for Measuring and reporting on change were reported as 'commenced – on track'.

The NMHC notes there is a delay in the development of a Fifth Plan evaluation plan. Although the evaluation of the Fifth Plan is not due for completion until June 2022, the commissioning of this evaluation, including clearing the evaluation plan through the Mental Health Information Strategy Standing Committee (MHISSC), was required by December 2018.

Given that the Fifth Plan is now entering its third year of implementation and that the development of an evaluation will require engagement with multiple stakeholders, the NMHC urges the Australian Government Department of Health to commence this action as a priority.

Priority Area 1: Achieving integrated regional planning and service delivery

The majority of actions for achieving integration of regional planning and service delivery were reported as 'commenced – on track'. This is particularly significant given the complexity of this priority area.

The development and release of *Joint Regional Planning for Integrated Mental Health and Suicide Prevention Services: a Guide for Local Health Networks and Primary Health Networks* (Guide for Joint Regional Planning), in October 2018 is particularly important as the guidance will enable PHNs and LHNs to ensure that Fifth Plan priority areas (specifically priority areas 2, 3, 4 and 5) are considered in their regional mental health and suicide prevention plans.

The work currently underway by the University of Queensland (commissioned by the Australian Government Department of Health) to address the limitations of the National Mental Health Service Planning Framework (NMHSPF) Planning Support Tool for rural, remote and Aboriginal and Torres Strait Islander populations is intended to result in wider use of the tool. This is particularly significant given that a number of stakeholders reported limitations of the tool across priority areas 1, 3 and 8 in the 2018 Progress Report. The Australian Government has recognised the limitations of the tool, and that addressing these limitations will increase the tool's ability to be used consistently across jurisdictions.

Consistent with the 2018 Progress Report, the PHNs report a lack of funding and resources needed to support integrated regional planning and service delivery. They report this as being a significant barrier to progress. PHNs describe regional planning as a complex and resource-intensive exercise that would particularly benefit from additional staff to lead the process, as well as funding to develop initiatives to support integrated regional service planning and delivery.

The NMHC notes that Action 2.5 of the Implementation Plan requires PHNs and LHNs to develop comprehensive regional plans by mid-2020. However, there appear to be variations across PHNs as to when this action will be delivered. Some PHNs reported that they expect to release a foundational plan by mid-2020, with comprehensive plans not expected until 2022. This is consistent with the Guidance for Joint Regional Planning released on the Australian Government Department of Health website but not with the milestone date specified in the Implementation Plan.

The majority of stakeholders reported strong engagement across the sector. However, a small number of PHNs reported a lack of engagement by state and territory governments, and LHNs, as significant barriers to progress. The NMHC notes that the Fifth Plan marks the first time that all governments have committed to working together to achieve integration in planning and service delivery at the regional level. For this reason, it is not surprising that some stakeholders have experienced difficulties in clarifying the roles, responsibilities and expectations involved in implementing this reform. Given that the implementation of the Fifth Plan has completed its second year, however, the NMHC hopes that these difficulties can be resolved promptly, and that stakeholders can work together to successfully implement Priority Area 1 of the Fifth Plan.

Priority Area 2: Effective suicide prevention

Implementation of Priority Area 2 is progressing well, with all actions reported as 'commenced – on track'. Of particular significance is the development of the National Suicide Prevention Implementation Strategy. The National Suicide Prevention Implementation Strategy for Australia's Health System 2020–2023 embodies a systems approach to suicide prevention and requires all health ministers to attempt to collaborate with non-health portfolios.

The provision of training to health providers and the local community by state and territory governments, and the additional funding dedicated to suicide prevention are noteworthy, as it demonstrates the commitment of jurisdictions to invest in suicide prevention activities.

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

The NMHC notes that no Coordination Points have been named to oversee the implementation of the actions under Priority Area 3. This makes it difficult to rate progress, as there is no overarching committee to coordinate the implementation of each action, and the NMHC must rely on self-reported progress updates from stakeholders. Despite this complexity, the actions under Priority Area 3 appear to be in progress.

The NMHC notes that all state and territory governments have an agreement with the Australian Government Department of Health for psychosocial support services, and that guidance material outlining expectations for coordinated treatment and supports for people with severe and complex mental illness has been provided to LHNs and PHNs. As noted by the South Australian Government, however, there may be a need for further guidance. Although additional guidelines will be developed under Action 9, this action is not scheduled for completion until 2020. The NMHC expects that these guidelines will involve consultation with PHNs to ensure the best possible alignment between current practice and future expectations.

The NMHC acknowledges the complexity of the intersection of the Fifth Plan with the NDIS. Going forward, the NMHC will seek to understand how agreements for psychosocial support services are resulting in outcomes for people living with severe and complex mental illness.

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

A number of actions under this priority area were reported as 'yet to commence'. This is concerning given that implementation of the Fifth Plan has completed its second year.

As noted in 'Governance', changes in the structure of ATSIMHSPPRG, including the resignation of the ATSIMHSPPRG Chair and the subsequent delay in recruiting a replacement, have significantly affected the group's ability to implement the actions under Priority Area 4. In addition, the ATSIMHSPPRG revised the Priority Area 4 actions and agreed to adjust the focus of some of the actions. This has delayed the commencement of a number of actions.

The NMHC anticipates that the work of the ATSIMHSPPRG can progress without further delay now that a new Chair has been appointed and secretariat support provided. The NMHC acknowledges the expertise of the ATSIMHSPPRG, and the value of adjusting the focus of specific actions to more appropriately address Aboriginal and Torres Strait Islander mental health and suicide prevention.

Action 13.5 involves scoping the development of mental health key performance indicators for Aboriginal and Torres Strait Islander primary healthcare. The MHISSC has requested that this action be coordinated by the ATSIMHSPPRG due to its expertise. Given that this action was scheduled to commence in 2018 and is due for completion in 2021, the NMHC is concerned that the ATSIMHSPPRG does not have sufficient time to deliver this work.

Given the importance and scale of the actions within Priority Area 4, and in light of the barriers reported by stakeholders in implementing this priority area, the NMHC urges the MHPC to consider the resourcing of the ATSIMHSPPRG to ensure that the actions can be implemented.

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

Implementation of this priority area is progressing well, and all actions were reported as 'commenced – on track'.

The NMHC acknowledges the achievements of stakeholders in working to improve the physical health of individuals living with mental illness. This includes the delivery of a range of programs and strategies to support physical health needs by LHNs, and PHNs commissioning targeted services in partnership with local organisations.

As more PHNs and LHNs release their joint regional mental health and suicide prevention plans in 2020, the NMHC will gain a more comprehensive picture of how joint service planning activity will focus on the treatment of physical illness in people living with mental illness.

Priority Area 6: Reducing stigma and discrimination

A number of actions within this priority area were reported as 'yet to commence' or 'commenced – not on track'. The NMHC acknowledges that the actions within this priority area are dependent on the completion of Action 18, namely, the development of options for a nationally coordinated approach to reduction of stigma and discrimination, with a focus on mental illness that is poorly understood in the community.

Consultations on options for a nationally coordinated approach were scheduled for completion by late 2018. The Australian Government Department of Health reported that these consultations will not take place until the first half of 2020. Given that subsequent actions within Priority Area 6 cannot commence until Action 18 is completed, the NMHC urges the progress of this work as a priority.

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

The majority of actions under this priority were reported as 'commenced – on track'.

The NMHC acknowledges that the Safety and Quality Partnership Standing Committee (SQPSC) is unable to progress the development of a mental health supplement to the National Safety and Quality Health Service (NSQHS) Standards (Action 22), until a process for revising the National Standards for Mental Health Services (NSMHS) (Action 21.4) has been finalised. The NMHC notes the progress towards the implementation of a process for revising the NSMHS (Action 21.4). As reported by the SQPSC, the NMHC recognises the value of broadening representation in the project advisory group being established by the SQPSC to ensure coverage of all relevant service delivery sectors. Once representatives are confirmed, the NMHC expects to see progress made towards the commencement of the mental health supplement to the NSQHS Standards.

The NMHC notes the high cost involved in the implementation of the World Health Organization (WHO) QualityRights Guide and training tools (Action 27), and the MHPC's decision not to support the initial proposal, as reported in the 2018 Progress Report. The MHPC has since agreed that this action is the responsibility of individual jurisdictions and will not attempt to progress this action further. Given the prohibitive cost of implementing the WHO QualityRights Guide however, it is unlikely that states and territories will adopt this model. On this basis, the NMHC is unclear as to the value of keeping this action in the Implementation Plan and suggests that governments revise the inclusion of this action in the Fifth Plan or explore alternative models for national implementation of comparable training instead.

Additionally, the NMHC acknowledges the change to the Coordination Point of Action 25, ensuring that services funded by the Australian Government and states and territories have safety and quality monitoring and public reporting. The NMHC encourages stakeholders to work together to ensure that the roles and responsibilities for this action are clear, and that this change does not negatively affect future progress.

The NMHC notes the completion of Action 21.2, with the MHISSC reporting that it has revised the National Mental Health Performance Framework. The revised framework will support the monitoring and reporting of performance and quality across all mental health service sectors.

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

The NMHC is pleased to note that the majority of actions were reported as 'commenced – on track'. Progress was reported for the development of the National Mental Health Research Strategy, the Peer Workforce Development Guidelines and the National Digital Mental Health Framework.

In agreement with the MHPC and the Australian Government Department of Health, the NMHC acknowledges the importance of aligning the development of the Workforce Development Program (Action 31) with the National Mental Health Workforce Strategy led by the Australian Government Department of Health.

Outputs from the NMHSPF will also inform the development of the Workforce Development Program. As reported in the 2018 Progress Report, the ongoing improvement of the NMHSPF to ensure that it includes rural, remote and Aboriginal and Torres Strait Islander populations is important if jurisdictions are to be able to use the framework fully.

The NMHC notes the work currently underway by the University of Queensland to address the limitations of the NMHSPF. This is also an important consideration in the development of the Workforce Development Program.

Key implementation developments since 2017–18

Overall, stakeholders reported that key initiatives are progressing through the relevant COAG Health Council committee structures. This includes the National Mental Health Research Strategy, Peer Workforce Development Guidelines, Safety and Quality Engagement Guide, the National Digital Mental Health Framework and the National Suicide Prevention Implementation Strategy. These are substantial pieces of work that have required the joint efforts of multiple stakeholders.

Of note, since the 2018 Progress Report, all governments have entered into an agreement with the Australian Government Department of Health for psychosocial support services through the National Psychosocial Support measure. The purpose of the National Psychosocial Support measure is to provide psychosocial support services to people with severe mental illness who are not more appropriately funded through the NDIS.

Stakeholders again reported that the expertise of Australian Health Ministers' Advisory Council (AHMAC) committees and effective stakeholder engagement were key enablers of implementation progress.

Additionally, it appears that consumer and carer engagement in implementation of the Fifth Plan is occurring mainly through representation on governance committees.

A material barrier reported in the 2018 Progress Report was the availability of guidance for the development of joint regional mental health and suicide prevention plans. Stakeholders reported they were unable to progress with their regional planning until guidance was provided that outlined expectations for PHNs and LHNs across a number of priority areas, including:

- coordinated treatment and supports for people with severe and complex mental illness (Action 7, Priority Area 3)
- integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples (Action 10, Priority Area 4)
- local treatment planning and clinical governance for the treatment of physical illness in people living with mental illness, by including it as part of joint service planning activity (Action 16.1, Priority Area 5) and joint clinical governance activity (Action 16.2, Priority Area 5).

This guidance (Guide for Joint Regional Planning) has since been developed by the Integrated Regional Planning Working Group and released through the Australian Government Department of Health website, and a number of PHNs and LHNs have subsequently progressed the development of their joint regional plans.

Areas in need of attention

The Implementation Plan specifies that comprehensive joint regional plans are to be delivered by mid-2020. However, the Guide for Joint Regional Planning recognises that for PHN and LHN regions that are faced with complications to joint regional planning, it may be more appropriate to publicly release a foundational joint regional plan by mid-2020, and commit to publishing a comprehensive joint regional plan by mid-2022. The Guide for Joint Regional Planning encourages regions that have the pre-existing capacity and partnerships required for joint regional planning to publish a comprehensive regional plan by mid-2020, and it appears that some PHNs are on track to release their comprehensive plans by this milestone date. Given the expected variation in delivery timelines between regions, the NMHC will work with key stakeholders to determine how best to monitor the development of joint regional plans for the remaining life of the Fifth Plan.

As implementation of the Fifth Plan is now entering its third year, it is crucial that work begins to formulate the Fifth Plan evaluation plan. Given that the evaluation will involve significant engagement with multiple stakeholders, the NMHC urges the Australian Government Department of Health to commence the implementation of this action, and consider the flow-on effects of any further delays.

It is clear that momentum is needed to commence actions in Priority Area 4 (Improving Aboriginal and Torres Strait Islander mental health and suicide prevention). Actions in this priority area have encountered significant delays in 2018–19 as a result of changes made by the ATSIMHSPPRG to the focus of a number of actions. The resignation of the ATSIMHSPPRG Chair and the subsequent delay in recruiting a replacement also negatively affected progress in this priority area. The NMHC expects that actions in this priority area will be progressed following the appointment of a new Chair and consideration of resources required for the ATSIMHSPPRG.

Priority Area 6 (Reducing stigma and discrimination), is facing delays in implementation, with a number of actions dependent on the outcome of consultations. These consultations were due for completion by the end of 2018, however they are now not expected to be held until the first half of 2020. The development of options for a nationally coordinated approach to stigma and discrimination will be informed by these consultations, held by the Australian Government Department of Health, which will then be presented to the AHMAC.

Similarly, a number of actions in Priority Area 7 (Making safety and quality central to mental health service delivery), have been reported as yet to commence. This is due to the interdependency of actions. The mental health supplement to the NSQHS Standards being developed in Action 22 needs to align with the National Standards for Mental Health Services. A process for revising the National Standards for Mental Health Services (Action 21.4) is not due for completion until 2021. In addition, the MHPC has agreed that Action 27 is the responsibility of individual jurisdictions and will not be progressing the action any further. Action 27 requires governments to make accessible the WHO QualityRights guidance and training to promote awareness of consumer rights. Given the prohibitive cost of these guidelines however, the NMHC recommends that governments revise the inclusion of this action or explore alternative models for national implementation of comparable training.

Performance indicators

The Fifth Plan identifies a set of 24 performance indicators, 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. With this long-term monitoring in mind, the identified performance indicators include broad measures of the health status of the population and the process of mental health care, rather than measures that closely align with the priority areas or actions under the Fifth Plan.

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.

The second half of this report includes a high-level summary of the available indicators and analyses each available indicator, including what the data can and cannot say about the mental health and wellbeing of Australians or the performance of the mental health sector. Additional data for each available indicator can be found on the NMHC's website.

The available indicators show that at the national level, some aspects of the health and wellbeing of Australians are stagnant and some are experiencing small, sustained deterioration. Nationally, some aspects of the mental health system are consistently improving, while others remain stagnant. These results are discussed in detail in the performance indicators section of this report.

Although the performance indicators can identify that change is needed to improve the health and wellbeing of Australians or the performance of the mental health system, they cannot indicate what change is necessary to see the desired improvements. Investigation beyond the Fifth Plan indicators is required to inform future reforms.

Looking forward

The 2019 Progress Report provides a comprehensive overview of progress towards completing the Fifth Plan actions. It also provides broad measures of the health status of the population and the performance of the mental health system.

Understanding how consumers and carers experience mental health care is a priority for the NMHC. The NMHC's 2019 Consumer and Carer Report provides a baseline understanding of consumer and carer experiences of mental health care. Although the 2019 Consumer and Carer Report is based on a small sample of consumers and carers, it highlights some key issues of significance in the community. Reported issues included the high rates and negative impact of experiences of mental health stigma and discrimination in the community and when accessing mental health services. In addition, issues of availability and cultural appropriateness of services were reported as key barriers by Aboriginal and Torres Strait Islander respondents.

Given the implementation delays in Fifth Plan actions to improve Aboriginal and Torres Strait Islander mental health and suicide prevention (Priority Area 4) and reduce stigma and discrimination (Priority Area 6), the NMHC does not expect to see a significant shift in these experiences in next year's consumer and carer report, based on Fifth Plan implementation. It will be important to continue to monitor these issues as implementation of actions is progressed.

The NMHC will continue to publish annual reports on the consumer and carer perspective to supplement Fifth Plan implementation progress reports. In seeking to understand the experiences of consumers and carers in conjunction with monitoring the progress of the Fifth Plan's implementation, the NMHC can gain an indication of whether the Fifth Plan has been successful in achieving its objectives.

Future considerations for policy makers

During the process of monitoring and reporting on the implementation progress of the Fifth Plan, the NMHC has identified several issues that policy makers should consider for future mental health and suicide prevention reforms.

The Fifth Plan primarily focuses on actions for governments and associated stakeholders to improve mental health and suicide prevention. It does not include actions for private, non-government or community organisations. These stakeholders have a key role in improving mental health and suicide prevention and capturing their role in future reforms should be considered.

Additionally, the Fifth Plan takes a health focus to improving mental health and suicide prevention. A whole-of-government approach to future reforms, including endorsement by, and actions for, related portfolios – such as education, justice and social services – would align with current government efforts.

Ensuring that all actions for future implementation of mental health and suicide prevention reform are specific, measurable and time-bound will help to clearly define the expectations and roles of stakeholders. Future reforms would also benefit from mechanisms built-in to the Implementation Plan that appropriately support and resource stakeholders to implement actions.

As the performance indicators identified in the Fifth Plan are not closely aligned with the actions of the Fifth Plan, they cannot be used to determine whether or not the Fifth Plan actions have been effective in improving the mental health system. Future National Mental Health and Suicide Prevention Plans should consider specifying measurable outcomes for individual actions, in addition to indicators that facilitate long-term monitoring of the performance of the mental health system and the health and wellbeing of Australians. This will make it clearer that the reform is making a difference.

Evaluation of the Fifth Plan will be a critical and important part of addressing the limitations of the Fifth Plan to inform future National Mental Health and Suicide Prevention Plans, as well as other related reforms.

Introduction

The release of the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) in August 2017 marked a significant point in the history of mental health reform in Australia. The Fifth Plan is the first mental health plan to commit all governments to working together to achieve integration in planning and service delivery at a regional level.

It is also the first plan to specifically outline an agreed set of actions to address social and emotional wellbeing, mental illness and suicide among Aboriginal and Torres Strait Islander people as a priority. As well, it is the first to elevate the importance of addressing the physical health needs of people who live with mental illness, and reducing the stigma and discrimination that accompany mental illness.

The aim of the Fifth Plan is to establish a national approach for collaborative government action to improve the provision of integrated mental health and related services in Australia. The Fifth Plan primarily focuses on actions for governments and associated stakeholders to improve mental health and suicide prevention. It does not include actions for private, non-government or community organisations.

The Fifth Plan is underpinned by eight priority areas and 32 actions, which are designed to improve the transparency, accountability, efficiency and effectiveness of the Australian mental health system. The eight 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 includes actions that aim to achieve specific outcomes under each of the priority areas, set the direction for change and provide a foundation for longer-term system reform. These actions have been committed to by governments and are detailed in the Fifth National Mental Health and Suicide Prevention Plan Implementation Plan (Implementation Plan). Governments also identified 24 indicators that will be used to measure the performance of the mental health and suicide prevention sector over the life of the Fifth Plan.

Reporting on the progress of mental health reform is essential in order to know that the commitments in the Fifth Plan are being honoured and are making a difference. The National Mental Health Commission (NMHC) has been given responsibility for delivering an annual report, for presentation to health ministers, on the implementation progress of the Fifth Plan actions and performance against the identified indicators. The first of these reports (2018 Progress Report) was delivered to the Council of Australian Governments (COAG) Health Council in October 2018 and described the progress made towards the implementation of the Fifth Plan actions in its first year.

To supplement the implementation progress report, the NMHC sought to understand whether the implementation of the Fifth Plan was leading to genuine improvements for consumers and carers, by conducting a national survey to capture the experiences of consumers and carers. The results from this public consultation formed the basis of the report *Fifth National Mental Health and Suicide Prevention Plan, 2019: The consumer and carer perspective* (2019 Consumer and Carer Report), which was published in September 2019.

The aim of the 2019 Consumer and Carer Report was to establish a baseline against which the performance of the Fifth Plan reform can be measured. The 2019 Consumer and Carer Report highlighted some frequently raised issues that can inform the ongoing implementation of the Fifth Plan by stakeholders. Annual consumer and carer reports will help the NMHC to understand the progressive impact of the Fifth Plan for consumers and carers over time.

As the second report on the implementation progress of the Fifth Plan, this report outlines the progress achieved against the Implementation Plan actions as at 30 June 2019, and presents additional performance indicators.

The NMHC will continue to monitor and report annually on the implementation progress of the Fifth Plan. In addition, the NMHC will use annual reports on the consumer and carer experience to supplement the implementation progress reports, and to develop a more detailed understanding of the true nature of the Fifth Plan's progress.

Implementation of the Fifth National Mental Health and Suicide Prevention Plan

Methodology

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

In response to feedback following the 2018 Progress Report, and to improve engagement with stakeholders named in the Implementation Plan, the NMHC established a technical advisory group to guide planning for the 2019 Progress Report.

The Fifth Plan Technical Advisory Group (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 (SQPSC), the Suicide Prevention Project Reference Group , the Mental Health Information Strategy Standing Committee (MHISSC), and the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group (ATSIMHSPPRG). The group also includes consumer and carer representatives.

The FPTAG provided extensive feedback and advice to the NMHC on the reporting timeframes, survey methodology (including questions) and stakeholder guidance for the 2019 Progress Report. This feedback informed the differences in approach used for this year's report, which aimed to capture targeted, more detailed data from stakeholders. The key differences between the 2018 and 2019 processes are outlined in Table 1.

Table 1: Key differences in reporting approach

2018	2019
The NMHC independently designed survey questions.	Survey questions were designed in consultation with FPTAG which included representatives from each state and territory and a number of AHMAC committees.
Stakeholders received guidance in the form of 'frequently asked questions' at the same time as the survey opened.	Stakeholders received formal guidance and survey questions approximately six weeks before the survey opened online. The online survey was open for one month. Stakeholders had 11 weeks to collect their data and submit their responses.
Relevant stakeholders identified against each action of the Implementation Plan were asked to rate the progress of their contribution on a four point scale.	Stakeholders identified as *Coordination Points* and *Implementers* based on their role specified in the Implementation Plan.
Stakeholders were asked to *rate* the level of consumer and carer engagement on a seven point scale.	Stakeholders were asked to *describe* how they have involved or engaged with consumers and carers throughout the implementation of each priority area.

To understand the progress made against each of the Fifth Plan's actions, the NMHC developed surveys using an online consultation tool. Relevant stakeholders were identified against each action of the Implementation Plan. They were classified as either 'Coordination Points' (stakeholders responsible for coordinating the action), or 'Implementers' (stakeholders responsible for implementing the action) (see Box 1). A small number of stakeholders were identified as both Coordination Points and Implementers, which demonstrates the complexity of the Implementation Plan.

Box 1: Implementation Plan roles

Coordination Points are the stakeholders named in the Implementation Plan as having responsibility for coordinating the implementation of the action. The stakeholders named as Coordination Points are:

- the Australian Health Ministers Advisory Council (AHMAC)
- the Mental Health Principle Committee (MHPC)
- the National Mental Health Service Planning Framework Steering Committee (NMHSPF Steering Committee)
- the Mental Health Information Strategy Standing Committee (MHISSC)
- the Safety and Quality Partnership Standing Committee (SQPSC).

Implementers are the stakeholders named under 'roles' for each action in the Implementation Plan. The surveyed stakeholders identified as Implementers are:

- the Australian Government Department of Health
- State and territory government health departments
- the National Mental Health Commission (NMHC)
- State mental health commissions
- Primary Health Networks (PHNs)
- the Mental Health Expert Reference Panel (MHERP)
- the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group (ATSIMHSPPRG)
- the Mental Health Information Strategy Standing Committee (MHISSC)
- the Mental Health Principal Committee (MHPC)
- the Safety and Quality Partnership Standing Committee (SQPSC).

A unique survey was developed for each stakeholder type. Stakeholders were only asked questions that related to actions they were directly involved in as identified in the Implementation Plan. Survey questions were designed to provide a mix of quantitative and qualitative measures of progress against actions within each priority area of the Fifth Plan.

To assist all stakeholders in responding to the survey, the NMHC developed detailed guidance in consultation with the FPTAG. The guidance outlined the reporting process and the changes that had been made from the process used in the previous year. The guidance also provided descriptions of each stakeholder type (Coordination Points and Implementers), and expectations of the level of detail required for each answer in the survey.

Stakeholders were provided with the guidance and their survey questions (in a Word template) approximately six weeks before the survey opened online. The online survey portal was live for the month of July, which provided stakeholders with approximately 11 weeks to collect their data and submit their responses.

As Coordination Points are responsible for coordinating or overseeing the implementation of an action, they provide a unique perspective on the action's overall progress. For this reason, Coordination Points were asked to provide a description of what had been done to progress the action over the reporting period. They were also asked to rate the status of the action on a progress scale (see Box 2). Taken together, the description of progress and the current status of the action provided the NMHC with a better understanding of the progress of each action from the perspective of the stakeholders responsible for coordinating implementation.

Box 2: Status scale

Yet to commence: There has been no activity towards achieving 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 according to the milestone date listed in the Implementation Plan. Where an action does not have a milestone date listed, respondents should still select this option if the action is progressing as reasonably expected.

Complete: The action has been completed and no further work is required.

Whereas questions for Coordination Points related to the progress of the action as a whole, questions for Implementers asked about how the stakeholder's contribution to the action was progressing. To understand this contribution, Implementers were asked specific questions that related directly to their role in implementing the action. These questions included a mix of open-text and check-box response options.

All surveyed stakeholders named in the Implementation Plan, as Coordination Points and as Implementers, were also asked to describe the key achievements, barriers and enablers to implementation progress. The NMHC identified the central themes from these responses, and used these as the basis for the key observations and recommendations at the conclusion of each priority area in this report.

The final element of the survey required stakeholders to describe how they have engaged consumers and carers throughout the implementation process. As consumer and carer participation is central to how mental health services are planned, delivered and evaluated under the Fifth Plan, it is critical that the stakeholders responsible for implementing the Fifth Plan are involving consumers and carers wherever possible.

To supplement the survey responses, PHNs, governments, and state mental health commissions were invited to submit a case study to highlight an initiative implemented under the Fifth Plan. A selection of these case studies are included in this report as they relate to each priority area. In some instances, stakeholders provided case studies that the NMHC had already published in 2018. These case studies were not included in this year's report. All other case studies submitted by stakeholders are included in Appendix B.

Limitations

As with any survey process, the NMHC acknowledges the limitations of self-reporting progress. Despite the provision of guidance, stakeholders' responses varied in terms of the level of detail provided. The Implementation Plan is complex and broad in its scope, and some stakeholders are responsible for coordinating or implementing a large number of actions. Implementing and reporting on progress is a substantial piece of work for these stakeholders.

Priority Area 1: Achieving integrated regional planning and service delivery, outlines actions requiring joint accountability between PHNs and LHNs. While each PHN was surveyed directly, aggregated information about LHN activity was gained through state and territory governments. As a result, information on individual LHN activity towards joint regional planning has not been captured in this report. Going forward, the NMHC will work with stakeholders to ensure information on LHN activity is adequately captured.

During the data collection process, the NMHC was notified by the AHMAC that it had delegated its responsibility for reporting on Fifth Plan action progress to the MHPC. The AHMAC stated that the MHPC was better placed to coordinate progress ratings for Fifth Plan actions. Therefore, where the AHMAC has been named as the Coordination Point, the rating of progress has been provided by the MHPC. Going forward, the NMHC will work with stakeholders to better clarify the reporting role of the Coordination Points to ensure that progress is reported by the most appropriate stakeholder.

The NMHC would like to acknowledge the time taken by stakeholders to coordinate a large amount of information to adequately answer the survey questions. The NMHC received many examples to demonstrate progress in priority areas, however, not all of these examples are included in the report. The NMHC identified examples from survey responses that best described the implementation progress as it related to each action.

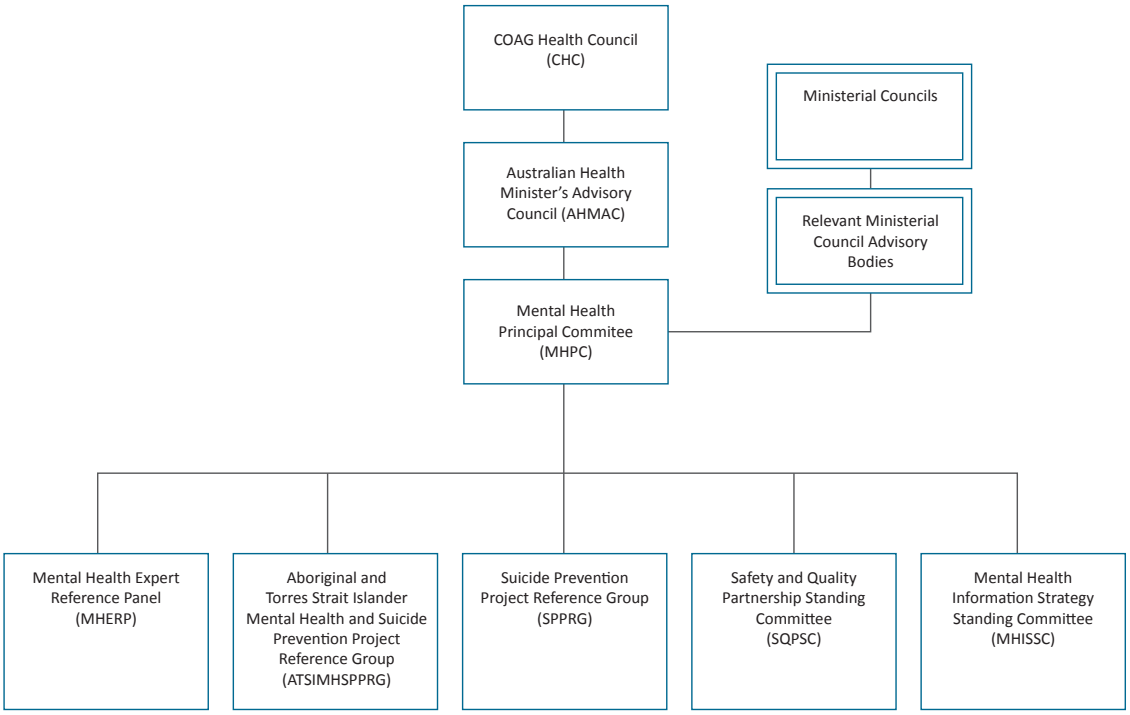
Fifth Plan implementation progress – survey results

Governance

Governance arrangements for the Fifth Plan have been designed to assist the COAG Health Council to deliver on improved outcomes. These arrangements (Figure 1) provide the appropriate authority to implement actions; include mechanisms to receive appropriate advice from members of the Australian community who understand the impact of mental illness and suicide and how best to address it and; recognise the important contribution of consumers and carers.

As reported in the 2018 Progress Report, all governance arrangements to oversee the implementation of the Fifth Plan are now well established. In light of this achievement, the NMHC sought an update from the MHPC on the activities of these committees.

Figure 1: Governance arrangements



ACTION i:

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

The MHERP has met three times and provided status reports to the MHPC following each meeting.

ACTION ii:

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

The Suicide Prevention Project Reference Group has met regularly and drafted the National Suicide Prevention Implementation Strategy, which has been considered by the MHPC at regular intervals.

ACTION iii:

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

The Chair of the ATSIMHSPPRG resigned in early 2019, and a new Chair has only recently been recruited. This change resulted in a delay in progressing the work of the ATSIMHSPPRG.

As a new Chair has been recruited, the NMHC hopes that the work of the group can now be progressed without further delay.

ACTION iv:

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

This action requires the MHPC to undertake a review of the National Mental Health Policy. Secretariat support will be provided by the Australian Government Department of Health, and the MHERP will provide advice to the MHPC on the renewal of the National Mental Health Policy.

The MHPC reported that it deferred commencing work on the renewal of the National Mental Health Policy in 2018 as a result of other national activities being progressed, such as the Productivity Commission Inquiry into the social and economic benefits of improving mental health and the development of the Vision 2030: a blueprint for mental health services. In March 2019, the MHPC agreed to the development of a project plan to implement this action, and supported the direction of the project proposal at its meeting in June 2019.

The NMHC understands that a working group to lead the renewal of the National Mental Health Policy has recently been established by the MHPC.

The MHPC, on behalf of the Coordination Point of this action, the AHMAC, reported that overall progress of this action is 'commenced – not on track'.

Table 2: Governance – overview of progress

Action	Status	Coordination Point	Milestone date in Implementation Plan
i	Complete	MHPC	December 2017, first meeting before June 2018.
ii	Complete	MHPC	First meeting mid-2018.
iii	Complete	MHPC	First meeting mid-2018.
iv	Commenced – not on track	AHMAC (progress reported by the MHPC)	Commence January 2018, completed December 2020.

Measuring and reporting on change

All governments are committed to working together to achieve outcomes in the eight priority areas of the Fifth Plan over the life of the plan and beyond. Reporting on the progress of mental health reform is essential in order to know that the commitments in the Fifth Plan are being honoured and are making a difference.

Stakeholders responsible for coordinating this area are the MHPC, the AHMAC and the MHISSC. Stakeholders responsible for implementing this area are the Australian Government Department of Health, the NMHC, and the MHISSC.

ACTION v:

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

This action requires the Australian Government Department of Health to negotiate with the NMHC about the delivery of an annual report. The NMHC will consult with jurisdictions on agreed data and reporting processes.

The NMHC presented the 2018 Progress Report, accompanied by case studies and a performance indicators workbook, to the COAG Health Council in October 2018. The NMHC has earlier provided the 2018 Progress Report to the MHPC.

Following a review of the processes for development of the annual report, the NMHC established the FPTAG (see 'Methodology' for further details), with representatives from each jurisdiction nominated by MHPC members.

As the Coordination Point for this action, the MHPC is satisfied with the NMHC's approach to consultation with jurisdictions, and that data from states and territories is provided as requested to enable the NMHC to fulfil its monitoring and reporting role. The NMHC also works with the MHISSC to report on the Fifth Plan performance indicators. The MHISSC reported that 18 of 24 indicators have been specified, and that work on the remaining indicators is ongoing.

ACTION vi:

Governments will evaluate the Fifth Plan, commencing in the final year of the Plan, to inform future directions in mental health policy.

This action requires the Australian Government Department of Health to commission an independent evaluation of the Fifth Plan. It will include the development of an evaluation plan that will be cleared through the MHISSC. The contracted provider will be required to consult with the MHISSC, the SQPSC, the NMHC and other key stakeholder on the development of the evaluation plan.

Although the evaluation of the Fifth Plan is not due for completion until June 2022, an evaluation is required to be commissioned, and an evaluation plan cleared through the MHISSC, by December 2018. The Australian Government Department of Health reported that it has not yet agreed to an evaluation plan, as a result of resourcing and capacity issues during 2018–19.

The NMHC notes the delay towards the development of an evaluation plan. Given the requirement for engagement with multiple stakeholders to develop the plan and that the Fifth Plan is now entering its third year of implementation, the NMHC urges the Australian Government to commence this action to prevent further delays.

The MHPC, on behalf of the Coordination Point of this action, the AHMAC, reported that overall progress of this action is 'yet to commence'.

ACTION vii:

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

This action is being implemented and report against under Action 24.

Table 3: Measuring and reporting on change – overview of progress

Action	Status	Coordination Point	Milestone date in Implementation Plan
v	Commenced – on track	MHPC	Negotiations commence January 2018 and implementation will be ongoing
vi	Yet to commence	AHMAC (progress reported by the MHPC)	Evaluation plan agreed December 2018. Evaluation completed June 2022
vii	Commenced – on track (as per Action 24)	MHISSC	Published by December 2018

Priority Area 1: Achieving integrated regional planning and service delivery

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

In the context of the Fifth Plan, integration is concerned with building relationships between organisations that have similar aims in improving the outcomes and experiences of consumers and carers. Integration can be implemented at different levels, but integration at any level can deliver better experiences and outcomes for consumers and carers.

Stakeholders responsible for coordinating the actions under this priority area are the MHPC, the NMHSPF Steering Committee, the MHISSC and the AHMAC. Stakeholders responsible for implementing the actions under this priority area are the Australian Government Department of Health, state and territory governments, PHNs and the MHERP.

ACTION 1:

Governments will support integrated planning and service delivery at the regional level by:

ACTION 1.1:

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

This action requires the Australian Government Department of Health and state and territory governments to direct PHNs and LHNs to jointly develop and release regional mental health and suicide prevention plans.

All state and territory government health departments, with the exception of Western Australia (see Box 3), reported that they have directed LHNs to jointly develop regional plans with PHNs for public release. In addition, the Australian Government Department of Health reported that all PHNs have been contracted to develop plans with LHNs by mid-2020. In Western Australia, the WA Primary Health Alliance (WAPHA) (which oversees the commissioning functions of the three Western Australian Primary Health Networks) are developing joint regional plans, beginning with a foundational plan – a blueprint for shared decision making for mental health service development across the state. The WAPHA are working together with LHNs (Western Australian Department of Health and individual Health Service Providers) as well as the Western Australian Mental Health Commission to establish strong state-based regional plans (metropolitan region and country Western Australia).

States and territories reported that they have completed this action via mechanisms such as regional plan working groups, coordination committees, and close engagement with PHNs and LHNs (including data sharing agreements).

The Coordination Point of this action, the MHPC, rated overall progress as 'commenced – on track'.

Box 3: Mental health care in Western Australia

Unlike the NMHC, and other state-based mental health commissions, the Western Australian Mental Health Commission purchases mental health services for the state. In this way, the Western Australian Mental Health Commission has a similar function to state and territory government health departments as they fund mental health services within their jurisdiction.

The Western Australian Mental Health Commission has a unique role in commissioning, providing and partnering in the delivery of prevention, promotion and early intervention programs; treatment services and supports; and research policy and system improvements. This means that it is responsible for implementing the same Fifth Plan actions as state and territory governments (in most cases). For this reason, throughout this report the Western Australian Mental Health Commission is named alongside state and territory governments (including the Western Australian Department of Health) as Implementers of particular actions.

ACTION 1.2:

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

This action requires governments to jointly develop and release guidance material for a single regional plan that will cover scope, timeframes, governance arrangements, consultation processes and requirements for government endorsement.

The Integrated Regional Planning Working Group, established by the MHPC, is leading this activity. The Integrated Regional Planning Working Group includes representatives of all states and territories, the ATSIMHSPPRG, and a PHN representative. Responses from a number of state and territory health departments however, also focused on local approaches (through regional networks and steering committees) to guiding and informing regional mental health and suicide prevention plans.

The Australian Government Department of Health reported that *Joint regional planning for integrated mental health and suicide prevention services: a guide for Local Health Networks and Primary Health Networks* (Guide for Joint Regional Planning) was published on its website in October 2018. Before its release, the guide was endorsed by the MHPC.

The Guide for Joint Regional Planning is a resource document for PHNs and LHNs to use when undertaking joint regional planning. PHNs and LHNs are required to prepare joint regional plans and to make these publicly available. The Guide for Joint Regional Planning recognises that some PHNs and LHNs are more advanced than others in terms of joint regional planning, and acknowledges the valuable efforts that are already underway.

The Guide for Joint Regional Planning also tackles several fundamental issues relating to the context for developing the regional plans.

The Coordination Point of this action, the MHPC rated overall progress as 'commenced – on track'.

ACTION 1.3:

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

This action requires governments to agree on the process for the ongoing refinement, application and resourcing of the NMHSPF. The Australian Government Department of Health is also expected to manage contractual arrangements with an expert provider for the ongoing development of the NMHSPF.

The NMHSPF Steering Committee, managed by the Australian Government Department of Health, is responsible for coordinating and implementing this action.

The NMHSPF Steering Committee reported that the University of Queensland has been contracted to further develop the NMHSPF. This project commenced in March 2018 and is due to be completed in March 2021. Within the first year of the project, the University of Queensland conducted four streams of work:

- revising the overall epidemiology to incorporate the latest evidence
- refining the epidemiology and service modelling for Aboriginal and Torres Strait Islander people, and rural and remote populations
- scoping the epidemiology for transcultural populations
- scoping the feasibility of national epidemiology and service modelling for forensic populations.

The Australian Government Department of Health manages the contract with the University of Queensland for the ongoing development of the NMHSPF. Costs for this contract are shared between the Australian Government Department of Health and state and territory governments.

As the Coordination Point for this action, the NMHSPF Steering Committee rated the progress of this action as 'commenced – on track'.

ACTION 1.4:

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

This action requires governments to agree on licensing arrangements or agreements, and for the Australian Government Department of Health to issue licences to authorised users of the NMHSPF. The Australian Government Department of Health is also required to release planning tools and support materials, and lead the provision of training to be provided by a contracted expert provider.

The NMHSPF Steering Committee, managed by the Australian Government Department of Health, is responsible for coordinating and implementing this action.

Key activities towards the implementation of this action in the past 12 months included:

- 29 of 31 PHNs signing license agreements and being provided with copies of the NMHSPF
- more than 200 licensed users across PHNs and LHNs (and their state and territory equivalents) using the NMHSPF – Planning Support Tool to develop integrated regional mental health plans
- establishing the NMHSPF Super User Network to enable members to work together to support the use and improve understanding of the NMHSPF–Planning Support Tool
- developing plans for a revised training program
- revising the licensing and accessibility of the tool to enable broader access for organisations with a legitimate need to use the NMHSPF–Planning Support Tool for integrated regional planning and service delivery
- the Productivity Commission Inquiry into the social and economic benefits of improving mental health and the Royal Commission into Victoria's Mental Health System using the NMHSPF–Planning Support Tool to publish their analyses.

Governments have also developed and released planning tools based on the NMHSPF, by transferring the NMHSPF and the NMHSPF–Planning Support Tool from Excel to a more stable and user-friendly Tableau web-based system. The NMHSPF–Planning Support Tool version 1.1 was released in Tableau in March 2019. By mid-May 2019, analytics showed approximately 200 logins to the Tableau Planning Support Tool by almost 100 users from more than 50 organisations across Australia.

As the Coordination Point for this action, the NMHSPF Steering Committee rated the progress of this action as 'commenced – on track'.

ACTION 1.5:

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

This action requires governments to contribute relevant data for the development of regional data.

Local-level data tables have been published on Mental Health Services in Australia for community mental health, residential mental health, emergency departments and restrictive practices. Local-level tables for admitted patient mental health care are expected to be released in October 2019. Data tables for the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme are currently under development and are expected to be released in 2020.

As the Coordination Point for this action, the MHISSC reports that all governments have contributed to the development of regional data reporting.

ACTION 2:

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

ACTION 2.1:

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

This action requires governments to use existing agreements to facilitate a coordinated approach to regional planning and service delivery.

All governments reported that they have been using existing agreements to facilitate this action. This includes use of a bilateral agreement between the Australian Government Department of Health and a state government for coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services (Department of Health Tasmania), the National Psychosocial Support Measure (ACT Health Directorate and NSW Health), and the Way Back Support Service (ACT Health Directorate). Governments also reported the use of a memorandum of understanding (between the Western Australian Mental Health Commission and the Western Australian Primary Health Alliance), and a cross-funders collaboration group (Northern Territory Department of Health) to facilitate coordinated approaches to service planning and delivery.

A number of state and territory governments also report strong collaboration with PHNs through co-commissioning of services (ACT Health Directorate and NSW Health), working to ensure that integrated planning and service delivery at the regional level is aligned with existing bilateral agreements such as Care Coordination and the National Psychosocial Support Measure (Department of Health and Human Services Victoria), and providing resources to support Health and Hospital Services to work with PHNs (Queensland Health).

The Northern Territory Department of Health reported that there are currently no formal agreements in place between the department and the Northern Territory PHN. Efforts are currently underway to further negotiate and reach a data sharing agreement.

The MHPC, on behalf of the Coordination Point of this action, the AHMAC, reported that overall progress of this action is 'commenced – on track'.

ACTION 2.2:

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

This action requires PHNs and LHNs to work collaboratively to engage regional stakeholders in the regional planning and service delivery process. Governments are required to strengthen existing partnerships with stakeholders to engage the local community, while the MHERP will provide advice to governments on strategies to maximise this engagement.

The majority of PHNs reported organised and systemic approaches to engaging with the local community. This included direct engagement with consumers and carers, community-managed organisations, Aboriginal Community Controlled Health Services (ACCHSs), NDIS providers, the National Disability Insurance Agency (NDIA), social service agencies and private providers. PHNs also reported engaging in strategic consultation and partnerships with LHNs, mental health alliances and service providers. Approximately one-third of PHNs also reported engaging with local communities through co-design processes.

State and territory governments reported ongoing engagement directly with LHNs (and their equivalents) and PHNs through various governance structures (Western Australian Mental Health Commission, Department of Health Tasmania, Queensland Health, NSW Health and Northern Territory Department of Health). Collaborations across major planning and development activities were also reported, including implementation of the LifeSpan Suicide Prevention Framework (ACT Health Directorate), and joint consultation and engagement activities across the sector to inform a tailored approach to regional planning (Department of Health and Human Services Victoria) and a draft Suicide Prevention Action Plan 2020–2025 (Western Australian Mental Health Commission). SA Health reported that progress towards strengthening existing partnerships with stakeholders to engage with the local community is at the very early stage of development.

The MHERP reported the provision of advice to government on engagement strategies through its revision of the draft Guide for Joint Regional Planning before its endorsement by the MHPC.

The MHPC, on behalf of the Coordination Point of this action, the AHMAC, reported that overall progress of this action is 'commenced – on track'.

ACTION 2.3:

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

This action requires PHNs and LHNs to work towards data sharing to map regional service provision, and identify areas of duplication, inefficiency and service gaps. PHNs and LHNs will use the NMHSPF and other planning tools to facilitate this regional needs assessment and planning.

The majority of PHNs reported that they have been working with LHNs to undertake a regional needs assessment, with the exception of Adelaide PHN and Murray PHN, which are yet to commence this activity. Murray PHN reported that it plans to commence a shared regional needs assessment with LHNs to identify service gaps, duplications and inefficiencies as part of its regional mental health and suicide prevention planning process. Adelaide PHN reported that, although it has undertaken a needs assessment for the Adelaide metropolitan region, and SA Health has undertaken its own analysis in individual LHN regions using the NMHSPF, joint activity in this space is yet to occur.

Of the PHNs that reported progress in this area, many specified working groups, planning days and consultations as key mechanisms for collaboration. Data sharing agreements in particular, as well as informal commitments to share data, were reported as critical for successful joint regional needs assessments. However, not all PHNs are reporting success in this area. Capital Health Network (ACT PHN) described consistent challenges around data sharing and transparency, with key stakeholders reluctant to commit to formal data sharing agreements, or provide relevant data to the PHN.

Although 29 of the 31 PHNs have signed licence agreements and have been provided with copies of the NMHSPF, not all PHNs are able to use it consistently in its current form. Six PHNs reported that they have not used the NMHSPF, opting to use other tools instead. These PHNs reported that they were unable to use the tool as a result of its inapplicability to rural and remote populations (Country SA PHN and Western NSW PHN) and Aboriginal and Torres Strait Islander populations (Western NSW PHN and Northern Queensland PHN), as well as staff turnover in those trained in using the tool (Brisbane South PHN and Northern Queensland PHN). Additionally, South East Melbourne PHN reported that, despite using the NMHSPF in early stages of planning they have since developed a series of population health models to use instead. Although Hunter New England and Central Coast PHN has previously used other analytics tools for needs assessments, it intends to use the NMHSPF in conjunction with other data sources to inform its joint regional mental health and suicide prevention plan.

It is important to note that although other PHNs are using the NMHSPF, the framework still has a number of limitations. These limitations are consistent with those described above. A number of PHNs reported that use of the framework for assessing the needs of their region has been restricted by the framework's inapplicability to rural and remote populations (Northern Territory PHN and South Eastern NSW PHN), Aboriginal and Torres Strait Islander populations (South Eastern NSW PHN), and populations that are small in size (South Eastern NSW PHN) or experiencing rapid growth (North Western Melbourne PHN). Furthermore, PHNs reported that the lack of training opportunities (Gold Coast PHN and South Western Sydney PHN) and lack of staff trained to use the tool (Eastern Melbourne PHN) have impeded their ability to use the tool effectively.

The NMHC notes that these limitations are currently being addressed through the ongoing development of the NMHSPF by the University of Queensland (under Action 1.3).

As the Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track'. Additional commentary provided by the MHPC noted that governments have instituted several initiatives to support joint regional planning through high-level state and regional meetings.

ACTION 2.4:

Examining innovative funding models, such as joint commissioning of services and fund pooling for packages of care and support, to create the right incentives to focus on prevention, early intervention and recovery.

This action is not scheduled to commence until mid-2020.

ACTION 2.5:

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

This action requires PHNs and LHNs to jointly develop comprehensive regional mental health and suicide prevention plans. These plans should cover the lifespan — from children, through young adults and to older people. PHNs and LHNs will use these plans to progressively guide service development and commissioning.

PHNs described strong engagement and collaboration with LHNs (or their regional equivalent) in jointly developing their regional mental health and suicide prevention plans. This collaboration occurred via a number of mechanisms, including joint governance structures (Gold Coast PHN, Nepean Blue Mountains PHN and Western Victoria PHN), steering committees and working groups (South Eastern NSW PHN, South Western Sydney PHN, Western Sydney PHN, Capital Health Network (ACT PHN), Darling Downs and West Moreton PHN, Northern Sydney PHN, Nepean Blue Mountains PHN, Central and Eastern Sydney PHN, Eastern Melbourne PHN and Murrumbidgee PHN), collaborative frameworks (Nepean Blue Mountains PHN and Central Queensland, Wide Bay and Sunshine Coast PHN), suicide prevention networks (North Coast PHN and North Western Melbourne PHN), and memoranda of understanding (Gippsland PHN and WA Primary Health Alliance).

PHNs also reported working with LHNs through co-design processes to inform service development (Gold Coast PHN), regional planning (Northern Territory PHN) and workshops and events to develop goals and actions for implementation (Eastern Melbourne PHN).

The Implementation Plan specifies that comprehensive plans are to be delivered by mid-2020. However, the Guide for Joint Regional Planning recognises that for PHN and LHN regions that are faced with complications to joint regional planning, such as particular geographic challenges to traditional planning approaches or tools, or where the two or more organisations need to further develop their working arrangements on mental health and suicide prevention, it may be more appropriate to publicly release a foundational joint regional plan by mid-2020, and commit to publishing a comprehensive joint regional plan by mid-2022. The Guide for Joint Regional Planning encourages regions that have the pre-existing capacity and partnerships required for joint regional planning to publish a comprehensive regional plan by mid-2020, and it appears that some PHNs are on track to release their comprehensive plans by this milestone date.

As of the time of reporting, Brisbane North PHN, Brisbane South PHN, Country SA PHN, South Eastern NSW PHN, Darling Downs and West Moreton PHN, Nepean Blue Mountains PHN, and Western Queensland PHN have all developed their foundational regional plans.

The remaining 24 PHNs reported that they are progressing as expected with their regional planning, with the exception of Hunter New England and Central Coast PHN, which has not commenced this activity. It is expected that progress towards the development of their joint regional mental health and suicide prevention plan will commence shortly.

As the Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track', noting that some regional plans are more developed than others. The MHPC also noted that governments released the Guide for Joint Regional Planning in October 2018, under Action 1.2.

ACTION 2.6:

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

This action requires regional plans (as developed by PHNs and LHNs under Action 2.5) to make best use of existing and emerging technology, and digital mental health services within an integrated, stepped care approach.

PHNs have been using a range of digital technologies to improve access to mental health and suicide prevention treatments and supports. This includes promoting the use of local and national online mental health resources such as Head to Health (Gold Coast PHN; Brisbane South PHN; Central Queensland, Wide Bay and Sunshine Coast PHN; Darling Downs and West Moreton PHN; Western Queensland PHN; and South Eastern NSW PHN), My Health Record (Gold Coast PHN; Brisbane South PHN; WA Primary Health Alliance; Central Queensland, Wide Bay and Sunshine Coast PHN; North Coast PHN; and Western Queensland PHN), and MyMentalHealth (Brisbane North PHN).

Other digital platforms adopted by PHNs include Clevertar, an evidence-based self-help app for people experiencing anxiety or depression (South Eastern NSW PHN, Western Sydney PHN, Northern Sydney PHN and Western NSW PHN), the Recovery Point app to help people find the right mental health services in their region (South Western Sydney PHN), Beyond Blue's Beyond Now Safety Planning App (North Coast PHN), the Stay Strong e-mental health and wellbeing app for Aboriginal and Torres Strait Islander communities (Western Queensland PHN).

To support primary care clinicians in providing appropriate treatment for mental illness and suicidality, PHNs have introduced a number of digital tools and resources. These include the Black Dog Step Care Platform in general practices, which provides tablet-based screening for anxiety, depression and risky drinking in general practitioner (GP) waiting rooms (Northern Sydney PHN; Central Queensland Wide Bay and Sunshine Coast PHN; and Central and Eastern Sydney PHN); the RediCase client information management system to connect patients to the most appropriate services using a stepped care approach (Central and Eastern Sydney PHN; Brisbane North PHN; Brisbane South PHN; and Northern Queensland PHN); refeRHEALTH, a client referral and information management system linking clients to mental health and psychosocial supports (Darling Downs and West Moreton PHN); and HealthPathways, a live online portal for GPs and health professionals to access clinical assessment, management and referral information to use at the point of care (Northern Sydney PHN; Northern Territory PHN; Eastern Melbourne PHN; Darling Downs and West Moreton PHN; WA Primary Health Alliance; and Central and Eastern Sydney PHN).

PHNs also continue to commission telehealth services for aged people living at home or in residential aged care facilities (Murray PHN), and for people who live in remote regions (Country SA PHN, Darling Downs and West Moreton PHN and Northern Queensland PHN).

A small number of PHNs reported that due to the early development stage of their regional plans, digital health and technology strategies have not yet been considered for inclusion (Tasmania PHN, Adelaide PHN, Capital Health Network (ACT PHN) and Hunter New England and Central Coast PHN) or are currently in the early planning stages (Nepean Blue Mountains PHN, Western Victoria PHN and South Eastern Melbourne PHN).

As the Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track'.

ACTION 2.7:

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

This action requires PHNs and LHNs to work towards integrating existing bilateral agreements and broadening these to be regional in coverage. The new agreements will be developed to ensure the engagement of all relevant service providers. The MHERP will provide advice to the MHPC on mechanisms to improve integration, including best-practice approaches to shared care, triage and information sharing.

The majority of PHNs reported the use of new or existing regional agreements to improve integration and assist consumers and carers to navigate the system. These mechanisms included partnership groups (Brisbane North PHN), partnership protocols (Brisbane South PHN), partnership agreements (Northern Territory PHN) working groups (WA Primary Health Alliance), collaborations (Eastern Melbourne PHN and Western NSW PHN), alliances (Murrumbidgee PHN) and joint governance arrangements (Nepean Blue Mountains PHN).

PHNs also described investments in referral services (North Coast PHN; Hunter New England and Central Coast PHN; Central Queensland Wide Bay and Sunshine Coast PHN; and Northern Queensland PHN) and the HealthPathways platform (as discussed under Action 2.6) to support health professionals with referral and care pathways (Brisbane North PHN; Country SA PHN; Brisbane South PHN; South Eastern NSW PHN; Capital Health Network (ACT PHN); Nepean Blue Mountains PHN; North Western Melbourne PHN; Murray PHN; and Western Queensland PHN).

Tasmania PHN, Adelaide PHN, Gippsland PHN, South Eastern Melbourne PHN, Central and Eastern Sydney PHN and Western Victoria PHN reported that they do not currently have regional agreements in place. These PHNs expect to establish agreements during the process of developing their regional mental health and suicide prevention plans, with Tasmania PHN and South Eastern Melbourne PHN forming governance groups to progress this action. In addition, Gippsland PHN and Western Victoria PHN reported that a number of initiatives are already in place to improve integration, such as the HealthPathways platform discussed above.

As the Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track'. The MHPC also noted that members of the MHERP were involved in the review and development of the Guide for Joint Regional Planning as described under Action 1.2.

ACTION 2.8:

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

This action requires PHNs and LHNs to jointly develop shared clinical governance mechanisms to ensure that the service pathways established, and the services commissioned across the system, are clinically appropriate.

PHNs described the use of clinical governance working groups, committees, councils and frameworks to facilitate the development of regional shared care pathways, referral mechanisms and quality processes (Tasmania PHN; Central Queensland, Wide Bay and Sunshine Coast PHN; Northern Queensland PHN; Eastern Melbourne PHN; South Western Sydney PHN; Western Sydney PHN; Nepean Blue Mountains PHN; North Coast PHN; Northern Territory PHN; Northern Sydney PHN; Central and Eastern Sydney PHN; Murray PHN; and Murrumbidgee PHN). A number of PHNs reported that these shared clinical governance mechanisms will be developed as a component of their regional mental health and suicide prevention plans (Gippsland PHN; South Eastern NSW PHN; North Western Melbourne PHN; Hunter New England and Central Coast PHN; and Western NSW PHN).

Brisbane North PHN, Adelaide PHN and Brisbane South PHN reported that activity in this area is yet to commence. Reasons for this include the need to identify joint activities (Brisbane South PHN), the need to establish shared governance arrangements (Adelaide PHN) and the need for more guidance to understand expectations (Brisbane North PHN).

As the Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track'.

Priority Area 1: Achievements and enablers

The stakeholders responsible for implementing Priority Area 1 reported a number of achievements. These included:

- **Establishing strong and meaningful relationships with key stakeholders.** PHNs reported strong engagement with state governments (Tasmania PHN, Northern Territory PHN and Darling Downs and West Moreton PHN), LHNs (Gippsland PHN, Brisbane South PHN, Eastern Melbourne PHN, Darling Downs and West Moreton PHN, Nepean Blue Mountains PHN, Central and Eastern Sydney PHN and Murrumbidgee PHN), state mental health commissions (WA Primary Health Alliance), and mental health alliances or agencies (Darling Downs and West Moreton PHN).
- **Developing new partnerships and initiatives.** This includes the establishment of a state-wide formal postvention referral mechanism in South Australia (Country SA PHN with Adelaide PHN and other stakeholders), the national PHN Regional Planning Network (co-chaired by South Western Sydney PHN and South Eastern Melbourne PHN) and the Northern Beaches Suicide Response Working Group (Northern Sydney PHN). PHNs have also co-funded projects to extend mental health care in remote and under-serviced areas (Northern Queensland PHN), co-funded place-based suicide prevention trial sites (Western Victoria PHN with the Department of Health and Human Services Victoria) and developed joint-resourcing agreements (Northern Territory PHN with the Northern Territory Government).
- **Utilising the NMHSPF to plan for services.** Western Victoria PHN reported investing in training and application of the NMHSPF to assist with planning services based on expected prevalence rates, allocating funding across a stepped care model, distributing program funding across four regions in western Victoria and identifying systemic interfaces to analyse integration opportunities. Queensland Health reported 41 licensed users of the NMHSPF across Hospital and Health Services and the Queensland Department of Health. The Department of Health Tasmania has partnered with Tasmania PHN to co-commission the University of Queensland to undertake a system-wide mapping exercise (as described under Action 1.3) to identify gaps and duplication across the spectrum of services in mental health and suicide prevention. The outputs of this project will inform Tasmania's integrated regional mental health and suicide prevention plan.

State and territory governments reported data sharing protocols and collaborative engagements with PHNs and LHNs as enablers to progress in this priority area.

Priority Area 1: Barriers

Barriers to achieving integrated regional planning and service delivery that were reported by stakeholders are listed below. Although strong partnerships and use of the NMHSPF were reported as achievements for a number of stakeholders, these presented challenges and were barriers to progress for others:

- **Limitations of the NMHSPF.** As described under Action 2.3, PHNs reported that the NMHSPF is limited in its application to regional populations and requires training to use effectively. This has resulted in reliance on other methodologies for needs assessments and evidence-informed planning (Northern Territory PHN). The recent transfer of the framework from an Excel platform to Tableau has also highlighted a need for further training (Queensland Health). Turnover of staff trained in the use of the framework and the lack of training opportunities have presented significant challenges for some PHNs (Brisbane South PHN, Brisbane North PHN, and Gold Coast PHN).
- **Lack of funding, resources and time to support integrated regional planning and service delivery.** Almost one quarter of PHNs (Central Queensland, Wide Bay and Sunshine Coast PHN; South Eastern NSW PHN; Northern Queensland PHN; Eastern Melbourne PHN; Western Sydney PHN; Northern Territory PHN; and Darling Downs and West Moreton PHN) reported a lack of funding, available resources and sufficient time to implement specific actions, including the development of a joint regional plan.

- **Managing competing priorities of multiple stakeholders.** PHNs reported challenges in managing the competing priorities, overarching policies, differing funding arrangements and workforce requirements that exist between multiple stakeholders at both the state and Australian Government level (Gold Coast PHN, Tasmania PHN, WA Primary Health Alliance, Western Sydney PHN and Central and Eastern Sydney PHN). The Western Australian Mental Health Commission noted a lack of coordination between state and federal government-led suicide prevention services – particularly in the Kimberley region where there is significant Australian Government activity.
- **Meaningful engagement with stakeholders.** Some PHNs reported a perceived lack of commitment by stakeholders to progress the development of integrated regional plans. Barriers to progress included the consistency and level of representation by state and territory governments at steering committee meetings (Adelaide PHN and the Capital Health Network (ACT PHN)), resistance to change from health care providers (North Coast PHN), and internal restructures in government (Brisbane South PHN).
- **Access to data.** A small number of PHNs reported complexities regarding privacy, governance and security (Gold Coast PHN and North Coast PHN), as well as difficulties in accessing region-specific data (Nepean Blue Mountains PHN and Western Sydney PHN) and the lack of region-specific data for vulnerable populations (Western Sydney PHN).

Table 4: Priority Area 1 – overview of progress

Action	Status	Coordination Point	Milestone date in Implementation Plan
1.1	Commenced – on track	MHPC	Progressively from December 2017.
1.2	Commenced – on track	MHPC	Completed mid-2018.
1.3	Commenced – on track	NMHSPF Steering Committee	December 2017.
1.4	Commenced – on track	NMHSPF Steering Committee	Progressively to June 2018.
1.5	Commenced – on track	MHISSC	Completed June 2018.
2.1	Commenced – on track	AHMAC (progress reported by the MHPC)	Commencing early 2018.
2.2	Commenced – on track	AHMAC (progress reported by the MHPC)	Commencing early 2018.
2.3	Commenced – on track	MHPC	Progressively from June 2018.
2.4	Not scheduled to commence until mid-2020	MHPC	Commencing mid-2020.
2.5	Commenced – on track	MHPC	Commencing late 2017. Completed mid-2020.
2.6	Commenced – on track	MHPC	Commencing 2017. Completed mid-2020.
2.7	Commenced – on track	MHPC	Mid-2021.
2.8	Commenced – on track	MHPC	Mid-2021.

The majority of actions for achieving integration of regional planning and service delivery were reported as 'commenced – on track'. This is particularly significant given the complexity of this priority area.

The development and release of Guide for Joint Regional Planning in October 2018 is particularly important as the guidance will enable PHNs and LHNs to ensure that Fifth Plan priority areas (specifically priority areas 2, 3, 4 and 5) are considered in their regional mental health and suicide prevention plans.

The work currently underway by the University of Queensland (commissioned by the Australian Government Department of Health) to address the limitations of the NMHSPF – Planning Support Tool for rural, remote and Aboriginal and Torres Strait Islander populations is intended to result in wider use of the tool. This is particularly significant given that a number of stakeholders reported limitations of the tool across priority areas 1, 3 and 8 in the 2018 Progress Report. The Australian Government has recognised the limitations of the tool, and addressing these limitations will increase the tool's ability to be used consistently across jurisdictions.

Consistent with the 2018 Progress Report, the PHNs report a lack of funding and resources needed to support integrated regional planning and service delivery. They report this as being a significant barrier to progress. PHNs describe regional planning as a complex and resource-intensive exercise that would particularly benefit from additional staff to lead the process, as well as funding to develop initiatives to support integrated regional service planning and delivery.

The NMHC notes that Action 2.5 of the Implementation Plan requires PHNs and LHNs to develop comprehensive regional plans by mid-2020. However, there appear to be variations across PHNs as to when this action will be delivered. Some PHNs reported that they expect to release a foundational plan by mid-2020, with comprehensive plans not expected until 2022. This is consistent with the Guidance for Joint Regional Planning released on the Australian Government Department of Health website, but not with the milestone date specified in the Implementation Plan.

The majority of stakeholders reported strong engagement across the sector. However, a small number of PHNs reported a lack of engagement by state and territory governments, and LHNs, as significant barriers to progress. The NMHC notes that the Fifth Plan marks the first time that all governments have committed to working together to achieve integration in planning and service delivery at the regional level. For this reason, it is not surprising that some stakeholders have experienced difficulties in clarifying the roles, responsibilities and expectations involved in implementing this reform. Given that the implementation of the Fifth Plan has completed its second year, however, the NMHC hopes that these difficulties can be resolved promptly, and that stakeholders can work together to successfully implement Priority Area 1 of the Fifth Plan.

Case study 1: Achieving integrated health systems by regional collaboration

North Coast Collective is a regional collaboration between North Coast PHN, the Mid North Coast Local Health District and the Northern NSW Local Health District. The North Coast Collective is currently focused on planning and delivering a range of services that will improve the lives of people living with mental illness and alcohol and other drug issues. The North Coast Collective's work will be driven by the shared regional strategy and be informed by system dynamics and investment optimisation modelling.

To guide investment optimisation in the future, the North Coast Collective is engaging with government, non-government organisations, Aboriginal and Torres Strait Islander community members, people with lived experience, and consumers and carers. Through shared investment and making joint decisions, North Coast PHN, Mid North Coast Local Health District and Northern NSW Local Health District will be able to provide an optimal range of services for the community, instead of delivering services in silos.

Improving the lives of people living with mental illness and alcohol and other drug issues was identified by the North Coast community as their highest priority, and is therefore the first area of focus for the North Coast Collective. During the next phases, membership of the North Coast Collective will expand to include partners outside the health sector to deliver a regional strategy that considers all the known social determinants of health.

In another example, Murrumbidgee PHN has established the Murrumbidgee Mental Health Drug and Alcohol Alliance. The alliance provides a forum for key stakeholders from the health, community and social sectors, and consumers and carers, to develop a strategic approach to meet the mental health, and drug and alcohol needs and expectations of consumers in the Murrumbidgee population.

The principles of the alliance include focusing on consumer outcomes and recognising the value that the community and social sectors contribute to addressing the needs of consumers. Other principles include communicating and working together in a collaborative, open and transparent manner that recognises the values, skills and expertise that members bring to the alliance. The alliance meets monthly to develop, design, and improve services and service delivery while advocating for the consumer in the system. The alliance also ensures appropriate communication of available services to consumers across the Murrumbidgee population.

In direct response to consumer feedback that the service system was considered to be fragmented, complex and difficult to navigate, the alliance implemented the Alliance Service Integration Project. This Project has identified a number of priorities for improvement, including development of an online, interactive mental health and drug and alcohol service map; a common referral and consent form shared across all member agencies; and a consumer-led care and wellness plan app that will be available on consumers' devices and can be shared by the consumer with the agencies they are working with.

Priority Area 2: Suicide prevention

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

The stakeholder responsible for coordinating the actions under this priority area is the MHPC. Stakeholders responsible for implementing the actions under this priority area are the Australian Government Department of Health, and the state and territory governments.

ACTION 3:

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

This action requires the MHPC to establish a suicide prevention subcommittee, and lead the joint development of its terms of reference and membership; followed by the development of a project plan. The terms of reference will include defining the scope, establishing timeframes, outlining governance arrangements and developing a consultation strategy.

The Suicide Prevention Project Reference Group has been established, as reported in the 2018 Progress Report. The MHPC reported that this group has met five times during 2018–19.

As the Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track'.

ACTION 4:

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

This action requires the Suicide Prevention Project Reference Group to lead the development of the National Suicide Prevention Implementation Strategy. The strategy will include a focus on Aboriginal and Torres Strait Islander suicide prevention. A version will be released for public consultation to ensure stakeholder input.

The MHPC reported that the National Suicide Prevention Implementation Strategy for Australia's Health System 2020–2023 has been developed by the Suicide Prevention Project Reference Group. The draft strategy is expected to be presented to the COAG Health Council in November 2019 for endorsement.

As the Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track'.

ACTION 5:

Governments will support PHNs and LHNs to develop integrated, whole-of-community approaches to suicide prevention.

This action requires governments to direct PHNs and LHNs to jointly develop suicide prevention approaches as a discrete component of Actions 1.1 and 10. Governments will jointly develop and provide guidance to PHNs and LHNs on regional approaches to suicide prevention, informed by the systems-based approach outlined in the World Health Organization's (WHO) *Preventing suicide: a global imperative.*

The Australian Government Department of Health reported that it has provided guidance to PHNs on regional approaches to suicide prevention. This guidance, *Regional Planning for Mental Health and Suicide Prevention – a Guide for Primary Health Networks* was released in August 2017. The guide was developed in consultation with a number of PHNs, states and territories, peak bodies, and consumers and carers.

The majority of state and territory governments also reported that they have directed LHNs to work with PHNs to develop a joint approach to suicide prevention. Additionally, these state and territory governments reported strong engagement with LHNs in the development of regional plans, as well as in their suicide prevention activities. This includes the active participation of LHNs in the Integrated Regional Mental Health and Suicide Prevention Plan Steering Committee (Department of Health Tasmania), the provision of briefings to LHNs on the development of joint regional plans (Northern Territory Department of Health and SA Health), and collaboration with LHNs on local suicide prevention initiatives that engage a broad range of community stakeholders (NSW Health).

In the Australian Capital Territory, the ACT Health Directorate is responsible for the stewardship of the health system and is the administrator of the ACT Local Hospital Network. The ACT Health Directorate leads the suicide prevention activities across the ACT, which includes working closely with the Capital Health Network (ACT PHN) to develop a regional plan to co-commission suicide prevention services. Similarly, the Western Australian Mental Health Commission has been working directly with the WA Primary Health Alliance through the WA Primary Health Alliance/ Mental Health Commission Suicide Prevention Working Group. It has also engaged with the WA Primary Health Alliance to identify opportunities for suicide prevention activities involving PHNs and LHNs in the future.

Queensland Health reported that it had not directed LHNs to develop a joint approach to suicide prevention with PHNs because its LHN equivalent – Hospital and Health Services – is already working collaboratively with PHNs to develop joint mental health and suicide prevention plans. This includes collaborative planning and delivery of suicide prevention initiatives in partnership with PHNs.

As the Coordination Point of this action, the MHPC rated progress as 'commenced – on track'. The MHPC also noted that the National Suicide Prevention Implementation Strategy will provide guidance for regional planning when it is released in 2020.

Priority Area 2: Achievements and enablers

The stakeholders responsible for implementing Priority Area 2 reported a number of achievements in suicide prevention activities. These included:

- **Improvements in data access.** The Department of Health and Human Services Victoria reported establishing a memorandum of understanding with the Coroners Prevention Unit to allow regular and timely access to suicide data, and working with key data custodians to improve information provided to health services and PHNs engaged in suicide prevention trials.
- **Provision of training to health providers and the general public.** Training was provided to health providers and the general public by a number of state and territory governments. During the 2018–19 reporting period, 1,680 Queensland Health staff participated in some aspect of the Suicide Risk Assessment and Management in Emergency Department Training Program. Pre- and post-evaluation showed a significant increase in confidence in responding to people at risk of suicide. In addition, 77% of the school-based youth health nurse workforce has been trained in Supporting a Suicidal Young Person (Queensland Health). A number of training activities were achieved in the Australian Capital Territory, including roll-out of Question, Persuade, Refer free online suicide prevention training to the Australian Capital Territory community, in collaboration with the Capital Health Network (ACT PHN). Since its release, more than 350 people have completed the training. The ACT Health Directorate also provided Collaborative Assessment and Management of Suicidality (CAMS) training for mental health professionals. CAMS training will continue to be provided through the ACT LifeSpan trial.
- **Additional funding for suicide prevention activities.** Two state governments received additional funding for suicide prevention activities. The Western Australian Mental Health Commission received a further $8.1 million investment to extend services under the state-based Suicide Prevention 2020 strategy until December 2020. This funding will allow the continued delivery of suicide prevention initiatives in Western Australia, and also facilitate the planning of the next suicide prevention strategy. In October 2018, the New South Wales Premier launched the Strategic Framework for Suicide Prevention 2018–23 and announced a record $87 million investment in suicide prevention initiatives. The Towards Zero Suicides initiative will establish a comprehensive state-wide system of suicide prevention services.

Additional enablers of the successful implementation of this priority area include dedicated positions responsible for driving suicide prevention initiatives (NSW Health), and the agreement by health ministers that suicide prevention should be recognised as a whole-of-government priority (the MHPC).

Priority Area 2: Barriers

No significant or common barriers were identified across stakeholder groups at this stage of implementation.

Implementation of Priority Area 2 is progressing well, with all actions reported as 'commenced – on track'. Of particular significance is the development of the National Suicide Prevention Implementation Strategy. The National Suicide Prevention Implementation Strategy for Australia's Health System 2020–2023 embodies a systems approach to suicide prevention and requires all health ministers to attempt to collaborate with non-health portfolios.

The provision of training to health providers and the local community by state and territory governments, and the additional funding dedicated to suicide prevention are noteworthy, demonstrating the commitment of jurisdictions to invest in suicide prevention activities.

Table 5: Priority Area 2 – overview of progress

Action	Status	Coordination Point	Milestone date in Implementation Plan
3	Commenced – on track	MHPC	December 2017. First meeting early 2018.
4	Commenced – on track	MHPC	Commence 2018. Release of strategy for public consultation by mid-2019. Release of final strategy by 2020.
5	Commenced – on track	MHPC	Commence 2019 and ongoing.

Case study 2: Reducing the impact of suicide by early intervention for the bereaved

As part of the Perth South Suicide Prevention Trial Site, the WA Primary Health Alliance has contributed to the Peel and Rockingham Kwinana Community Postvention Response pilot. This pilot includes support for the immediate family affected by suicide, such as an immediate notification service following a critical incident involving a suspected suicide, ensuring a rapid response and allowing support services to reach out to the family to offer counselling.

The pilot has been achieved through a partnership of government and non-government agencies, groups and community members, and in collaboration with the WA Primary Health Alliance, the Western Australian Police, and the Rockingham Peel Group. The six month pilot builds on a comprehensive postvention plan developed by local agencies in response to several suicides in the Rockingham and Mandurah area in 2016.

During the past year, the postvention plan has allowed local agencies to support a number of families, along with friends and community members.

The recent addition of the immediate notification service and the rapid response means that services can reach out to more people even earlier – offering support in the critical period immediately following a sudden loss. The impact has been immediately identifiable. In the first three months of the immediate notification pilot, 100% of losses by suspected suicide were identified, and families were offered support. The pilot highlights that suicide prevention is everyone's business and that meaningful outcomes can result from better integration.

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

The needs of people with severe mental illness are not homogeneous. Some people have episodic illness. Others have more persistent illness that can reduce their ability to function, experience full physical health or manage the day-to-day aspects of their lives. Some people can be supported through time-limited clinical services in the primary care setting, while others require hospital-based services or some form of community support. Some people are frequent users of the hospital system and have physical illnesses, disabilities or substance use problems that may be untreated or poorly managed.

There are differences in the clinical and community supports that a person needs over time. These can include GPs, services provided through Aboriginal Community Controlled Health Services, medical specialists, allied health providers, housing and employment support, personal carers, and other types of disability services. Despite ongoing efforts by governments and service providers, many people with severe and complex mental illness still do not receive the supports they need.[1]

Priority Area 3 does not have designated Coordination Points for any of its actions. For this reason, the NHMC sought descriptions of progress from the Implementers of each action. Stakeholders responsible for implementing the actions under this priority area are the Australian Government Department of Health and the state and territory governments.

ACTION 6:

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

This action requires the Australian Government Department of Health and state and territory governments to negotiate agreements for psychosocial support services. This action was due for completion by December 2018. As the Implementers of this action, all governments were asked to provide an update on whether these agreements have been finalised.

The Australian Government Department of Health reported that all state and territory governments have signed bilateral agreements for the National Psychosocial Support (NPS) measure. The NPS measure provides psychosocial support services to people with severe mental illness that results in reduced psychosocial functional capacity who are not more appropriately funded through the NDIS. Whilst these bilateral agreements are not currently publicly available, states and territories will report to the Australian Government Department of Health on progress under the bilateral agreements in the 2019–20 financial year.

A new Mental Health Community Support Services program was established in July 2019 by Queensland Health as part of its matched funding for psychosocial supports. Services under this program are integrated between the Hospital and Health Service and contracted non-government providers. The service engages non-government organisations to provide community support services that are complementary to clinical services delivered through the Hospital and Health Service. The program targets the needs of individuals 18 years and over who are experiencing severe and persistent mental illness, and who access public mental health services through the Hospital and Health Service. Services are prioritised for individuals who are ineligible to receive NDIS packages.

The Department of Health and Human Services Victoria reported that Victorian PHNs have now commissioned providers to deliver the Australian Government Department of Health's contribution to the NPS measure. Commissioned services will provide time-limited psychosocial supports to people with a mental illness and psychosocial disability who do not meet the disability requirements of the NDIS.

ACTION 7:

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

This action requires the Australian Government Department of Health to direct PHNs to plan and commission services for people with severe and complex mental illness through PHN funding agreements. The Australian Government Department of Health reported that they have given this directive. In addition, PHNs have been contracted to deliver the NPS measure, and the Continuity of Support program, both of which require PHNs to commission services for people with severe and complex mental illness within their regions.

This action also requires governments to use the joint guidance material (as developed under Action 1.2) to outline their expectations of PHNs and LHNs for coordinated treatment and supports for people with severe and complex mental illness. This guidance will specifically consider the requirements of children and young people with, or at risk of, severe mental illness.

As reported under Action 1.2, the Guide for Joint Regional Planning was released on the Australian Government Department of Health website in October 2018. As noted by the Australian Government Department of Health, regional plans will be expected to prioritise opportunities for collaboration between LHNs and PHNs to develop joint services and pathways that support better outcomes and early intervention for people with severe mental illness. The guidance material includes considerations for planning services aimed at children and young people with severe mental illness.

SA Health noted that it would benefit from further guidance on how coordinated treatment and supports can be achieved (especially where more than one LHN is involved). Although national guidelines are expected to be developed to support improving coordination of treatment and supports for people with severe and complex mental illness (as per Action 9), these guidelines are not scheduled for completion until 2020.

Responses from Queensland Health and NSW Health indicate that the Health and Hospital Services and LHNs in their jurisdictions have found the guidance useful as a source document for facilitating the development of integrated regional plans.

ACTION 8:

Governments will establish a time-limited Mental Health Expert Advisory Group, as identified in the Governance Section of this Plan.

This action requires the establishment of a Mental Health Expert Advisory Group as per Action i. The action also requires this group to be reviewed by the MHPC. This component of the action will not commence until late 2021.

ACTION 9:

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

This action requires the Australian Government Department of Health to lead the joint development of national guidelines, to be endorsed by the AHMAC. This will include consultation with the social services sector.

The Australian Government Department of Health reported that it is yet to undertake a targeted consultation process to inform the development of the guidelines. The terms of reference for the Action 9 working group have been agreed through the MHPC. As at 30 June 2019 membership is still being finalised and the group is yet to meet. It is expected that the Action 9 working group will deliver the guidelines by December 2020.

Priority Area 3: Achievements and enablers

The stakeholders responsible for implementing Priority Area 3 reported a number of achievements. These included:

- **Establishing interface arrangements.** The ACT Health Directorate reported strong interface arrangements between community mental health services, the ACT Ambulance Service and ACT Policing. This includes the introduction of a mental health clinician in the ACT Police Operations Centre, supporting diversion to community-based care, rather than hospital-based care. The Western Australian government has established two Interagency Executive Committees (Adults with Exceptional Complex Needs and Young People with Exceptional Complex Needs) which assist with coordinating and prioritising referrals within their respective agencies and aim to develop a

whole-of-government service delivery response to improve the wellbeing and quality of life for these cohorts.

- **Establishing groups to drive progress.** In South Australia, the establishment of the SA NDIS Psychosocial Disability Transition Task Force and the NDIS Mental Health Implementation Group has facilitated a common understanding and approach to providing psychosocial supports between LHNs, PHNs and the South Australian Government. Additionally, state and territory governments reported working closely with regional stakeholders via an integration taskforce (Department of Health Tasmania), a project control group (Northern Territory Department of Health), and through the development of governance arrangements (Department of Health and Human Services Victoria) to deliver a cohesive and seamless psychological support service system for people with mental illness and psychosocial disability.

Regional and interagency engagement were reported as enablers to progress; two state governments reported that these relationships are critical for the delivery of coordinated treatment and supports for people with severe and complex mental illness.

Priority Area 3: Barriers

Difficulties in accessing the NDIS was reported as a barrier to progress by Queensland Health and NSW Health. Queensland Health reported that the lack of understanding by providers of the psychosocial disability needs of people living with severe and complex mental illness resulted in delays in eligible clients gaining access to the NDIS. These delays have required additional resources from the Queensland Government to ensure continuity of care during the transition to the NDIS.

NSW Health reported that NDIS uncertainty and inconsistencies have delayed access to psychosocial supports for people with severe and enduring mental illness. These delays have increased complexity for Local Health Districts and PHNs and other care providers in coordinating care.

Table 6: Priority Area 3 – overview of progress

Action	Status	Milestone date in Implementation Plan
6	Complete	Commence in 2017. Finalised by the end of 2018.
7	Complete	Completed mid-2018.
8	Part 1 of this action is complete as per Action i, governance.	2019.
	Part 2 of this action is not scheduled to commence until late 2021.	Commence late 2021.
9	Commenced – not on track	Commence in 2018. Release in 2020.

The NMHC notes that no Coordination Points have been named to oversee the implementation of the actions under Priority Area 3. This makes it difficult to rate progress, as there is no overarching committee to coordinate the implementation of each action, and the NMHC must rely on self-reported progress updates from stakeholders. Despite this complexity, the actions under Priority Area 3 appear to be in progress.

The NMHC notes that all state and territory governments have an agreement with the Australian Government Department of Health for psychosocial support services, and that guidance material outlining expectations for coordinated treatment and supports for people with severe and complex mental illness has been provided to LHNs and PHNs. As noted by the South Australian Government, however, there may be a need for further guidance. Although additional guidelines will be developed under Action 9, this action is not scheduled for completion until 2020. The NMHC expects that these guidelines will involve consultation with PHNs to ensure the best possible alignment between current practice and future expectations.

The NMHC acknowledges the complexity of the intersection of the Fifth Plan with the NDIS. Going forward, the NMHC will seek to understand how agreements for psychosocial support services are resulting in outcomes for people living with severe and complex mental illness.

Case study 3: Anticipating change in the psychosocial sector

A recent significant change in the mental health sector was the introduction of the NDIS, and the transition of a number of national psychosocial programs into new psychosocial funding streams. Eastern Melbourne PHN led three large Partners in Recovery programs across east and northeast Melbourne, and took a number of actions in its approach to transition planning.

In 2018 before the transition from Partners in Recovery to the NDIS, the Eastern Melbourne PHN ran a 'psychosocial support pilot'. The pilot enabled consumers to access psychosocial support with a one-to-one worker in addition to the usual service provided by Partners in Recovery. To increase transition success, the pilot also provided an opportunity for the system to retain and build a strong and knowledgeable psychosocial support workforce.

Eastern Melbourne PHN also commenced early transition planning for the new psychosocial support program with neighbouring PHNs: North Western Melbourne PHN and South East Melbourne PHN. The collaboration resulted in early agreement on the psychosocial support specifications, aiding service system consistency for both providers and consumers and carers.

Eastern Melbourne PHN commissioned the Psychosocial Support Service in January 2019, using National Psychosocial Support and Continuity of Service funding. The service is delivered by Neami National. It was important for the Psychosocial Support Service to appear as a single program offering services 'on the ground' to reduce consumer and carer confusion and enhance continuity of care during the transition period.

As a result of this planning approach, in March 2019, Eastern Melbourne PHN was able to respond quickly to the new National Psychosocial Support Transition funding to improve the continuity of care while consumers transitioned into NDIS services. The response included the design and implementation of psychosocial transition supports for consumers who were previously Partners in Recovery, Day to Day Living or Personal Helpers and Mentors Service participants. The service commenced in July 2019.

Eastern Melbourne PHN is currently planning to develop a 'regional psychosocial interface', ensuring that psychosocial services provided by PHNs, the Victorian Government and the National Disability Insurance Scheme are easy to navigate for consumers and carers, as well as for GPs and other health providers.

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

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

Most Aboriginal and Torres Strait Islander people want to be able to access services in which the best possible mental health, and social and emotional wellbeing strategies are integrated into a culturally capable model of health care. This approach needs an appropriate balance of clinical and culturally informed mental health system responses, including access to traditional and cultural healing.

Stakeholders responsible for coordinating the actions under this priority area are the MHPC and the MHISSC. Stakeholders responsible for implementing the actions under this priority area are the Australian Government Department of Health, the state and territory governments, the ATSIMHSPPRG and the MHISSC.

ACTION 10:

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

This action requires governments to ensure that the guidance for PHNs and LHNs, as developed under Action 1.2, outlines expectations regarding integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples. It must include:

- expectations for involvement of ACCHSs and Aboriginal and Torres Strait Islander communities
- engagement of Aboriginal and Torres Strait Islander helpers and peer workers
- operationalising the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026 within regional mental health service systems
- governance structures and mechanisms that include Aboriginal and Torres Strait Islander perspectives.

As noted under Action 1.2, the Guide for Joint Regional Planning was released by the Integrated Regional Planning Working Group in October 2018. The Australian Government Department of Health reported that guiding principles have been included in the guide that require ACCHSs and PHNs to commit to working together to improve access to health services. The guiding principles were developed in consultation with ACCHSs and PHNs, and provide guidance for actions to be taken by both ACCHSs and PHNs across key domains: Closing the Gap; cultural competency; commissioning; engagement and representation; accountability, data and reporting; service delivery; and research.

Aims outlined in the guiding principles include improved engagement between ACCHSs and PHNs – for example, Aboriginal and Torres Strait Islander representation within PHN governance structures.

The Mental Health Division of the Australian Government Department of Health is also finalising the *PHN primary mental health care programme guidance 2019: Aboriginal and Torres Strait Islander mental health services*. This guidance will include requirements for joint planning, cultural governance and commissioning for Aboriginal and Torres Strait Islander people, and ensure that integrated services and clear referral pathways are in place.

As the Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track'.

ACTION 11:

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

This action requires the MHPC to establish a subcommittee for Aboriginal and Torres Strait Islander mental health and suicide prevention. This action has been completed as reported under Action iii (under 'Governance').

ACTION 12:

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

ACTION 12.1:

Developing and distributing a compendium of resources.

This action requires the ATSIMHSPPRG to develop and distribute sector resources. The project reference group will be required to consult widely on the development and distribution of these resources to ensure strong sector engagement.

The ATSIMHSPPRG reported that they have revised some actions within Priority Area 4 and adjusted the focus of some actions. With the MHPC's approval, the ATSIMHSPPRG will now focus on identifying and evaluating existing tools (such as self-management tools, mental health literacy resources, clinical tools, and assessment and outcome measures) that are culturally safe and appropriate for Aboriginal and Torres Strait Islander people, instead of developing sector resources. The proposal for this project is currently being prepared for endorsement and will commence in the second half of 2019.

As a result of the revised approach being undertaken by the ATSIMHSPPRG and with the project proposal yet to be endorsed, the MHPC (the Coordination Point of this action) rated the progress of this action as 'yet to commence'.

ACTION 12.2:

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

This action requires the ATSIMHSPPRG to develop joint guidance for mental health providers to increase knowledge and improve cultural competence. The guidance will articulate government expectations for funded service providers and provide practical advice based on existing agreed policy documents, including the National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023, the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026 and the Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023, and relevant state and territory strategies.

The ATSIMHSPPRG reported that it will use the outputs of Action 12.1 to inform work under this action. For this reason the MHPC (the Coordination Point of this action) rated the progress of this action as 'yet to commence'.

ACTION 12.3:

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

This action requires the ATSIMHSPPRG to provide advice to the MHPC on practical strategies to improve Aboriginal and Torres Strait Islander leadership.

The ATSIMHSPPRG reported that it has not provided this advice to the MHPC, as this action is being progressed by the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH). The NATSILMH has held workshops in several jurisdictions as well as for the MHERP. These workshops have focused on increasing Aboriginal and Torres Strait Islander presence and leadership across the mental health system, and on ensuring that Aboriginal and Torres Strait Islander communities have access to cultural healers, as well as other healing options, within a range of mental health treatment options.

The NATSILMH will prepare a report on the outcomes of the workshops that will be reviewed by the ATSIMHSPPRG before being delivered to the MHPC.

As the Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track'.

ACTION 12.4:

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

This action requires all governments to ensure that training in trauma-informed care is provided to all staff in their mental health services. This training will be informed by advice from the ATSIMHSPPRG.

SA Health, the ACT Health Directorate and NSW Health all reported that trauma-informed training has been provided. This included mandatory Aboriginal and cultural training that specifically addresses the historical and generational experiences of trauma and is intended to increase cultural competency (NSW Health), and the introduction of an Aboriginal Liaison Team to deliver a range of training options on trauma-informed care for mental health staff (ACT Health). In South Australia, trauma-informed training is available to staff, although participation is voluntary (SA Health). Further work is also needed to improve the curriculum of the available training program developed in the United States, so that it is appropriate for the Australian context. This work will be conducted by the working group that oversees the integrity of the training program.

Funding has been provided by the AHMAC to the Northern Territory to lead and manage the Trauma Informed Care Project, with support from Western Australia. This project will review training in trauma-informed care and cultural safety practice for all staff delivering mental health services to Aboriginal and Torres Strait Islander people, particularly those in forensic settings, and deliver findings to the MHPC.

The remaining state governments described progress towards the implementation of this action. In Tasmania, new models of care have been developed that include the principles of the recovery model, triangle of care and trauma-informed care and practice. These new models of care are expected to be implemented in from 2019–20 (Department of Health Tasmania). In Queensland, an e-learning module on trauma-informed care has been developed for all staff working in mental health and alcohol and other drugs services (Queensland Health). The Western Australian Mental Health Commission provides workshops on trauma-informed care and practice twice per year, targeting providers whose clients use alcohol and other drugs.

This action also requires all governments to put in place strategies for delivering training in trauma-informed care to providers of mental health services to Aboriginal and Torres Strait Islander people. All state and territory governments, with the exception of Tasmania and Queensland, reported that these strategies have been implemented.

The Australian Government Department of Health reported that strategies for delivering training in trauma-informed care will be developed once the findings of the Trauma Informed Care Project currently being undertaken by the Northern Territory are delivered to the MHPC.

As the Coordination Point of this action, the MHPC rated progress as 'yet to commence'. This is because the Trauma Informed Care Project has only recently commenced. However, it is clear that the majority of state and territory government health departments have independently implemented training processes.

ACTION 13:

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

ACTION 13.1:

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

This action requires the Australian Government Department of Health to commission the establishment of a clearinghouse of resources, tools and program evaluations. The MHPC will also ask the ATSIMHSPPRG to provide advice on the implementation of this action.

As reported under Action 12.1, the ATSIMHSPPRG has revised the focus of some of the actions within Priority Area 4. Based on this revision, the ATSIMHSPPRG has advised the MHPC that the focus of this work should initially be on identifying and evaluating existing tools (self-management tools, mental health literacy resources, clinical tools, and assessment and outcome measures) that are culturally safe and appropriate for Aboriginal and Torres Strait Islander peoples, which can then be shared via an agreed mechanism.

The MHPC has agreed to the revised focus of this project. However, as a result of this change the MHPC has rated the status of this action as 'yet to commence'.

ACTION 13.2:

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

This action requires the MHISSC to develop strategies for ongoing testing of, and reporting on, the accuracy of identification of Aboriginal and Torres Strait Islander people within key national mental health data collections.

The MHISSC reported that, at its June 2019 meeting, it endorsed a review of the quality of Indigenous identification in the national data collections, and mechanisms to improve the data. The outcomes of this review will be provided to the ATSIMHSPPRG at an upcoming meeting.

As the Coordination Point of this action, the MHISSC rated progress as 'commenced – on track'.

ACTION 13.3:

Ensuring future investments are properly evaluated to inform what works.

This action requires all governments to embed appropriate evaluation of their respective investments in mental health initiatives for Aboriginal and Torres Strait Islander people, and report annually on achievement of this requirement through the MHPC. The ATSIMHSPPRG will provide advice on how to best embed evaluation of government investment into program design.

All state and territory government health departments, with the exception of the Tasmania and South Australia health departments, reported that they have embedded an evaluation process into mental health investment for Aboriginal and Torres Strait Islander people. The Department of Health Tasmania reported that it does not currently have an evaluation framework for the mental health services it funds – either clinical or psychosocial – at the whole-of-population level or for specific population groups. However, it is currently implementing the Integration Taskforce Report, which will include a framework to evaluate impact and monitor implementation of taskforce recommendations. It is envisaged that this framework will include whole-of-population and specific population groups including Aboriginal and Torres Strait Islander people.

SA Health reported that an evaluation process is yet to be embedded, and welcomes the advice of the ATSIMHSPPRG on how to best embed evaluation of government investment into program design.

The Australian Government Department of Health reported that the Indigenous Health Division plans to evaluate the PHN Aboriginal and Torres Strait Islander Mental Health Program in the future. Currently, not enough data is available for an evaluation.

The Coordination Point for this action, the MHPC, reported that the ATSIMHSPPRG is yet to provide advice on how to best embed evaluation into program design. For this reason, the MHPC rated progress as 'yet to commence'. However, it is clear that state and territory government health departments have commenced these evaluation processes.

ACTION 13.4:

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

This action requires the MHISSC to work with stakeholders to ensure that the development and construction of mental health performance indicators include the capacity to disaggregate by Indigenous status, wherever possible.

The MHISSC reported that it has been working with stakeholders to ensure that data, including the Fifth Plan performance indicators, is disaggregated by Indigenous status, where possible. The MHISSC will seek expert advice from the ATSIMHSPPRG on the existing Fifth Plan indicators at an upcoming meeting.

As the Coordination Point for this action, the MHISSC rated progress as 'commenced – on track'.

ACTION 13.5:

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

This action requires the MHISSC to work with stakeholders to create opportunities for collating and reporting data on provision of mental health services to Aboriginal and Torres Strait Islander people. The Australian Government Department of Health will facilitate this through existing funding arrangements with the Australian Institute of Health and Welfare (AIHW), and will ask the AIHW and the MHISSC to scope the development of mental health indicators in the key performance indicators for Aboriginal and Torres Strait Islander primary health care.

The Australian Government Department of Health reported that it is funding a number of Indigenous mental health projects that will be delivered by the AIHW. These projects are in the early stages of development, and include:

- improving the identification of Aboriginal and Torres Strait Islander people undergoing clinical care for mental illness. This will involve assessing the level of under-identification in mental health datasets and developing strategies to address under-identification in a targeted way.
- reviewing datasets for improved data collection on the mental health and wellbeing of Aboriginal and Torres Strait Islander people, and working to ensure that Fifth Plan performance indicators and work resulting from the Closing the Gap refresh are fit-for-purpose and can be disaggregated by Indigenous status
- using health service data to improve mental health services for Aboriginal and Torres Strait Islander people. This will involve examining the prevalence of mental health-related issues among Aboriginal and Torres Strait Islander people; assessing access to mental health services including community mental health and specialist mental health services; and assessing gaps in service delivery.

The Australian Government Department of Health reported that it has funded the AIHW to scope the development of mental health indicators. The Social and Emotional Wellbeing (SEWB) Clinical Working Group (a subcommittee of the Health Services Data Advisory Group) has reported a number of challenges in progressing this activity. The working group describes SEWB as a highly complex area where the risk of using an imperfect measure is greater than the benefit of implementing one. It also advises that a SEWB key performance indicator should be based on a SEWB measure developed and validated specifically for the Aboriginal and Torres Strait Islander population; however such a measure does not currently exist.

The SEWB Clinical Working Group recommends that SEWB measures from the *Aboriginal and Torres Strait Islander Health Performance Framework* report, Medicare Benefits Schedule (MBS) data, and Online Services Report data should be used until a more specific and appropriate measure of SEWB becomes available.

As the Coordination Point of this action, the MHISSC rated progress as 'yet to commence'. The MHISSC reported that this action would be better managed by the ATSIMHSPPRG because of its expertise. The MHISSC remains willing to provide technical advice as required. The MHISSC secretariat is working with the ATSIMHSPPRG secretariat to identify opportunities to progress this action.

Priority Area 4: Achievements and enablers

The stakeholders responsible for implementing Priority Area 4 reported a number of achievements. These included:

- **Introduction of new initiatives.** New initiatives reported by stakeholders included the Aboriginal Older Person's Mental Health Community of Practice (NSW Health) and the co-location of a mental health nurse and psychiatric registrar within an ACCHS (ACT Health Directorate). The Northern Territory Department of Health reported the development of a centralised regional Community Action Planning support network in the Northern Territory to guide community engagement for suicide prevention activities, and access to associated community awareness and support services.

- **Provision of training.** Provision of training to Aboriginal and Torres Strait Islander people to support their communities was reported as an achievement by two state governments. Two Aboriginal Mental Health First Aid (MHFA) instructors have completed the new Older Person's MHFA trainer course, with a view to providing this training to older Aboriginal people in New South Wales (NSW Health). In Western Australia, the Aboriginal Family Wellbeing Project aims to address the physical, mental, emotional and spiritual issues that affect an individual's wellbeing, family unity and community harmony by building capacity within Aboriginal organisations and their surrounding communities. This includes providing training to Aboriginal and non-Aboriginal workers in an adapted version of the Certificate II in Family Wellbeing. The project will ensure that Aboriginal Health Council of Western Australia (AHCWA) staff, the AHCWA Youth Committee, all 23 ACCHSs across Western Australia, and other local Aboriginal organisations attain the Certificate II in Family Wellbeing. The project will also support collaboration between AHCWA and ACCHS staff to deliver appropriate elements of the course to local Aboriginal communities.

Priority Area 4: Barriers

Stakeholders reported a number of challenges in implementing actions to improve Aboriginal and Torres Strait Islander mental health and suicide prevention. These included:

- **Recruitment issues.** Stakeholders reported difficulties in recruiting Aboriginal and Torres Strait Islander mental health staff to support new initiatives for Aboriginal social and emotional wellbeing (Department of Health and Human Services Victoria), as well as a lack of a suitably trained and qualified Aboriginal workforce (NSW Health) to provide appropriate mental health care.
- **Governance changes and resourcing.** The Chair of the ATSIMHSPPRG resigned in early 2019, and a new Chair has only recently been recruited. This resulted in a delay in progress of the group's work plan (ATSIMHSPPRG). The lack of sufficient support and resourcing for the ATSIMHSPPRG was also reported as a barrier to progressing the work plan (Queensland Health). To address this, there has been a recent change in resourcing with secretariat support now being provided through the AHMAC Secretariat office. These were significant barriers given the critical role of the ATSIMHSPPRG in progressing the actions of this priority area.
- **Lack of subject matter expertise.** The MHISSC reported that its lack of subject matter expertise in Aboriginal and Torres Strait Islander primary mental health care was a significant disadvantage to creating opportunities for collating and reporting on data on the provision of mental health services to Aboriginal and Torres Strait Islander people (Action 13.5). For this reason, the MHISSC has recommended that it would be more appropriate for the ATSIMHSPPRG to manage this action.

Table 7: Priority Area 4 – overview of progress

Action	Status	Coordination Point	Milestone date in Implementation Plan
10	Commenced – on track	MHPC	Commence mid-2018.
11	Complete (as per Action iii)	MHPC	First meeting mid-2018.
12.1	Yet to commence	ATSIMHSPPRG	Commence 2018. Completed 2020.
12.2	Yet to commence	MHPC	Commence 2018 and ongoing.
12.3	Commenced – on track	MHPC	Commence 2018 and ongoing.
12.4	Yet to commence	MHPC	Commence 2018 and ongoing.
13.1	Yet to commence	MHPC	Commence 2018 and ongoing.
13.2	Commenced – on track	MHISSC	Commence 2018. Completed 2021.
13.3	Yet to commence	MHPC	From 2017 and ongoing.
13.4	Commenced – on track	MHISSC	Commencing 2018 and ongoing.
13.5	Yet to commence	MHISSC	Commence 2018. Completed mid-2021.

A number of actions under this priority area were reported as 'yet to commence'. This is concerning given that implementation of the Fifth Plan has now completed its second year.

As noted in 'Governance', changes in the structure of ATSIMHSPPRG, including the resignation of the ATSIMHSPPRG Chair and the subsequent delay in recruiting a replacement, have significantly affected the group's ability to implement the actions under Priority Area 4. In addition, the ATSIMHSPPRG revised the Priority Area 4 actions and agreed to adjust the focus of some of the actions. This has delayed the commencement of a number of actions.

The NMHC anticipates that the work of the ATSIMHSPPRG can progress without further delay now that a new Chair has been appointed and secretariat support provided. The NMHC acknowledges the expertise of the ATSIMHSPPRG, and the value of adjusting the focus of specific actions to more appropriately address Aboriginal and Torres Strait Islander mental health and suicide prevention.

Action 13.5 involves scoping the development of mental health key performance indicators for Aboriginal and Torres Strait Islander primary healthcare. The MHISSC has requested that this action be coordinated by the ATSIMHSPPRG due to its expertise. Given that this action was scheduled to commence in 2018 and is due for completion in 2021, the NMHC is concerned that the ATSIMHSPPRG does not have sufficient time to deliver this work.

Given the importance and scale of the actions within Priority Area 4, and in light of the barriers reported by stakeholders in implementing this priority area, the NMHC urges the MHPC to consider the resourcing of the ATSIMHSPPRG to ensure that the actions can be implemented.

Case study 4: Kumpa Kiira Suicide Prevention Project

Coomealla Health Aboriginal Corporation provides health services to address the health needs of Aboriginal people in the Wentworth and Balranald regions of New South Wales. The communities serviced experience a range of complex issues including domestic violence, drug and alcohol issues, and mental and physical health concerns. The communities have also lost a number of Aboriginal and Torres Strait Islander people to suicide.

In response, Coomealla Health Aboriginal Corporation developed a suicide prevention project as part of the New South Wales Suicide Prevention Fund. Kumpa Kiira is an innovative health promotion program that seeks to prevent suicide by engaging Aboriginal and Torres Strait Islander people across the lifespan through activities grounded in culture and community connection. The project employs a team leader and two Aboriginal and Torres Strait Islander suicide prevention workers. They are supported in their roles by a dedicated Social and Emotional Wellbeing Worker who provides one-on-one support and counselling to clients.

Community engagement has been a key component of the work. The project engages Aboriginal and Torres Strait Islander youth with culture through youth groups for men and for women, using art, music and other. This engagement supports connection to community and to local schools. Kumpa Kiira has also engaged Elders to run regular groups that focus on culture, intergenerational exchange and connection. Program promotional materials include messaging to increase understanding of mental illness and suicide risk in at-risk groups, including aged people.

The project has also engaged local GPs through formal up-skilling and advice on identifying and managing suicide risk,and postvention support. Since 2017, Kumpa Kiira has brought its community together and promote culture as healing, which is a critical component of suicide prevention in Aboriginal and Torres Strait Islander communities.

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

People living with mental illness often have poorer physical health than other Australians, as their physical health needs are often overshadowed by their mental illness.

Ensuring that people living with mental illness receive better screening for physical illness, and that interventions are provided early as part of a person-centred treatment and care plan, is critical to improving the long-term physical and mental health outcomes of people living with mental illness, and people with a chronic or debilitating physical illness who may be at higher risk of a mental illness. This will lead to improved health outcomes, including better management of co-existing mental and physical health conditions, reduced risk factors and improved life expectancy.

Stakeholders responsible for coordinating the actions under this priority area are the MHPC and the MHISSC. Stakeholders responsible for implementing the actions under this priority area are the Australian Government Department of Health, state and territory governments, PHNs, the NMHC and the state mental health commissions.

ACTION 14:

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

This action requires all governments and mental health commissions to embed the elements of Equally Well, and to make changes in their areas of influence to improve the physical health of people with mental illness. The NMHC will monitor and report on implementation of the consensus statement across jurisdictions.

All jurisdictions and mental health commissions are responsible for coordinating this action.

State and territory governments reported embedding the principles of Equally Well through a variety of activities. These included frameworks, policies and tools (Western Australian Department of Health), and a Mental Health Service Integration Project (Northern Territory Department of Health).

In Queensland, the Mental Health, Alcohol and Other Drugs Branch (Queensland Health) has developed three clinical forms for documentation of physical health issues experienced by consumers of public mental health and alcohol and drug services. These forms are being implemented into the Consumer Integrated Mental Health Application for use by clinicians state-wide by mid-2020.

An Equally Well in Victoria framework was developed in response to the Equally Well consensus statement (Department of Health and Human Services Victoria). In New South Wales, the Physical Health of Mental Health Consumers Policy and Guidelines was developed to embed the Equally Well consensus statement into the core business of New South Wales health services (NSW Health). South Australia's proposed Mental Health Services Plan will provide future direction on its work embedding Equally Well (SA Health), and the Department of Health in Tasmania will provide a strategic response as part of its implementation of the Integration Taskforce Report.

State and territory mental health commissions reported embedding Equally Well principles in activities arising from strategic planning. For example, the Australian Capital Territory Office for Mental Health and Wellbeing is commencing work on an outcome framework that will consider physical health indicators for people with mental illness. The Queensland Mental Health Commission has commenced a staged project to identify reform opportunities to improve the physical health of people with a lived experience of mental illness and problematic alcohol and other drug use.

The NMHC established the Equally Well Implementation Committee (EWIC) to oversee the strategic implementation of the Equally Well consensus statement. The NMHC also supported a project team based at Charles Sturt University to provide project support activities across the network of more than 70 organisations that have committed to the Equally Well consensus statement. The EWIC members agreed that, in 2019, the committee would start providing regular updates to the Safety and Quality Partnership Standing Committee on the work of the Equally Well initiative.

ACTION 15:

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

This action requires the Australian Government Department of Health, and state and territory governments to review existing guidelines and resources, and determine whether they require updating, or whether additional guidelines and resources are required.

The majority of governments reported that they have reviewed existing guidelines and resources. Where relevant, guidelines are being updated to incorporate physical health. Guidelines and additional resources are also being developed as part of regional plans, and other state and territory policies and frameworks.

The South Australian Government reported that directions for future work in this space will be informed by the Mental Health Services Plan once it is approved. South Australia will review resources developed elsewhere and consider which of them would be useful for promoting the Equally Well agenda.

As the Coordination Point for this action, the MHPC rated progress as 'commenced – on track'. The MHPC noted that work against this action is being progressed by the EWIC with links to the Safety and Quality Partnerships Standing Committee. The first National Equally Well Symposium was held in March 2019. The aim of the symposium was to share innovation and experiences in implementing the Equally Well consensus statement across the jurisdictions.

ACTION 16:

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

ACTION 16.1:

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

This action requires governments to ensure that the guidance for PHNs and LHNs as developed in Action 1.2, outlines expectations for the inclusion of mechanisms to support the physical health of people living with mental illness in joint service planning activity. The action also requires PHNs and LHNs to jointly release regional plans that include mechanisms to support the physical health needs of people living with mental illness.

The Australian Government Department of Health and the MHPC reported that Section 3.5 of the Guide for Joint Regional Planning addresses this action. It outlines the expectations for PHNs and LHNs to include mechanisms to support the physical health of people living with mental illness in joint service planning. Most state and territory governments reported that expectations are appropriately addressed in the provided guidance material Western Australian Mental Health Commission, ACT Health Directorate, NSW Health, SA Health and Northern Territory Department of Health). However, the Department of Health and Human Services Victoria reported that guidance material does not appropriately outline the expectations. The Northern Territory Department of Health noted that further guidance and/or examples of proposed reporting and governance structures could be considered.

Four PHNs reported the release of a joint regional mental health and suicide prevention plan, including mechanisms to support the physical health needs of people living with mental illness (Brisbane North PHN, Country SA PHN, Brisbane South PHN and South Eastern NSW PHN) (see Box 4). The majority of the PHNs yet to release a joint regional mental health and suicide prevention plan noted that the plan was in development and that the comprehensive (or foundational) plan is expected to be released by June 2020. Many PHNs without a finalised plan noted that they are undertaking a range of initiatives to support the physical health needs of people living with mental illness in the interim. Adelaide PHN reported that the steering committee is yet to provide a clear commitment to action in this area.

As Coordination Point for this action, the MHPC rated the progress of this action as 'commenced – on track'. The MHPC noted the Guide for Joint Regional Planning was endorsed by the MHPC in September 2018, and disseminated to PHNs and LHNs in October 2018.

Box 4: PHNs and regional plans – perceived discrepancy between actions 2.5 and 16.1

Under Action 2.5, PHNs and LHNs are required to jointly develop comprehensive regional mental health and suicide prevention plans. Under Action 16.1, these plans are required to include mechanisms to support the physical health needs of people living with mental illness. As reported under Action 2.5, seven PHNs have developed regional plans. However, not all of these PHNs have released the plans or included mechanisms to support physical health needs.

ACTION 16.2:

Including it as part of joint clinical governance activity.

This action requires governments to use guidance material on joint regional plans to outline their expectations of PHNs and LHNs that joint clinical governance activity should include mechanisms for supporting the physical health of people with mental illness.

As noted under Action 1.2, the Guide for Joint Regional Planning was released by the Australian Government Department of Health in October 2018. The Australian Government Department of Health has reported that this guidance outlines expectations for PHNs and LHNs to include mechanisms for supporting physical health. Additionally, the Australian Government noted that LHNs and PHNs are expected to include these mechanisms in joint service planning activities by mid-2020.

As the Coordination Point for this action, the MHPC rated progress as 'commenced – on track'. The MHPC noted that the inclusion of the treatment of physical health of people living with mental illness by including it as part of joint governance activity within local treatment plans, is described in Section 3.5 of the Guide for Joint Regional Planning, which was endorsed by the MHPC in September 2018.

ACTION 16.3:

Requiring roles and responsibilities to be documented as part of local service agreements.

This action is not scheduled to commence until mid-2020.

ACTION 17:

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

This action requires the MHISSC to identify mechanisms for reporting on the physical health of Australians with mental illness; develop one or more nationally-consistent performance indicators on the physical health of Australians with mental illness; and identify strategies for ongoing analysis and reporting of the mortality gap for Australians with mental illness.

The MHISSC reported that two of the four physical health indicators have been specified. This data has been included in the performance indicators section of this report. Development of the remaining two indicators– potentially preventable physical health hospitalisations and the mortality gap– is being led by NSW Health.

Implementation progress of this action also includes the provision of funding by the AHMAC and the Australian Government Department of Health to the AIHW for a project officer, and the development of an options paper under the governance of a MHISSC working group. The options paper is expected to be considered by the MHISSC and the SQPSC at their respective meetings in October and November 2019, and provided to the MHPC by the end of the year.

As the Coordination Point for this action, the MHISSC rated progress as 'commenced – on track'.

Priority Area 5: Achievements and enablers

The stakeholders responsible for implementing Priority Area 5 reported a number of achievements. These included:

- **Targeted education and training.** Multiple stakeholders reported delivering targeted education and training as an achievement throughout the implementation of Priority Area 5. This included education and training for general practice staff in areas such as multimorbidity (WA Primary Health Alliance), mental health service options (South Eastern NSW PHN), referral pathways (Western Queensland PHN) and mental health skills (Northern Territory PHN). Education and training also aimed to upskill the mental health workforce to respond to physical health needs (Murrumbidgee PHN and the ACT Health Directorate), and a physical health assessment tool has been developed to better enable nurses to improve the health of people living with mental illness (the NMHC).
- **Establishment of programs and services.** State and territory governments reported establishing, and an increase in the uptake of, programs and services to improve the physical health of individuals living with mental illness (ACT Health Directorate, NSW Health and Queensland Health). LHNs are delivering a range of programs and strategies. For example, NSW Health reported LHN projects include: a health passport to guide the implementation of physical health screening for consumers; a physical health care clinic offered to consumers new to the service monitoring weight and vital signs; and inpatient physical health screening. Similarly, multiple PHNs reported commissioning targeted services in partnership with local organisations (Northern Queensland PHN; Eastern Melbourne PHN; South Western Sydney PHN; North Western Melbourne PHN; Western New South Wales PHN; and Central and Eastern Sydney PHN). Specific services delivered by LHNs include an Integrated Subspecialty Clinic (South Western Sydney PHN), an Integrated Team Care Program (Central and Eastern Sydney PHN) and a Psychiatric Advice and Consultation Service that supports screening, monitoring and treatment of the physical health needs of consumers with mental illness (Eastern Melbourne PHN). South Eastern NSW PHN and Northern Territory PHN also reported the development of HealthPathways, (as discussed in Actions 2.6 and 2.7 in Priority Area 1), to support the planning of care through primary and secondary health care systems.
- **Encouraging consideration and assessment of physical health needs of individuals with mental illness.** Some PHNs have included specifications in existing programs (Northern Queensland PHN and Murray PHN). Guidelines positioning physical health as a priority for commissioned mental health services have also been developed (Murray PHN). In December 2018, Queensland Health introduced into the state-wide key performance indicators an indicator relating to the completion of physical health assessments for all community mental health consumers.
- **Investment in trials in collaboration with local services.** Trials include a facilitated group exercise and nutrition program (Brisbane North PHN), a smoking ban trial at the Albany Health Campus and co-design of an evidence based Recovery College Model of Service (Western Australian Mental health Commission), agreement to a metabolic syndrome/clozapine model of care in a local general practice clinic (Central Queensland, Wide Bay and Sunshine Coast PHN), and researching the implementation of a Physical Health Nurse Consultant service to be offered alongside usual mental health care (ACT Health Directorate).
- **Commitment to Equally Well.** Multiple stakeholders reported that commitment to Equally Well is a key mechanism for action in Priority Area 5. The MHPC noted that the National Equally Well Symposium, held in March 2019, included a key discussion on the implementation of nationally consistent initiatives to address physical health of people with a mental illness. The Department of Health and Human Services Victoria reported successful production, and launch of the Equally Well in Victoria Framework, and its dissemination to all specialist mental health services in March 2019. PHNs and governments reported clear mandates

for action from mental health reform and high-profile reviews as enablers of progress.

As in Priority Area 1 and Priority Area 3, strong relationships with LHNs and other stakeholders were commonly reported as a key enabler to progress. These relationships are particularly important to the ongoing development of integrated regional plans, which provides a mechanism to address the issue of the physical health of people living with a mental illness.

The Queensland Mental Health Commission noted the Queensland Government's commitment to establishing a Health and Wellbeing Commission in Queensland, and noted the strategic opportunity this presents to integrate government policies and priorities for mental and physical health. Similarly, the South Australian Government has committed to establishing a new department called Wellbeing SA where physical and mental health promotion and prevention will be brought together. A focus on Equally Well will be a priority of this new entity.

Priority Area 5: Barriers

Stakeholders reported a number of challenges in implementing actions to improve physical health of people living with mental illness. These included the following:

- **Existing funding structures.** Four PHNs reported that existing funding structures limit their ability to address physical health needs and drive change in Priority Area 5 (Western Sydney PHN, North Coast PHN, Brisbane North PHN and Gold Coast PHN). Limitations include the currently specified focus areas of reporting (North Coast PHN and Gold Coast PHN), and the availability of funds to continue and expand relevant programs and services (Brisbane North PHN).
- **Challenges in working effectively with GPs.** These challenges included the ability to influence and change GP systems (South Eastern NSW PHN), the reluctance of GPs to provide support to patients living with mental illness (Western Sydney PHN and NSW Health), the ability to obtain information from GPs (Queensland Health), and difficulties linking consumers with GPs due to limited access to GPs who bulk bill (NSW Health).
- **Resourcing.** As reported by stakeholders in Priority Area 1, resourcing is a common barrier to implementation. Barriers include workforce shortages (Northern Territory PHN), staff turnover (Western Sydney PHN and Western Queensland PHN), and the large number of priorities to be addressed (New South Wales Mental Health Commission; and Central Queensland, Wide Bay and Sunshine Coast PHN). Funding and resource barriers are echoed by state and territory government departments (Department of Health and Human Services Victoria and NSW Health).
- **Complexity of regional planning.** The development of joint regional plans is a key mechanism to drive change in Priority Area 5. As reported by stakeholders in Priority Area 1, the timeframe for regional planning (Western NSW PHN), and challenges with buy-in from LHNs (South Eastern Melbourne PHN) limits the capacity to embed a focus on physical illness in the joint regional planning process. Similarly, PHNs reported that time constraints for commissioning services are a barrier to addressing physical health needs during commissioning activities (Central Queensland, Wide Bay and Sunshine Coast PHN; and Western Victoria PHN). Additionally, state government restructuring of LHN regions was reported as an added complexity for partnerships and planning (Country SA PHN).

Additional barriers noted by state and territory governments include the fact that young people may not be identified as 'at risk' for physical health issues due to their age (Queensland Health), and challenges of coordination of care through sectors (Northern Territory Department of Health).

Table 8: Priority Area 5 – overview of progress

Action	Status	Coordination Point	Milestone date in Implementation Plan
14	Commenced – on track	All jurisdictions	From 2017 following release of Equally Well.
15	Commenced – on track	MHPC	Commence mid-2018. Completed late 2019. Annually from 2020.
16.1	Commenced – on track	MHPC	June 2018. By mid-2020.
16.2	Commenced – on track	MHPC	June 2018.
16.3	Not scheduled to commence until mid-2020	MHPC	From mid-2020.
17	Commenced – on track	MHISSC	Commence October 2017. Completed 2022.

Implementation of this priority area is progressing well, and all actions were reported as 'commenced – on track'.

The NMHC acknowledges the achievements of stakeholders in working to improve the physical health of individuals living with mental illness. This includes the delivery of a range of programs and strategies to support physical health needs by LHNs, and PHNs commissioning targeted services in partnership with local organisations.

As more PHNs and LHNs release their joint regional mental health and suicide prevention plans in 2020, the NMHC will gain a more comprehensive picture of how joint service planning activity will focus on the treatment of physical illness in people living with mental illness.

Case study 5: Improving the physical health of people living with severe mental illness

As recognised in Priority Area 5 of the Fifth Plan, people living with mental illness often have poorer physical health than other Australians, as physical health needs are often overshadowed by their mental health condition.

In early 2019, based on insights gained through community engagement and analysis of regional data, North Western Melbourne PHN invited tenders for a locally based and integrated approach to supporting the physical health needs of people with severe mental illness.

The Integrated Chronic Care service is a 2-year trial that seeks to improve health outcomes for people living with severe mental illness through delivery of recovery focused mental health support and support for chronic conditions using a self-management approach. The service is targeted at people with severe and persistent mental illness, and a diagnosis of one or more chronic health physical conditions such as diabetes and cardiovascular disease. The service uses a multi-disciplinary workforce, including peer workers, to deliver a flexible and person-centred model that enhances the coordination of care. The service supports people to participate in and connect with their community and to increase their confidence to self-manage their health care. The service was recently implemented and will use consumer self-reported experience and outcome indicators to continually improve.

Priority Area 6: Reducing stigma and discrimination

Reducing stigma and discrimination is critical to improving the wellbeing of people living with mental illness and promoting better mental health in society. Although there have been some improvements in knowledge about mental illness, there is still widespread misunderstanding, and people living with mental illness still experience significant stigma. A sustained, collective effort is needed to dispel the myths associated with mental illness, change ingrained negative attitudes and behaviours and, ultimately, support social inclusion and recovery.

Stakeholders responsible for coordinating the actions under this priority area are the MHPC and the AHMAC. Stakeholders responsible for implementing the actions under this priority area are the Australian Government Department of Health and the MHPC.

ACTION 18:

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

This action requires the Australian Government Department of Health to engage an expert provider to undertake a review of existing initiatives and evidence to inform the approach to implementation of this action. The MHPC and the Australian Government Department of Health will lead targeted consultations on options for a nationally coordinated approach to reduction of stigma and discrimination, with a focus on the stigma and discrimination experienced by people with mental illness that is poorly understood in the community. The MHPC will also propose a direction to the AHMAC for collaborative future government action.

The Australian Government Department of Health reported that a draft plan to address this action was presented to the MHPC's Reducing Stigma and Discrimination Working Group at its meeting in April 2019. To assist planning for this project, the Australian Government Department of Health (on behalf of the MHPC) engaged the University of Melbourne to undertake a review of existing initiatives and evidence to inform the approach to implementation of this action.

The Reducing Stigma and Discrimination Working Group has completed a review of existing initiatives and evidence. The findings of this review have informed the development of a project proposal for consultations with consumers, carers, community groups and other key organisations. The Australian Government Department of Health is in the process of procuring a consultant to undertake these consultations which will be completed in the first half of 2020.The proposed direction to AHMAC for collaborative future government action will be prepared following this consultation process.

As the Coordination Point for this action, the MHPC rated progress as 'commenced – not on track'.

ACTION 19:

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

ACTION 19.1:

Developing and implementing training programs that build awareness and knowledge about the impact of stigma and discrimination.

This action requires the MHPC to seek advice from the MHERP about an approach for developing and implementing training programs for the health workforce that build awareness and knowledge about the impact of stigma and discrimination. The MHPC will engage with consumers and carers, professional bodies, workforce accreditation bodies, mental health commissions, service providers and other key stakeholders on the development and implementation of training programs. The MHPC will also engage with other AHMAC principal committees on the approach to implementing training programs for the health workforce.

The MHPC reported that, although there has been some initial discussion at the MHERP meetings on stigma, discrimination and the health workforce, the MHPC has not yet formally sought the advice of the MHERP on training programs on stigma and discrimination for the health workforce. Implementation of this action will be informed by the outcomes of Action 18. Likewise, engagement with consumers, carers and other key stakeholders in developing stigma and discrimination training programs will not progress until Action 18 is completed. However, the MHPC noted that the Reducing Stigma and Discrimination Working Group comprises of

consumers and carers, and representatives from the ATSIMHSPPRG, SANE Australia, the Australian Medical Council, the Australian Federation of Disability Organisations and Mental Health Australia.

The MHPC, on behalf of the Coordination Point of this action, the AHMAC, reported that overall progress of this action is 'commenced – not on track'.

ACTION 19.2:

Responding proactively and providing leadership when stigma or discrimination is seen.

This action requires the MHPC to seek advice from the MHERP about where national responses and leadership are needed to support reduction of stigma and discrimination in the health workforce.

The MHPC reported that implementation of this action will be informed by the outcomes of Action 18. For this reason, as the Coordination Point of this action, the MHPC rated progress as 'yet to commence'.

ACTION 19.3:

Empowering consumers and carers to speak about the impacts of stigma and discrimination.

This action requires the MHPC to seek advice from the MHERP about approaches for reducing stigma and discrimination in the health workforce by empowering consumers and carers to speak about the impacts of stigma and discrimination.

The MHPC reported that implementation of this action will be informed by the outcomes of Action 18. For this reason, as the Coordination Point of this action, the MHPC rated progress as 'yet to commence'.

ACTION 20:

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

This action is being implemented under Action 29 of Priority Area 8.

Priority Area 6: Achievements and enablers

No significant achievements or enablers were reported by stakeholders at this stage of implementation.

Priority Area 6: Barriers

No significant barriers were reported by stakeholders at this stage of implementation.

Table 9: Priority Area 6 – overview of progress

Action	Status	Coordination Point	Milestone date in Implementation Plan
18	Commenced – not on track	MHPC	Completed mid-2018. Completed late 2018. Completed early 2019.
19.1	Commenced – not on track	AHMAC (progress reported by the MHPC)	Completed by mid-2021.
19.2	Yet to commence	MHPC	Completed by mid-2018.
19.3	Yet to commence	MHPC	Completed by mid-2018.
20	Commenced – on track (as per Action29)	MHPC	Commence mid-2018. Completed 2021.

A number of actions within this priority area were reported as 'yet to commence' or 'commenced – not on track'. The NMHC acknowledges that the actions within this priority area are dependent on the completion of Action 18, namely, the development of options for a nationally coordinated approach to reduction of stigma and discrimination, with a focus on mental illness that is poorly understood in the community.

Consultations on options for a nationally coordinated approach were scheduled for completion by late 2018. The Australian Government Department of Health reported that these consultations will not take place until the first half of 2020. Given that subsequent actions within Priority Area 6 cannot commence until Action 18 is completed, the NMHC urges the progress of this work as a priority.

Case study 6: A charter to address the stigma of mental illness

The Fifth Plan identifies reducing the stigma and discrimination surrounding mental illness as a significant priority. This issue was reflected as a primary concern by the participants of a Partners in Recovery program in Murray PHN. As a result, Murray PHN initiated a co-design working group consisting of program participants, carers, and other stakeholders to develop strategies to address stigma.

An outcome of the working group was the development of a charter that demonstrates the commitment of organisations to addressing the stigma of mental illness. The Stop Mental Illness Stigma Charter includes seven commitments that are proven strategies to address the stigma of mental illness.

A signatory organisation commits for their staff to increase their understanding of mental illness, the myths and stereotypes that surround mental illness, and how to support people who are experiencing mental ill health. A requirement of signing the charter is that, the organisation displays the charter and the signed pledge in a prominent location. This ensures that all visitors, customers, and consumers are aware that the signatory organisation is committed to addressing the stigma of mental illness and that their interaction with staff will be free from stigma.

At the time of reporting, more than 70 organisations from a variety of sectors across Australia have adopted the charter. Implementation of the charter within these organisations has had a positive impact, with 83% of attendees at regional Stop Stigma workshops indicating that the charter had made a difference within their organisations.

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

Safety and quality have been integral to mental health reform over the past three decades and the subject of significant collaboration between governments. A safe health system minimises or avoids potential or actual harm to consumers. A quality health system provides the right care to consumers, improves health outcomes for consumers, and optimises value. When combined, the concepts of safety and quality promote a focus on minimising harm and maximising effectiveness in healthcare.

Stakeholders responsible for coordinating the actions under this priority area are the MHPC, the MHISSC and the SQPSC. Stakeholders responsible for implementing the actions under this priority area are the Australian Government Department of Health, state and territory governments, the NMHC and the SQPSC.

ACTION 21:

Governments will develop a National Mental Health Safety and Quality Framework to guide delivery of the full range of health and support services required by people living with mental illness. The Framework will describe the national agenda and work program for safety and quality over the next five years, and will include:

ACTION 21.1:

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

This action requires the SQPSC to work with the Australian Commission on Safety and Quality in Health Care (ACSQHC) to update the National Safety Priorities in Mental Health.

The Queensland SQPSC member assumed leadership of this project in March 2019. A conceptual framework has subsequently been developed, as well as a plan for revising the National Safety Priorities in Mental Health. These were both tabled for discussion at the SQPSC Fifth Plan workshop held in July 2019 and progress will be reported and discussed at the November 2019 SQPSC meeting.

The SQPSC is also working to identify new and emerging national safety and quality priorities in mental health to consider for inclusion in the National Safety Priorities in Mental Health.

As the Coordination Point of this action, the SQPSC rated progress as 'commenced – not on track'.

ACTION 21.2:

A revised national mental health performance framework to support reporting on performance and quality across all mental health service sectors.

This action requires the MHISSC to revise the National Mental Health Performance Framework in line with: the development of the National Mental Health Safety and Quality Framework, the amalgamation of the National Health Performance Framework and the Performance and Accountability Framework (that is being undertaken by the AHMAC) and the updated National Standards for Mental Health Services (NSMHS) being developed by the ACSQHC.

The MHISSC reported that they developed an updated National Mental Health Performance Framework, which was endorsed by the MHPC at its March 2019 meeting.

As the Coordination Point of this action, the MHISSC rated the status of this action as 'complete'.

ACTION 21.3:

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

This action requires the NMHC to progress the development of a consumer and carer guide. The NMHC will consult with the National Mental Health Consumer and Carer Forum and the SQPSC on the development of the guide.

The NMHC has established the Safety and Quality Engagement Group (SQEG) to oversee the development of the consumer and carer guide. The group comprises representatives from consumer and carer groups; public, private and community sectors; and the ACSQHC. Following advice from the SQEG, the Safety and Quality Engagement Guide will target consumers and carers who engage with safety and quality matters at the system and governance levels of mental health service initiatives. The research process to inform the development of the guide will focus on in-depth consultations with consumers,

carers, and mental health service providers. The NMHC will engage an external researcher to undertake these consultations and work in collaboration with this researcher to draft the guide.

The NMHC has provided regular project updates and sought feedback from the SQPSC via its Fifth Plan workshops. The NMHC has also asked state and territory members of the SQPSC to nominate a jurisdictional contact to provide direct input and feedback as the project progresses.

As the Coordination Point of this action, the SQPSC rated progress as 'commenced – on track'.

ACTION 21.4:

A process for revising the National Standards for Mental Health Services that accounts for interfaces with other relevant standards such as the National Disability Standards.

This action requires the SQPSC to work with the ACSQHC to develop a suitable process for revising the National Standards for Mental Health Services.

The SQPSC reported that the South Australian member assumed leadership of this project in March 2019.

The SQPSC has identified the need for all jurisdictions to be represented on the project advisory group, which as at 30 June 2019 is being established. In addition, the SQPSC has also identified the importance of representation on the advisory group of the private mental health services sector, the community-managed sector, and the ACSQHC to ensure coverage of all relevant service delivery sectors. The NMHC is unaware if the SQPSC is currently recruiting additional members to represent these sectors.

As the Coordination Point of this action, the SQPSC rated progress as 'commenced – not on track'.

ACTION 21.5:

Coverage of all relevant service delivery sectors.

This action requires the SQPSC to develop an approach to ensure that all relevant service delivery sectors are covered by the National Mental Health Safety and Quality Framework.

The SQPSC reported that its membership covers all relevant service delivery sectors, including state and territory jurisdictions, Community Mental Health Australia, Mental Health Australia, the Australian Government Department of Health and the Australian Private Hospitals Association. Carer and consumer representatives nominated by the National Mental Health Consumer and Carer Forum are also members. Service delivery sectors are also represented on Fifth Plan working groups.

As the Coordination Point of this action, the SQPSC rated progress as 'commenced – on track'.

ACTION 22:

Governments will develop a mental health supplement to the NSQHS Standards (2nd ed.) which will align the NSQHS Standards and the NSMHS.

This action requires the SQPSC to work with the ACSQHC to develop a mental health supplement to the National Safety and Quality Health Service (NSQHS) Standards (2nd edition).

The SQPSC reported that Action 21.4 will need to be finalised before the implementation of this action can commence. For this reason, as the Coordination Point of this action, the SQPSC rated progress as 'yet to commence'.

ACTION 23

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

This action requires the MHISSC to lead work with the AIHW to pool data on consumer and carer experiences of care nationally to develop performance indicators of consumer and carer experience, and to report these indicators annually at the lowest level of geography possible. The MHISSC will lead the work required to develop a primary care version of the Your Experience of Service (YES) survey tool.

The MHISSC reported that data from the YES survey in specialised mental health services in New South Wales, Victoria and Queensland is published online in the 'Consumer perspectives' section of Mental Health Services in Australia. The MHISSC is overseeing the development of the PHN version of the YES survey, in consultation with consumers, carers and PHN clinicians. A field trial of the survey is currently underway with five PHNs, using both online and hard-copy forms. The survey will be

modified following the field trial before a final draft is presented to the MHISSC for endorsement.

As the Coordination Point of this action, the MHISSC rated progress as 'commenced – on track'.

ACTION 24:

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

This action requires the MHISSC to develop a third edition of the National Mental Health Information Priorities in consultation with consumers and carers, service providers, the NMHC, relevant professional organisations, governments, PHNs and other relevant bodies.

The MHISSC reported that the information priorities have been developed under its guidance. A two-stage consultation process has been completed and a final draft has been developed. The MHISSC expects to provide the information priorities to the MHPC by the end of 2019.

As the Coordination Point of this action, the MHISSC rated progress as 'commenced – on track'.

ACTION 25:

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

This action requires all services funded by governments to have monitoring and public reporting mechanisms for safety and quality.

The Australian Government Department of Health described two mechanisms for monitoring safety and quality measures:

- The NSQHS Standards aim to protect the public from harm and improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place, to ensure that expected standards of safety and quality are met.
- The National Standards for Mental Health Services (NSMHS) assist in the development and implementation of appropriate practices, and guide continuous quality improvement across the broad range of mental health services.

The Australian Government Department of Health did not specify whether the services they fund must comply with the NSQHS Standards and/or the NSMHS as part of their service agreements.

States and territories report annually on accreditation of their specialised mental health services against the NSMHS through the national Mental Health Establishments National Minimum Data Set. This data forms the national key performance indicator, National Service Standards compliance, which is reported on the AIHW's Mental Health Services in Australia website.

Some state and territory governments reported the use of the NSQHS Standards and the NSMHS to improve service quality and safety. Mental health services in Tasmania and the Northern Territory, and the Capital Health Service in the ACT, are accredited against the NSQHS Standards. The Northern Territory is currently working towards reaccreditation in 2020 against the revised NSQHS Standards (second edition) and the Capital Health Service (ACT) will be reassessed in 2021. The second edition includes a greater focus on key safety issues for mental health. Non-Government Organisations (NGOs) funded through the ACT Health Directorate must actively engage in quality improvement including self-assessment against the NSMHS. The WA Mental Health Commission requires all Mental Health Service providers (both Government and NGO) to meet accreditation for the NSMHS. Services purchased from NGOs are closely monitored through active contract management processes.

In addition to these national standards, states and territories reported the use of state-based mechanisms. These include Safer Care Victoria, the state's lead agency for improving quality and safety in Victorian healthcare. Safer Care Victoria supports health services to monitor performance, guide best practice, and identify and respond to areas of improvement. The Northern Territory Department of Health provides support to funded mental health community organisations to implement and retain accreditation for their services by providing training opportunities and assistance with the accreditation processes.

The NSW Clinical Excellence Commission leads patient safety and quality in NSW Health, including monitoring, reporting and improvement initiatives. NSW has established the state-wide Mental Health Patient Safety Program through the Clinical Excellence Commission to support Local Health Districts to create the organisational conditions that enable teams to continually improve the safety and quality of mental health care. Safety indicators are also included in all NSW Health/Local Health District service agreements and are monitored through the NSW Health Performance Network. SA Health has established the Strategic Mental Health Quality Improvement Committee, which works as part of the wider South Australian health safety and quality system; it specifically monitors and evaluates mental health standards of care to improve safety, quality, and the experience of consumers and carers.

Additional mechanisms include the role of the Office of the Chief Psychiatrist (reported by the Department of Health Tasmania, Department of Health and Human Services Victoria, WA Department of Health and NSW Health) in ensuring that assessment and treatment of people with mental illness are provided in accordance with the Mental Health Act in the respective jurisdiction; and the use of indicator data to measure performance (WA Department of Health and Department of Health Tasmania). The Primary Mental Health Care Minimum Data Set developed by the Australian Government Department of Health will provide the basis to monitor and report on the quantity and quality of service delivery, and to inform future improvements in the planning and funding of primary mental health care services funded by the Australian Government.

As the Coordination Point of this action, the SQPSC rated progress as 'commenced – on track'. Following discussions on the direction of this project at the SQPSC Fifth Plan Action workshop in March, the MHISSC agreed to take responsibility as the Coordination Point for this action. MHISSC will now be reporting on the overall progress of this action.

ACTION 26:

Governments will improve consistency across jurisdictions in mental health legislation.

This action requires all governments, through the SQPSC, to continue to work together to develop effective working relations within existing legislative provisions.

The MHPC reported that the SQPSC is leading this action. At the COAG Health Council meeting in August 2018, ministers noted the challenges involved in ensuring seamless and safe care for people subject to mental health orders who move between jurisdictions. In response to a request from ministers, an options paper was prepared by the SQPSC that outlines options within and outside existing provisions, to deal with the issue of mutual recognition of mental health orders.

The options paper was considered by the AHMAC in May 2019, and the AHMAC has supported the pursuit of a national legislative scheme as the preferred option for addressing the issue of mutual recognition of mental health orders. Further scoping work is currently being undertaken that focuses on the rationale and identification of key features of the approach. This scoping work will form the basis of advice that will progress through the AHMAC to the COAG Health Council in November 2019.

As the Coordination Point of this action, the MHPC rated progress as 'commenced – on track'. The MHPC also noted that it is seeing improved consistency across jurisdictions in mental health legislation.

ACTION 27:

Governments will make accessible the WHO QualityRights guidance and training tools.

This action requires all governments to take steps to ensure that the WHO QualityRights guidance and training tools pertaining to mental health care are accessible to promote awareness of consumer rights. Governments will ask their funded organisations to use this guidance and training tools.

In the 2018 Progress Report, the NMHC noted that the MHPC did not support the initial proposal to fund the WHO QualityRights guidance and training tools, because of the high cost of implementation. In response, implementation of this action was referred back to the SQPSC to further develop the approach.

The SQPSC reported that the MHPC have agreed that this action is the responsibility of individual jurisdictions and would not progress any further at this point in time.

Priority Area 7: Achievements and enablers

The stakeholders responsible for implementing Priority Area 7 reported a number of achievements. These included:

- **Development of audit tools and processes.** The development of audit tools was reported as an achievement by the Queensland and ACT governments in the implementation of Priority Area 7. These tools will enable Queensland Health and ACT Health Directorate to monitor and promote safety and quality of care in mental health services across their jurisdictions. The Department of Health and Human Services Victoria initiated a state-wide audit of aged persons' mental health services. This audit provided a review of programs of care in mental health residential services for older Victorians, through engagement across the sector and has been delivered in partnership with the Office of the Chief Mental Health Nurse.
- **Introduction of new initiatives.** The introduction of new initiatives to support effective system performance and system improvement was also reported as an achievement by state governments. New initiatives in Victoria included the state-wide initiation, development and rollout of: SafeWards, the Mental Health Intensive Care Framework, the Nursing Observations through Therapeutic Engagement in Psychiatric Inpatient Care guidelines, and the Chief Psychiatrist's Discharge Planning Guidelines. NSW Health reported the introduction of Local Health District initiatives designed to support consumer and carer participation in the ongoing improvement of services. Among these initiatives are a Strategic Management and Reporting Tool and Accountability Viewer, which reports performance against the district's service agreement, and the recruitment of a consumer member for the LHN Mental Health Executive Patient Safety and Quality meeting.

Enablers reported by stakeholders included frequent engagement with the Office of the Chief Psychiatrist and state mental health commission (WA Health), as well as willingness of the aged persons' mental health sector to engage meaningfully with the state government to improve quality and safety (Department of Health and Human Services Victoria). The establishment of the Safety and Quality Engagement Group, including consumer and carer representatives, has been a key enabler for the development of the Safety and Quality Engagement Guide (NMHC).

Priority Area 7: Barriers

Although state and territory governments did not report any barriers to progress, the SQPSC reported that a key challenge in implementing Action 21.3 has been in ensuring diversity of representation on the committee across multiple stakeholder perspectives, particularly states and territories. The SQPSC is conscious of the need to limit the size of the committee, while enabling contributions from all jurisdictions. To manage this, alternative forms of representation have been used for certain stakeholder groups, such as through seeking nominations for jurisdictional contacts for the Safety and Quality Engagement Project.

Table 10: Priority Area 7 – overview of progress

Action	Status	Coordination Point	Milestone date in Implementation Plan
21.1	Commenced – not on track	SQPSC	Commence 2018. Completed 2021.
21.2	Completed	MHISSC	Commence 2019. Completed 2020.
21.3	Commenced – on track	SQPSC	Commence 2018. Completed 2020.
21.4	Commenced – not on track	SQPSC	Commence 2019. Completed 2021.
21.5	Commenced – on track	SQPSC	Commence 2018. Completed 2020.
22	Yet to commence	SQPSC	Commence 2019. Completed 2021.
23	Commenced – on track	MHISSC	Commence 2018. Completed 2021.
24	Commenced – on track	MHISSC	Published by December 2018.
25	Commenced – on track	SQPSC, changing to the MHISSC	Completed end 2021.
26	Commenced – on track	MHPC	Commence 2017 and ongoing.
27	Yet to commence	SQPSC, changing to all jurisdictions	Commence 2018 and ongoing.

The majority of actions under this priority were reported as 'commenced – on track'.

The NMHC acknowledges that the Safety and Quality Partnership Standing Committee (SQPSC) is unable to progress the development of a mental health supplement to the National Safety and Quality Health Service (NSQHS) Standards (Action 22), until a process for revising the National Standards for Mental Health Services (NSMHS) (Action 21.4) has been finalised. The NMHC notes the progress towards the implementation of a process for revising the NSMHS (Action 21.4). As reported by the SQPSC, the NMHC recognises the value of broadening representation in the project advisory group being established by the SQPSC to ensure coverage of all relevant service delivery sectors. Once representatives are confirmed, the NMHC expects to see progress made towards the commencement of the mental health supplement to the NSQHS Standards.

The NMHC notes the high cost involved in the implementation of the World Health Organization (WHO) QualityRights Guide and training tools (Action 27), and the MHPC's decision not to support the initial proposal, as reported in the 2018 Progress Report. The MHPC has since agreed that this action is the responsibility of individual jurisdictions and will not progress further. Given the prohibitive cost of implementing the WHO QualityRights Guide however, it is unlikely that states and territories will adopt this model. On this basis, the NMHC is unclear as to the value of keeping this action in the Implementation Plan and suggests that governments revise the inclusion of this action in the Fifth Plan or explore alternative models for national implementation of comparable training instead.

Additionally, the NMHC acknowledges the change to the Coordination Point of Action 25, ensuring that services funded by the Australian Government and states and territories have safety and quality monitoring and public reporting. The NMHC encourages stakeholders to work together to ensure that the roles and responsibilities for this action are clear, and that this change does not negatively affect future progress.

The NMHC notes the completion of Action 21.2, with the MHISSC reporting that it has revised the National Mental Health Performance Framework. The revised framework will support the monitoring and reporting of performance and quality across all mental health service sectors.

Case study 7: Making safety and quality central to mental health services delivery

The Fifth Plan prioritises safety and quality as central considerations in the delivery of mental health services. At a foundational level, this includes ensuring the physical safety of consumers, carers, and service providers. Although it is not always possible to identify and eliminate risk entirely, Queensland Health is seeking to minimise the likelihood of an adverse outcome by providing a systematic structured and standardised approach to the identification, assessment and management of consumers who may pose a risk of violence towards others.

In March 2019, Queensland Health released the Violence Risk Assessment and Management Framework – Mental Health Services. State-wide implementation of the framework was completed by July 2019. The framework was developed in response to recommendations arising from the 2016 report 'When mental health care meets risk: a Queensland sentinel events review into homicide and public sector mental health services'.

The framework provides mental health services with a structured three-tiered approach. Tier 1 involves a brief risk screen undertaken by frontline clinical staff for all mental health service consumers. Tier 2 involves a comprehensive risk assessment undertaken by senior clinicians and consultant psychiatrists for consumers identified at tier 1 as having an elevated risk for violence. Tier 3 involves a targeted response by forensic mental health services for consumers assessed at tier 2 as having a significantly elevated risk profile and complex forensic behaviours requiring specialist input. Each tier is supported by clinical documentation and training modules to build clinical capability to undertake the required response.

An evaluation of a six month pilot of the framework demonstrated several benefits. The evaluation showed that the framework had improved the quality of information gathered pertaining to violence risk; encouraged discussion of risk during multidisciplinary team reviews; increased senior clinician input into risk assessment and management planning; enhanced the ability of clinicians and mental health services to manage risk; and improved liaison with, and referrals to, specialist forensic mental health services.

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

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

Stakeholders responsible for coordinating the actions under this priority area are the MHPC, the MHISSC and the AHMAC. Stakeholders responsible for implementing the actions under this priority area are the Australian Government Department of Health, the MHPC and the NMHC.

ACTION 28:

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

This action requires the NMHC to lead the development of a research strategy in collaboration with the National Health and Medical Research Council, consumers and carers, states and territories, research funding bodies and prominent researchers.

As reported by the MHPC, the NMHC convened the National Mental Health Research Strategy (NMHRS) Steering Committee to develop the research strategy. The NMHRS Steering Committee comprises research funders, researchers, and representatives from the Australian Government Department of Health, consumers and carers, the joint mental health commissions, states and territories, and the National Aboriginal and Torres Strait Islander Leadership in Mental Health.

The NMHRS Steering Committee has met twice. The work plan of the NMHRS Steering Committee is currently in development and the committee's next meeting will be held in the third quarter of 2019.

As the Coordination Point of this action, the MHPC rated progress as 'commenced – on track'.

ACTION 29:

Governments will develop Peer Workforce Development Guidelines.

This action requires the NMHC to lead the development of Peer Workforce Development Guidelines. The NMHC will consult with all governments, mental health commissions, consumers and carers, and the mental health sector on the development of these guidelines. Governments will ensure that the guidelines:

- create role delineations for peer workers that provide opportunities for meaningful contact with consumers and carers, and grassroots based advocacy
- identify effective anti-stigma interventions with the health workforce.

As reported by the MHPC, the NMHC has convened a steering committee to oversee this project, with representation from the mental health sector, and states and territories. The majority of committee members are peer workers. Also included are Aboriginal and Torres Strait Islander representatives, and representatives from the LGBTIQ+ community, and rural and remote regions.

The Steering Committee has met twice. Key elements of the project, including scope, project approach and engagement strategies, were finalised at its latest meeting in July 2019.

The NMHC recognises that an integral part of embedding the peer workforce in services, and improving care for consumers and carers, is to explore the cultural aspect of services and ensure a safe environment that is free from stigma and discrimination for staff (including peer workers) and people accessing services. This topic will be explored further by the steering committee and in broader stakeholder engagement activities.

As the Coordination Point of this action, the MHPC rated progress as 'commenced – on track'.

ACTION 30:

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

This action requires the MHISSC to continue developing data sources to monitor the growth of the national peer workforce in public sector mental health services. The MHISSC will also identify opportunities for reporting of employment of peer workers in the non-government sector, including PHNs.

The MHISSC and its Data Set Subcommittee have developed a proposed peer workforce survey for MHPC endorsement. This proposal will be discussed by the MHPC at its meeting in August 2019.

As the Coordination Point of this action, the MHISSC rated progress as 'commenced – on track'.

ACTION 31:

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

This action requires the Australian Government Department of Health to manage contractual arrangements with an expert provider to obtain outputs from the NMHSPF to inform the development of this activity. This action also requires the MHPC to agree on the scope of the Workforce Development Program and consult with relevant AHMAC committees on the approach to ensure alignment with policy arrangements for the broader health agenda.

The Australian Government Department of Health reported that it is currently managing these contractual arrangements, noting that the Australian Government required a National Mental Health Workforce Strategy in the Mid-Year Economic and Fiscal Outlook 2018. This strategy will inform the development of the Workforce Development Program.

Given that work on the National Mental Health Workforce Strategy is in its early stages, the MHPC has not yet agreed on the scope for the Workforce Development Program. As development of the strategy progresses, the MHPC will consult with relevant AHMAC committees to ensure that the Workforce Development Program is aligned with policy arrangements for the broader health workforce.

The MHPC, on behalf of the Coordination Point of this action, the AHMAC, reported that overall progress of this action is 'commenced – on track'.

ACTION 32:

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

This action requires the MHPC to agree on the approach to the development of the framework. The Australian Government Department of Health, in collaboration with the National Digital Health Agency, will engage a suitably qualified provider to scope the requirements of a National Digital Mental Health Framework through a comprehensive consultation process, including with the ATSIMHSPPRG. States and territories will contribute to Australian Government consultation and development of the framework.

The Australian Government Department of Health is currently preparing an approach to developing the National Digital Mental Framework. This approach will be presented to the MHPC at its August 2019 meeting, where agreement to the approach and associated timelines will be sought. Background work to support this action, including the development of national standards and a certification framework for digital mental health services, is in progress.

Consultation with the ATSIMHSPPRG is expected to commence once the project plan has been agreed to by the MHPC.

The MHPC, on behalf of the Coordination Point of this action, the AHMAC, reported that overall progress of this action is 'commenced – on track'.

Priority Area 8: Achievements and enablers

No significant or consistent achievements were reported by stakeholders at this stage of implementation.

Priority Area 8: Barriers

The Australian Government Department of Health reported that implementation of the National Digital Mental Health Framework did not commence in 2018–19 as a result of competing priorities and a lack of additional or dedicated resources. However, since implementation commenced in July 2019, the Department of Health reports that the expected timeframes for the completion of the National Digital Mental Health Framework can still be met.

Table 11: Priority Area 8 – overview of progress

Action	Status	Coordination Point	Milestone date in Implementation Plan
28	Commenced – on track	MHPC	Commence 2018. Completed 2021.
29	Commenced – on track	MHPC	Commence mid-2018. Completed 2021.
30	Commenced – on track	MHISSC	Commence mid-2018 and ongoing.
31	Commenced – on track	AHMAC (progress reported by the MHPC)	Commence early-2018. Completed 2022.
32	Commenced – on track	AHMAC (progress reported by the MHPC)	Commence mid-2018. Framework completed 2020.

The NMHC is pleased to note that the majority of actions were reported as 'commenced – on track'. Progress was reported towards the development of the National Mental Health Research Strategy, the Peer Workforce Development Guidelines and the National Digital Mental Health Framework.

In agreement with the MHPC and the Australian Government Department of Health, the NMHC acknowledges the importance of aligning the development of the Workforce Development Program (Action 31) with the National Mental Health Workforce Strategy led by the Australian Government Department of Health.

Outputs from the NMHSPF will also inform the development of the Workforce Development Program. As reported in the 2018 Progress Report, the ongoing improvement of the NMHSPF to ensure that it includes rural, remote and Aboriginal and Torres Strait Islander populations is important if jurisdictions are to be able to use the framework fully.

The NMHC notes the work currently underway by the University of Queensland to address the limitations of the NMHSPF. This is also an important consideration in the development of the Workforce Development Program.

Case study 8: Community-of-practice approach supports peer workers in grassroots-based advocacy

As identified in the Fifth Plan, creating opportunities for peer workers to advocate within a system at a grassroots level supports the reduction of stigma and discrimination. In support of grassroots advocacy, Brisbane South PHN worked with lived experience practitioners to establish a community of practice for people working from a lived experience perspective within community services.

The community of practice was developed through a series of co-design workshops to support the lived experience practitioners to create an environment of learning from their shared experiences. The design process also aimed to build capability for emerging leaders in the lived experience workforce. The co-design facilitators taught and modelled decision making, groundwork for hosting meetings, and project design techniques. Members of the community of practice named the group, the Community of Lived Experience Workers (CLEW), and developed a slogan, 'If you don't have a CLEW, then you don't have a CLUE!'.

In total, 67 individuals attended the workshops, with the majority of participants reporting that they felt more connected. By creating a sense of belonging, and a safe, supportive space, participants felt more supported in their lived experience role. Participants also reported that they felt more comfortable speaking up and that they would sustain the connections that they made through the CLEW.

Consumer and carer engagement

The ultimate aim of the Fifth Plan is to improve the lives of people living with a mental illness, as well as the lives of their families, carers and communities. For this reason, consumers and carers are central to the way in which services are planned, delivered and evaluated and it is critical that stakeholders closely engage with consumers and carers throughout the implementation of the Fifth Plan.

In the 2018 Progress Report, stakeholders were asked to rate participation and engagement of consumers and carers against seven levels of engagement. The majority of stakeholders reported that engagement and participation with consumers and carers was occurring by 'informing', 'consulting', 'involving' and 'collaborating'. In 2019, the NMHC revised its survey process to capture more descriptive and meaningful information from stakeholders. Stakeholders were asked to provide specific examples of how consumers and carers were engaged throughout the implementation of actions within each priority area.

Stakeholders described involving consumers and carers via a number of mechanisms. These included direct engagement with individual consumers and carers, as well as engagement through local, regional and national consumer and carer non-government organisations, consumer advisory councils and peer workforce networks.

Specific consultation activities included:

- co-design workshops with targeted communities, including Aboriginal and Torres Strait Islander people, LGBTIQ+ people, young people and culturally and linguistically diverse communities (Priority Area 1)
- public consultations to inform the development of regional plans (Priority Area 1), state-wide suicide prevention plans (Priority Area 2), and strategic frameworks and projects to improve physical health (Priority Area 5)
- inclusion of consumer and carer representatives in mental health research projects (Priority Area 3)
- facilitated yarning circles and focus groups (Priority Area 4).

A small number of PHNs reported funding consumer and carer representatives on external committees, forums and conferences to represent their region, such as the National Mental Health Consumer and Carer Forum and the PHN Stepped Care Conference (Priority Area 1). Similarly, a state and territory government has provided funding to the Mental Health Consumer Network to develop and implement information and education for consumers and carers on mental health legislation (Priority Area 3).

Of particular significance, a PHN reported having employed a dedicated consumer and carer engagement coordinator as part of its engagement framework, to facilitate and increase the level of engagement in support of integrated planning and service delivery (Priority Area 1).

The inclusion by stakeholders of consumer and carer representatives on formal governance structures was consistent across all eight priority areas. This included the AHMAC committees responsible for implementing, or coordinating the implementation of, the Fifth Plan; as well as steering committees, working groups, and reference groups convened by governments, PHNs and mental health commissions to progress specific actions within the plan.

The formal engagement of these consumer and carer representatives on governance structures has informed a number of key deliverables such as the Peer Workforce Development Guidelines (Priority Area 8), initiatives for seclusion and restraint prevention (Priority Area 7), joint regional plans (Priority Area 1) and the draft National Suicide Prevention Implementation Plan (Priority Area 2).

While stakeholders report strong consumer and carer engagement via governance structures, further work is needed in Priority Area 4. The ATSIMHSPPRG reported that, to date, there has been no formal involvement of consumers and carers in its implementation of actions. This is concerning given the key responsibility of the ATSIMHSPPRG in implementing the majority of actions within this priority area. However, the ATSIMHSPPRG reported that its new Chair will work with members to identify consumer and carer representatives to join the group. It is expected that consumers and carers will be consulted as project work progresses, and through the participation of consumers and carers in the MHPC and other AHMAC committees.

The NMHC notes that, although consumers and carers are represented via a working group to reduce stigma and discrimination in Priority Area 6, the delayed progress of actions in this area means that targeted consultations with consumers and carers are yet to take place.

In addition to representation on governance structures, peer support workers were reported by state and territory governments as a key mechanism for coordinating treatment and supports for people living with severe and complex mental illness (Priority Area 3). This was achieved through the introduction of peer support roles into the justice system and partnering with peer support services to support consumers as they transition into community living.

Participation of consumers and carers throughout the implementation of the Fifth Plan is paramount to achieving its objectives. The NMHC is encouraged by the engagement described by the majority of stakeholders as implementation progresses. Given the significant value the consumer and carer perspective brings to mental health planning, delivery and evaluation, it is critical that engagement with consumers and carers is maintained throughout the life of the plan.

Concluding statement

The Fifth Plan commits to a nationally agreed set of priority areas and actions that are designed to achieve an integrated mental health system. The NMHC has been given responsibility for reporting annually on the implementation progress of the Fifth Plan.

Following the 2018 Progress Report, the NMHC sought advice from the Fifth Plan Technical Advisory Group (FPTAG) on the 2019 survey process, survey questions and accompanying guidance sent to stakeholders. Stakeholders surveyed included the Australian Government Department of Health, state and territory departments of health, national and state mental health commissions, PHNs and relevant AHMAC sub-committees.

The 2019 Progress Report outlines the progress achieved throughout the second year of Fifth Plan implementation. Stakeholders responsible for implementing and coordinating each individual action, as named in the Fifth Plan Implementation Plan, were surveyed on their progress.

Although the majority of actions were reported by stakeholders as progressing well, a number of actions within Priority Area 4 (Improving Aboriginal and Torres Strait Islander mental health and suicide prevention), Priority Area 6 (Reducing stigma and discrimination) and Priority Area 7 (Making safety and quality central to mental health service delivery) must be addressed immediately to prevent further delays in these important areas.

The NMHC will continue to work with the FPTAG and the stakeholders responsible for implementing the Fifth Plan to ensure that monitoring of implementation progress is meaningful and can guide stakeholders in their ongoing implementation of Fifth Plan actions and consideration of future reforms.

The Fifth National Mental Health and Suicide Prevention Plan: 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 into the future. 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 a more detailed view for community groups or mental health services, and allow performance to be reported for different age groups, for males and females, and for Aboriginal and Torres Strait Islander people.

The Fifth Plan indicator set includes indicators that can currently be measured (see Box 5), as well as indicators that require various amounts of development before they will be available for reporting. Under Action v of the Fifth Plan, the Mental Health Information Strategy Standing Committee (MHISSC) has responsibility for identifying data sources and developing methodologies for the 24 performance indicators identified in the Fifth Plan. The MHISSC has completed this work for 18 of the 24 indicators, and data on these indicators is included in this report. This includes PI 1: Children who are developmentally vulnerable, PI 9: Social participation of adults with mental illness, PI 11: Adult carers of people with mental illness in employment, PI 13: Mental health consumer experience of service and PI 23: Involuntary hospital treatment, which are being reported for the first time.

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 NMHC's future reporting as they become available (see Appendix C for additional information).

Box 5: Available performance indicators, by area of monitoring

Available performance indicators that analyse the health and wellbeing of Australians:

- PI 1: Children who are developmentally vulnerable
- PI 2: Long-term health conditions in people with mental illness
- PI 3: Tobacco and other drug use in adolescents and adults with mental illness
- PI 6: Prevalence of mental illness
- PI 7: Adults with very high levels of psychological distress
- PI 9: Social participation in adults with mental illness
- PI 10: Adults with mental illness in employment, education or training
- PI 11: Adult carers of people with mental illness in employment
- PI 19: Suicide rate
- PI 24: Experience of discrimination in adults with mental illness

Available performance indicators that analyse the performance of the mental health system:

- PI 13: Mental health consumer experience of service
- PI 14: Change in mental health consumers' clinical outcomes
- PI 15: Population access to clinical mental health care
- PI 16: Post-discharge community mental health care
- PI 17: Mental health readmissions to hospital
- PI 18: Mental health consumer and carer workers
- PI 22: Seclusion rate
- PI 23: Involuntary hospital treatment

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 this 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 or not 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.

Reporting of the Fifth Plan indicators

A high-level summary of the available indicators is included below. The remainder of this report analyses each available indicator individually, including what the data can tell us about the mental health and wellbeing of Australians or the performance of the mental health sector, and what the data cannot tell us. A detailed description of the scope and rationale for the available indicators can be found in Appendix D, and additional data for each available indicator can be found on the NMHC's website in an Excel workbook.

Is the health and wellbeing of Australians improving?

Early life

Children who display poor early learning skills are likely to fall further behind, so early detection of, and intervention for, developmental vulnerabilities are important to children's longer-term outcomes. Nationally, the proportion of children who were developmentally vulnerable (PI 1) did not decrease between 2012 and 2018. Over this time, the proportion of Aboriginal and Torres Strait Islander children who were developmentally vulnerable was consistently more than double that of non-Indigenous children. The proportion of children who were developmentally vulnerable increased as remoteness increased; this disparity was stable from 2012 to 2018.

Physical health

Numerous studies have highlighted that people living with mental illness are more likely to die early.[3] Most of the causes of early death relate to physical illnesses such as cardiovascular disease, diabetes and cancer. Both nationally and in all states and territories, the presence of a long-term physical health condition (PI 2) is more common in people with mental illness than in people without mental illness. Although there is currently insufficient data to identify trends, the proportion of people with mental illness who had a long-term physical health condition was stable from 2014–15 to 2017–18.

Both legal and illicit drug use contributes to poorer health outcomes and decreased life expectancy for people with mental illness in Australia. Nationally, a higher proportion of adolescents and adults with mental illness smoked tobacco daily, compared to all adolescents and adults (PI 3). Although there is insufficient data to identify trends, the proportion of adolescents and adults with mental illness who smoked daily increased slightly from 2013 to 2016, while the proportion of all adolescents and adults who smoked daily was stable.

Rates of alcohol consumption were similar between people with mental illness and all Australians. Similar proportions of people with mental illness and all Australians consumed five or more standard drinks on a single occasion at least once in the past year, in both 2013 and 2016 (PI 3).

More people with a mental illness used illicit drugs in the past year (PI 3) compared to all Australians, in both 2013 and 2016. This disparity increased between 2013 and 2016.

Mental health and mental illness

Very high levels of psychological distress may signify a need for professional help. The proportion of adults with very high levels of psychological distress did not decrease between 2007–08 and 2017–18.

Mental illness prevalence rates provide a high-level indication of the mental health of Australians. In 2007, 20.0% of Australians aged 16-85 experienced a mental illness (PI 6). In 2013–14, 13.9% of children and adolescents aged 4-17 experienced a mental illness (PI 6). In 2010, 0.4% of Australians aged 18-64 had a psychotic disorder and were in contact with public specialised mental health services (PI 6). Currently, only a single year of in-scope data is available for each component of the prevalence of mental illness performance indicator, so it will not be possible to comment on change until more data becomes available. A survey to update the data for Australians aged 16-85 is in the early stages of development, but it is not clear when the remaining data will be updated.

Suicide is the leading cause of death among people aged 15-44 in Australia, and people with mental illness are at greater risk. Nationally, from 2009 to 2018, the suicide rate trended slightly upwards (PI 19). Over this time, no state or territory experienced a sustained reduction in its suicide rate. In 2009–2013, Aboriginal and Torres Strait Islander Australians had a suicide rate around double that of non-Indigenous Australians; a disparity that persisted through 2014–2018.

Contributing life

Maximising opportunities to participate in a range of community activities and contribute to the community are important factors in recovery from mental illness. In 2014, similar proportions of people with and without mental illness had engaged in social participation in the past 12 months (PI 9). This pattern was also observed for Aboriginal and Torres Strait Islander people. There is not sufficient data available to identify trends. However, the similarities between people with and without mental illness reported in this indicator do not align with other reports that people with mental illness experience high levels of social exclusion, including reduced participation in day-to-day activities.[4] More investigation is required to determine whether or not the data accurately reflect the experience of people with all types and severity levels of mental illness.

All governments are committed to ensuring a contributing life for people with mental illness. This includes an individual's ability to support their own livelihood and contribute to the greater community through employment. In all age groups, a lower proportion of people with mental illness were in employment, education or training (PI 10), compared to people without mental illness. Although there is not sufficient data available to identify trends, this disparity was consistent from 2014–15 to 2017–18.

A well-integrated, effective and sustainable mental health system for people with a psychosocial disability also supports carers to live a contributing life, including their participation in employment. In 2015, carers of people with mental illness had similar employment rates (PI 11) to carers of people with other condition types and lower employment rates than people who were not carers. This pattern is more pronounced in female carers than male carers and persisted through to 2018. There is not currently sufficient data available to identify trends for this indicator.

For people with mental illness, experiencing discrimination can increase feelings of isolation and create barriers to seeking help. Nationally, in 2014, the proportion of people with mental illness who experienced discrimination (PI 24) was nearly double that of people without mental illness. There is a similar pattern among Aboriginal and Torres Strait Islander people. Currently, there is insufficient data available to identify trends.

Is the performance of the mental health system improving?

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. Nationally, the rate of full-time equivalent consumer workers (PI 18) increased from 2007–08 to 2017–18, but the patterns observed varied for states and territories. Nationally, the rate of full-time equivalent carer workers (PI 18) increased from 2007–08 to 2017–18.

Measuring population treatment rates against what is known about the distribution of mental illness in the community gives a broad estimate of unmet need. While data on the prevalence of mental illness (see PI 6) is limited, assuming the prevalence of mental illness is stable, then higher proportions of people accessing clinical mental health care suggest less unmet need. From 2013–14 to 2017–18, the proportion of people accessing both public and private clinical mental health care was stable, at around 2% and 0.2% respectively (PI 15). In this time, the proportion of people accessing Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care increased to about 10%. From 2013–14 to 2017–18 the proportion of Aboriginal and Torres Strait Islander people accessing Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care services was comparable to that of non-Indigenous people.

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 total seclusion rate in public acute mental health hospital services (PI 22) showed a sustained reduction from 2008–09 to 2018–19. Seclusion rates for public acute mental health hospital services targeted at older people and the general population have also showed a sustained reduction during this period. However, seclusion rates fluctuated for services targeted at children and adolescents, while services targeted at the forensic population have experienced a sharp increase since 2015–16.

Involuntary care is a type of restrictive and coercive practice where treatment for mental illness is provided without the person's consent. The proportion of public sector acute mental health separations and patient days with involuntary specialised mental health care (PI 23) varied between states and territories in 2017–18. Currently there is insufficient data to identify trends.

State or territory clinical mental health services aim to reduce symptoms and improve functioning. Clinical mental health services are effective at improving clinical symptoms (PI 14) for the majority of consumers, but have not made progress in the last 10 years in reducing the proportion of consumers who experienced no significant change or significant deterioration of clinical symptoms.

Consumer experiences of care from mental health services are a measure of the performance of the service and are vital to inform ongoing quality improvement efforts. In 2016–17, the majority of consumers accessing admitted patient care and ambulatory care in New South Wales, Victoria and Queensland, who participated in data collection, reported a positive experience of service (PI 13). Data for other states and territories is not available. Experience of ambulatory care was consistently rated positively more often than admitted patient care. Nearly half of consumers accessing admitted patient services in Victoria and Queensland did not have a positive experience of care. A higher proportion of mental health consumers with a voluntary mental health legal status reported a positive experience of care, compared to mental health consumers with an involuntary mental health legal status. Time series data are not currently available, so it is not possible to comment on trends at this time.

Community mental health care following hospital discharge is essential to maintain clinical and functional stability and to minimise the need for hospital readmission. Nationally, the rate of post-hospital discharge community mental health care (PI 16) increased each year from 2011–12 to 2017–18. The largest increase in post-discharge community mental health care was for remote and very remote areas, which now have rates of post-discharge community mental health care that are comparable to that of major cities, inner regional and outer regional locations. However, even in 2017–18, post-hospital discharge community mental health care did not occur within seven days in 20–25% of cases.

Readmission to hospital within 28 days of discharge, also known as rapid readmission, 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. Nationally, the proportion of mental health-related hospitalisations that are followed by rapid readmission (PI 17) was relatively consistent from 2013–14 to 2017–18. Across geographical areas, major cities had a small upwards trend, while inner regional areas, outer regional areas and remote and very remote areas did not show a consistent trend.

Conclusion

At the national level, some aspects of the health and wellbeing of Australians have been stagnant, and some are experiencing small, sustained deterioration. The proportion of children who are developmentally vulnerable and the proportion of adults with very high levels of psychological distress have been stagnant. Health and wellbeing, as measured by suicide rates, has experienced small, sustained deterioration.

Although it is not currently possible to comment on a trend due to insufficient data, the disparity between people with and without mental illness in long-term physical health conditions, tobacco and other drug use, participation in employment, education and training, and experience of discrimination, suggests that more work is also needed in these areas.

Nationally, some aspects of the mental health system's performance are consistently improving, while others remain stagnant. We are seeing improvements in:

- population access to Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care
- seclusion rates
- employment of consumer and carer workers
- post-hospital discharge community mental health care access.

However, improvements have not been seen in:

- population access to public and private clinical mental health care
- the proportion of mental health-related hospitalisations that are followed by rapid readmission
- reducing the proportion of consumers who experienced no significant change or significant deterioration of clinical symptoms following clinical mental health care.

Although the performance indicators can identify that change is needed to improve the health and wellbeing of Australians or the performance of the mental health system, they are not able to indicate what change is necessary to see the desired improvements. Investigation beyond the Fifth Plan indicators is required to inform future reforms.

Performance indicator 1: Children who are developmentally vulnerable

Children who display poor early learning skills are likely to fall further behind, so early detection of, and intervention for, developmental vulnerabilities are important to children's longer-term outcomes. Higher proportions of children who are developmentally vulnerable suggest a greater need for support targeted at the early years of life.

What does the data tell us?

The Australian Early Development Census (AEDC) rates children's functioning in the domains of physical health and wellbeing, social competence, emotional maturity, language and cognitive skills, and communication skills and general knowledge. The proportion of Australian children who were developmentally vulnerable in one or more domain (approximately 22%), or two or more domains (approximately 11%) of the AEDC was consistent from 2012 to 2018.

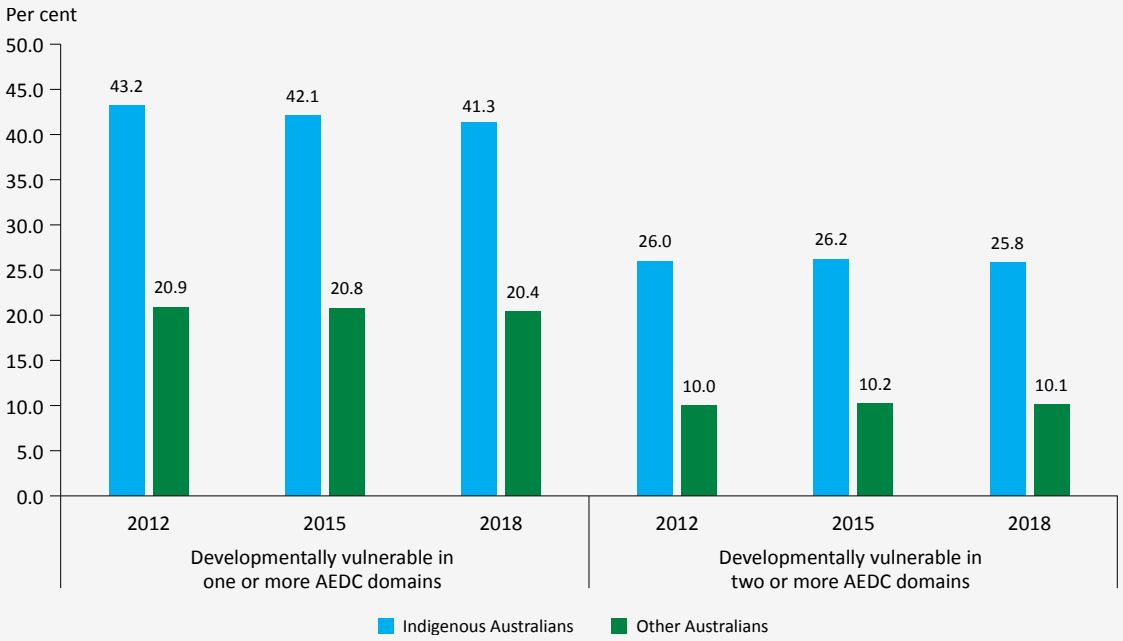
The disparity in developmental vulnerability between Indigenous and non-Indigenous children was stable from 2012 to 2018 (Figure PI 1). The proportion of Aboriginal and Torres Strait Islander children who were developmentally vulnerable was consistently more than double that of non-Indigenous children. The proportion of children who were developmentally vulnerable increased as remoteness increased; this disparity was stable from 2012 to 2018.

What can't the data tell us?

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

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 1: Children who are developmentally vulnerable, by Indigenous status, 2012, 2015 and 2018



Source: Australian Early Development Census

Performance indicator 2: Long-term health conditions in people with mental illness

The prevalence of long-term health conditions in people with mental illness is a measure of their physical health. Higher incidence of long-term health conditions in people with mental illness suggests poorer physical health.

What does the data tell us?

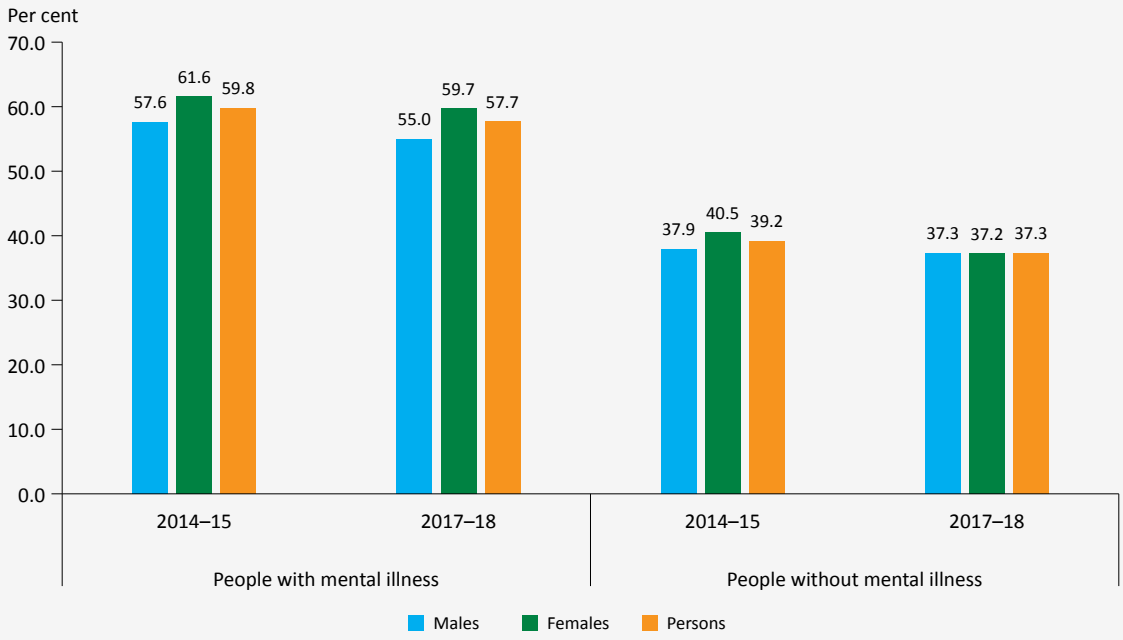
The presence of a long-term physical health condition is more common in people with mental illness than in people without mental illness (Figure PI 2). This pattern is the same across time for all states and territories and both males and females. The proportion of people with mental illness who had a long-term physical health condition was stable from 2014–15 to 2017–18.

What can't the data tell us?

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 do not support the analysis of differences in the physical health of people with different types of mental illness.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 2: People with a long-term physical health condition, by mental illness status and sex, 2014–15 and 2017–18



Source: ABS National Health Survey, 2014–15; ABS National Health Survey 2017–18.

Performance indicator 3:
Tobacco and other drug use in adolescents and adults with mental illness

Tobacco and other drug use in adolescents and adults with mental illness is a proxy measure for their physical health. Higher proportions of adolescents and adults who use tobacco and other drugs suggests poorer health.

What does the data tell us?

Nationally, a higher proportion of adolescents and adults with mental illness smoke daily, compared to all adolescents and adults. While the proportion of adolescents and adults with mental illness who smoke daily increased from 2013 to 2016 (21.0% and 24.1% respectively), the proportion of all adolescents and adults who smoke daily was stable (12.8% and 12.2% respectively). Although there appears to be a change in the proportion of Indigenous Australians with a mental illness who smoked daily between 2013 and 2016, the difference in these numbers is unlikely to be the result of a real difference in community behaviour. The proportion of other Australians with mental illness who smoked daily increased slightly from 2013 to 2016 (Figure PI 3).

Similar proportions of people with mental illness and all Australians consumed five or more standard drinks on a single occasion at least once in the past year in both 2013 and 2016 (41.8% of people with mental illness in 2013 and 44.3% in 2016, compared to 37.8% of all Australians in 2013 and 37.3% in 2016).

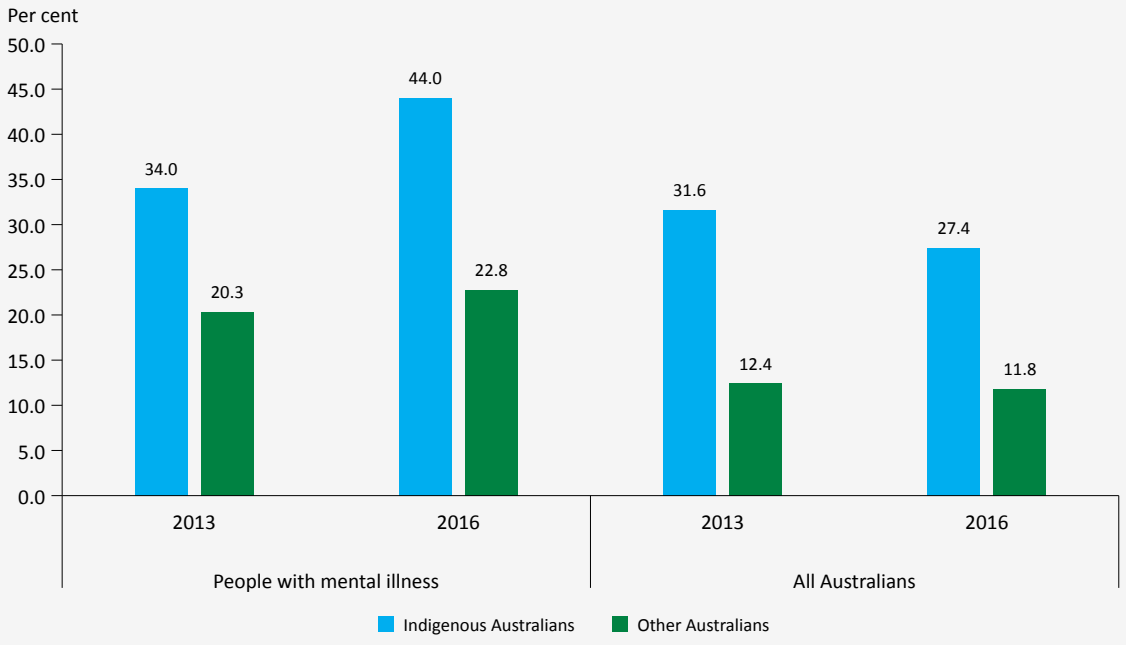
More people with mental illness used illicit drugs in the past year compared to all Australians, in both 2013 and 2016. This disparity increased between 2013 and 2016.

What can't the data tell us?

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.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 3: Daily tobacco use, by Indigenous status and mental illness status, 2013 to 2016



Source: National Drug Strategy Household Survey customised analysis.

Performance indicator 6: Prevalence of mental illness

The prevalence of mental illness provides a high-level indication of the mental health and wellbeing of Australians. Lower prevalence rates suggest higher levels of mental health and wellbeing.

What does the data tell us?

In 2007, 20.0% of Australians aged 16-85 experienced a mental illness (Figure PI 6). In 2013–14, 13.9% of children and adolescents aged 4-17 experienced a mental illness (16.3% of males, 11.5% of females). In this age group, attention deficit hyperactivity disorder (ADHD) was the most common mental illness (7.4% of persons, 10.4% of males and 4.3% of females), followed by anxiety disorders (6.9% of persons, 7.0% of males and 6.8% of females).

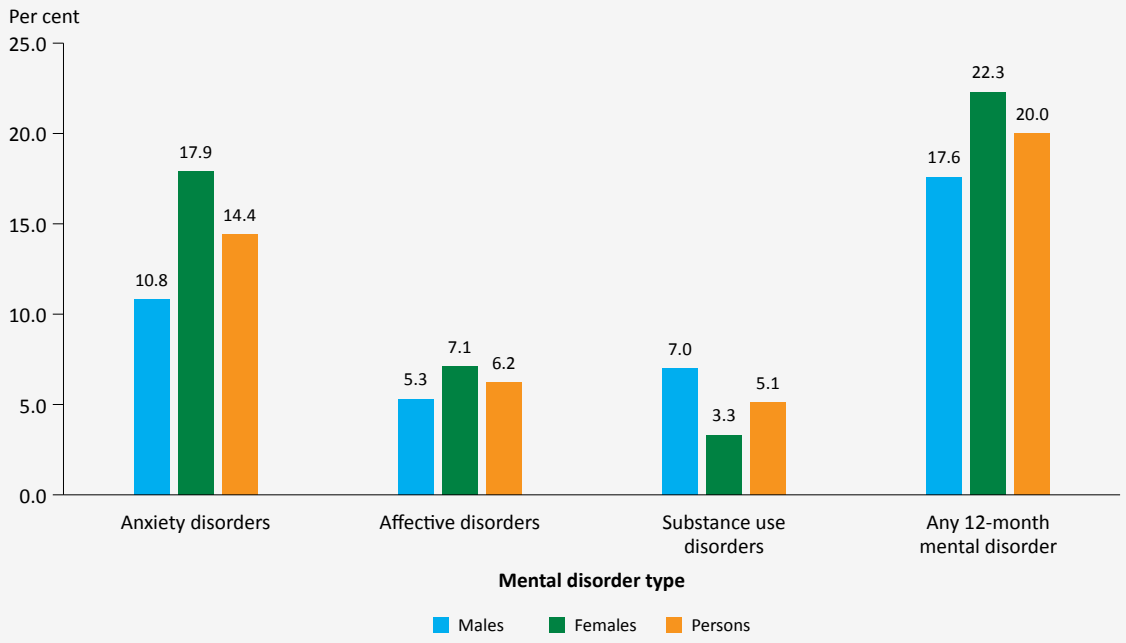
In 2010, 0.4% of Australians aged 18-64 (0.5% of males and 0.3% of females) had a psychotic disorder and were in contact with public specialised mental health services. People aged 25-34 and 35-44 had a psychotic disorder and were in contact with public specialised mental health services (0.6% respectively) more commonly than other age groups.

What can't the data tell us?

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.

Additional information about the scope of this indicator can be found in Appendix D.

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



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

Performance indicator 7: Adults with very high levels of psychological distress

Psychological distress is a proxy measure of the overall mental health and wellbeing of Australians, as very high levels of psychological distress may signify a need for mental health services. Higher proportions of Australians with very high levels of psychological distress suggests lower levels of wellbeing.

What does the data tell us?

The proportion of adults with very high levels of psychological distress did not decrease between 2007–08 and 2017–18 (Figure PI 7).

Although there appears to be a slight increase in national rate and fluctuation at the state and territory level, the apparent difference in these numbers is unlikely to be the result of a real change in the community's psychological distress levels.

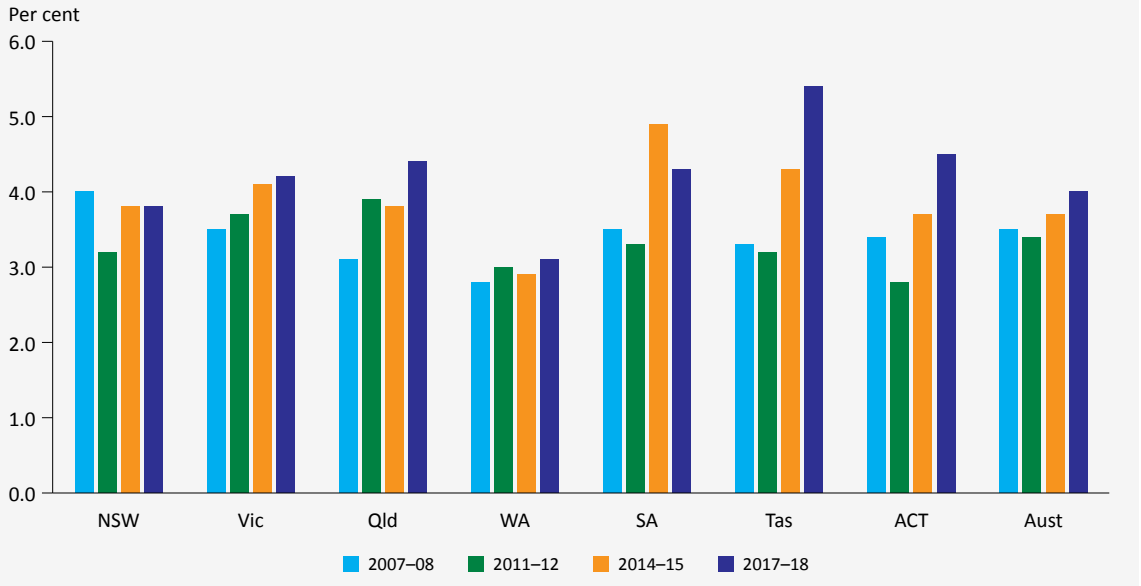
The proportion of Aboriginal and Torres Strait Islander adults with high and very high levels of psychological distress was more than double that of non-Indigenous adults from 2011–13 to 2017–19. The proportion of Aboriginal and Torres Strait Islander adults with high and very high levels of psychological distress did not decrease during this time.

What can't the data tell us?

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.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 7: Adults with very high levels of psychological distress, by state or territory, 2007–08 to 2017–18



Note: Due to data quality issues, data for the Northern Territory are not included in the figure. However, Northern Territory data are included in the Australian total.

Source: ABS National Health Survey 2017–18, (unpublished) National Health Survey, 2014–15; Australian Health Survey, 2011–13 (2011–12 NHS component); National Health Survey, 2007–08, Cat. no 4364.0.

Performance indicator 9: Social participation in adults with mental illness

Maximising opportunities to participate in a range of community activities, and contribute to the community are important factors in recovery from mental illness. Higher proportions of adults with a mental illness who report social participation suggest that more people with mental illness have a contributing life.

What does the data tell us?

In 2014, similar proportions of people with and without mental illness engaged in social participation in the past 12 months (Figure PI 9). This pattern was also observed for Aboriginal and Torres Strait Islander people; 91.2% of Indigenous people with mental illness and 89.9% of Indigenous people without mental illness engaged in social participation in the past 12 months.

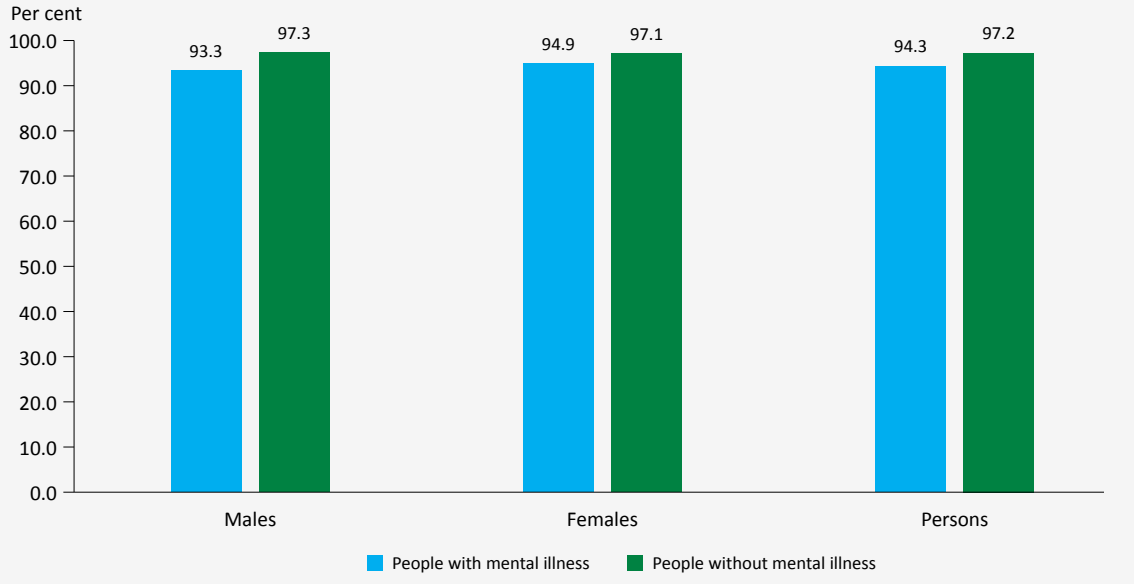
What can't the data tell us?

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.[5] 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 or not the data accurately reflect the experience of people with all types and severity levels of mental illness.

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

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 9: People who engaged in social participation in the past 12 months, by mental illness status and sex, 2014



Source: ABS General Social Survey, 2014 (unpublished)

Performance indicator 10: Adults with mental illness in employment, education or training

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

What does the data tell us?

In all age groups, a lower proportion of people with mental illness were in employment, education or training, compared to people without mental illness (Figure PI 10). This disparity was consistent from 2014–15 to 2017–18.

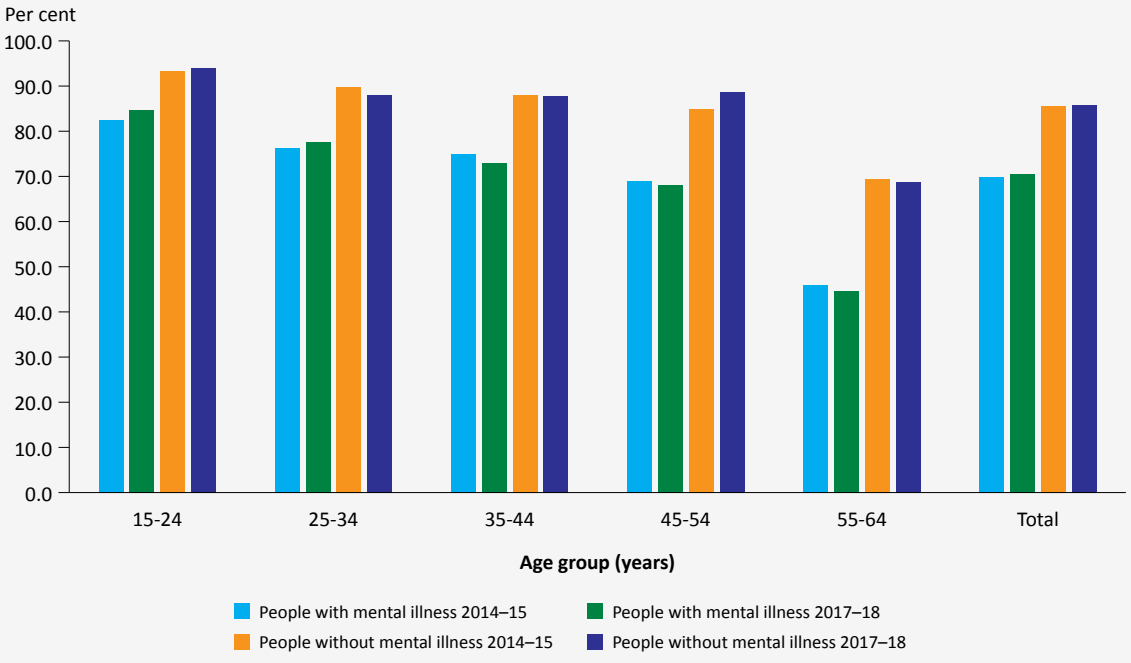
A lower proportion of Aboriginal and Torres Strait Islander people with mental illness were in employment education or training, compared to Aboriginal and Torres Strait Islander people without mental illness, in 2018–19.

What can't the data tell us?

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

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 10: People in employment, education or training, by mental illness status and age group, 2014–15 and 2017–18



Source: ABS National Health Survey, 2014–15 and National Health Survey, 2017–18

Performance indicator 11: Adult carers of people with mental illness in employment

A well-integrated, effective and sustainable mental health system for people with a psychosocial disability also supports carers to live a contributing life, including participation in employment.[6] Higher proportions of carers of people with mental illness in employment suggests that more carers are being supported to live a contributing life.

What does the data tell us?

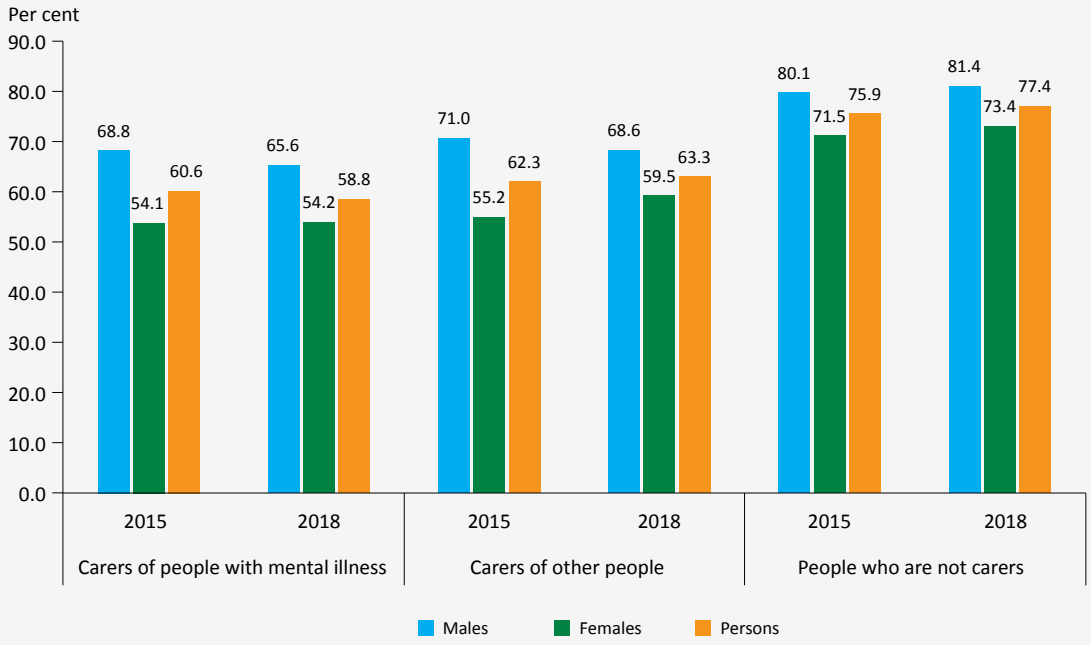
In 2015, carers of people with mental illness had similar employment rates to carers of people with other condition types, and lower employment rates than people who were not carers (Figure PI 11). This pattern is more pronounced in female carers than male carers and persisted through to 2018.

What can't the data tell us?

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

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 11: Participation in employment, by carer status and sex, 2015 and 2018



Source: ABS Survey of Disability, Ageing and Carers (SDAC), 2015; ABS SDAC 2018.

Performance indicator 13: Mental health consumer experience of service

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

What does the data tell us?

In 2016–17, the proportion of consumers who reported a positive experience of service was higher in ambulatory care services than in admitted patient services (Figure PI 13). Nearly half of consumers who accessed admitted patient services in Victoria and Queensland, and contributed to data collection, did not have a positive experience of care.

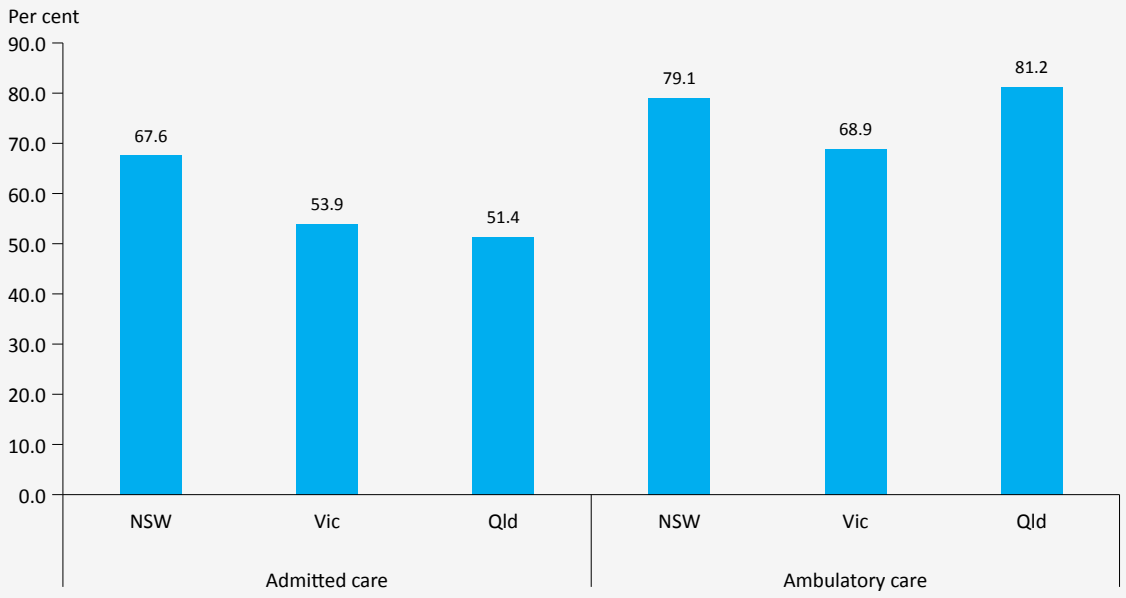
A higher proportion of mental health consumers who accessed admitted patient care with a voluntary mental health legal status, and participated in data collection, reported a positive experience of care (New South Wales 73.6%, Victoria 66.5% and Queensland 61.6%), compared to mental health consumers with an involuntary mental health legal status (New South Wales 63.2%, Victoria 44.4% and Queensland 44.1%).

What can't the data tell us?

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.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 13: Mental health consumers with a positive experience of service, by state and service setting, 2016–17



Source: Your Experience of Service survey

Performance indicator 14: Change in mental health consumers' clinical outcomes

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

What does the data tell us?

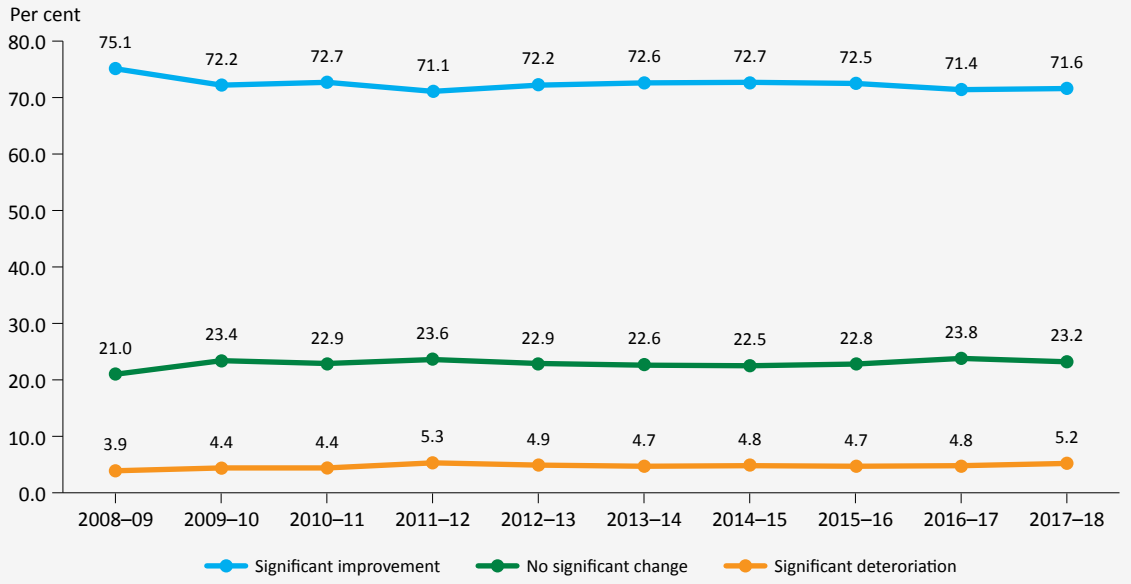
Over 70% of consumers' clinical symptoms significantly improved after completing inpatient care each year from 2008–09 to 2017–18 (Figure PI 14). Over this time, the proportion of consumers who experienced no significant change or significant deterioration of clinical symptoms was also consistent. A similar pattern occurred for consumers who completed ambulatory care.

What can't the data tell us?

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

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 14: Change in mental health consumers' clinical symptoms after completing inpatient care, 2008–09 to 2017–18



Source: National Outcomes and Casemix Collection.

Performance indicator 15: Population access to clinical mental health care

Measuring population treatment rates against what is known about the distribution of mental illness in the community gives a broad estimate of unmet need. If the prevalence of mental illness is stable (see PI 6), then higher proportions of people accessing clinical mental health care suggest less unmet need.

What does the data tell us?

From 2013–14 to 2017–18, the proportion of people accessing public and private clinical mental health care was stable, at around 2% and 0.2% respectively. In this time, the proportion of people accessing Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care increased to about 10%, with increases occurring for all provider types (Figure PI 15). General practitioners provided the highest proportion of clinical mental health care services that are subsidised by Medicare and Department of Veterans' Affairs, and experienced the largest increase from 2013–14 to 2017–18.

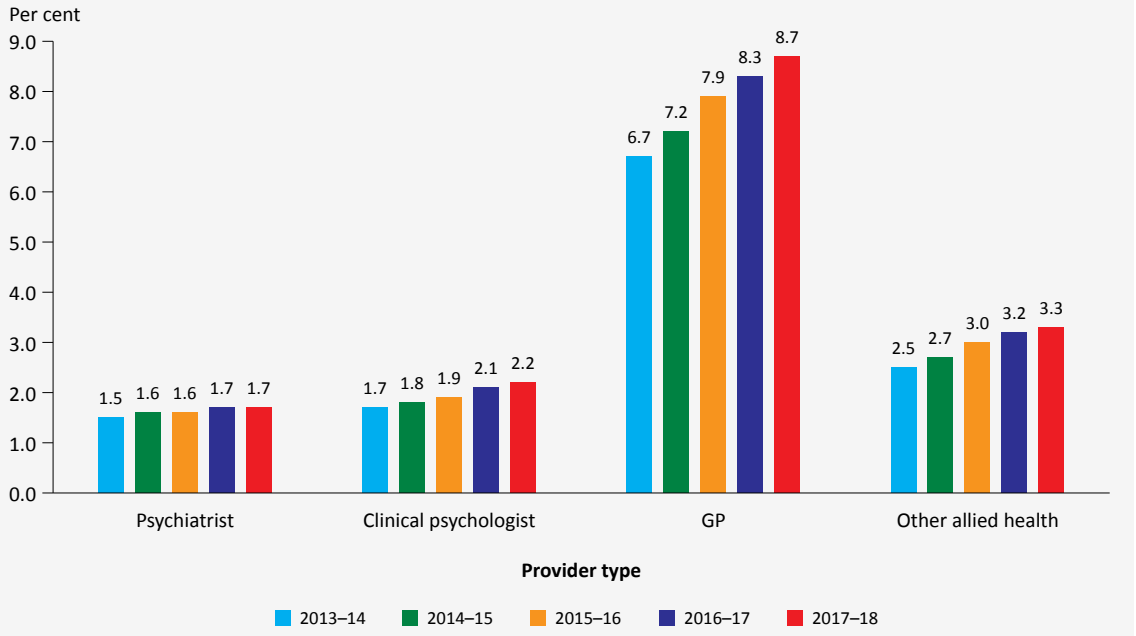
From 2013–14 to 2017–18, the proportion of Aboriginal and Torres Strait Islander people accessing Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care services was comparable to that for non-Indigenous people, and increased from 8.1% to 10.6%.

What can't the data tell us?

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.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 15: Population accessing Medicare-subsidised and Department of Veterans' Affairs-subsidised clinical mental health care services, by service provider type, 2013–14 to 2017–18



Source: Department of Health MBS statistics (unpublished); Department of Veterans' Affairs Treatment Account System data (unpublished).

Performance indicator 16: Post-discharge community mental health care

Post-hospital discharge community mental health care is essential to maintain clinical and functional stability, and to minimise the need for hospital readmission. Higher proportions of people who access community mental health care following their discharge from hospital suggest a more effective mental health system.

What does the data tell us?

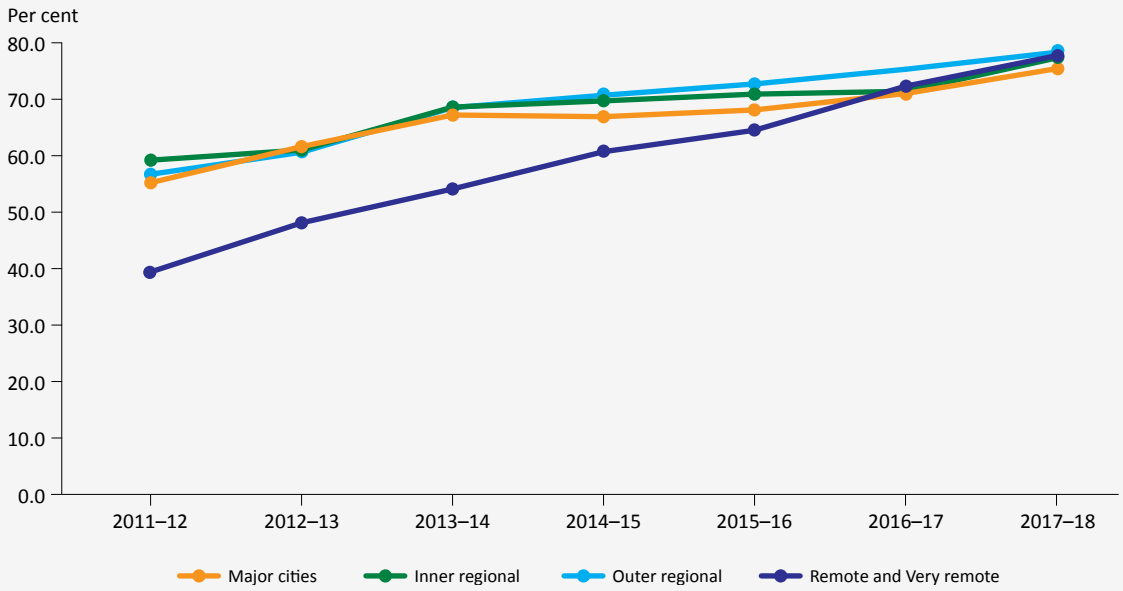
Nationally, the proportion of public acute admitted patient separations with 7-day post-discharge community mental health care increased each year from 2011–12 to 2017–18 (from 55.1% in 2011–12 to 75.2% in 2017–18). The largest increase in post-discharge community mental health care was for remote and very remote areas, which now have rates of post-discharge community mental health care that are comparable to that in major cities, inner regional and outer regional locations (Figure PI 16). However, even in 2017–18, post-hospital discharge community mental health care did not occur within seven days in 20–25% of cases.

What can't the data tell us?

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.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 16: Public acute admitted patient separations with 7-day post-discharge community mental health care, by remoteness, 2011–12 to 2017–18



Source: State and territory governments (unpublished).

Performance indicator 17: Mental health readmissions to hospital

Readmission to hospital within 28 days of discharge, also known as rapid readmission, 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. Higher rates of rapid readmission suggest that less effective care is being provided by the mental health system.

What does the data tell us?

Nationally, the proportion of overnight acute admitted patient mental health care separations that are followed by mental health readmissions to hospital within 28 days was relatively consistent from 2013–14 to 2017–18.

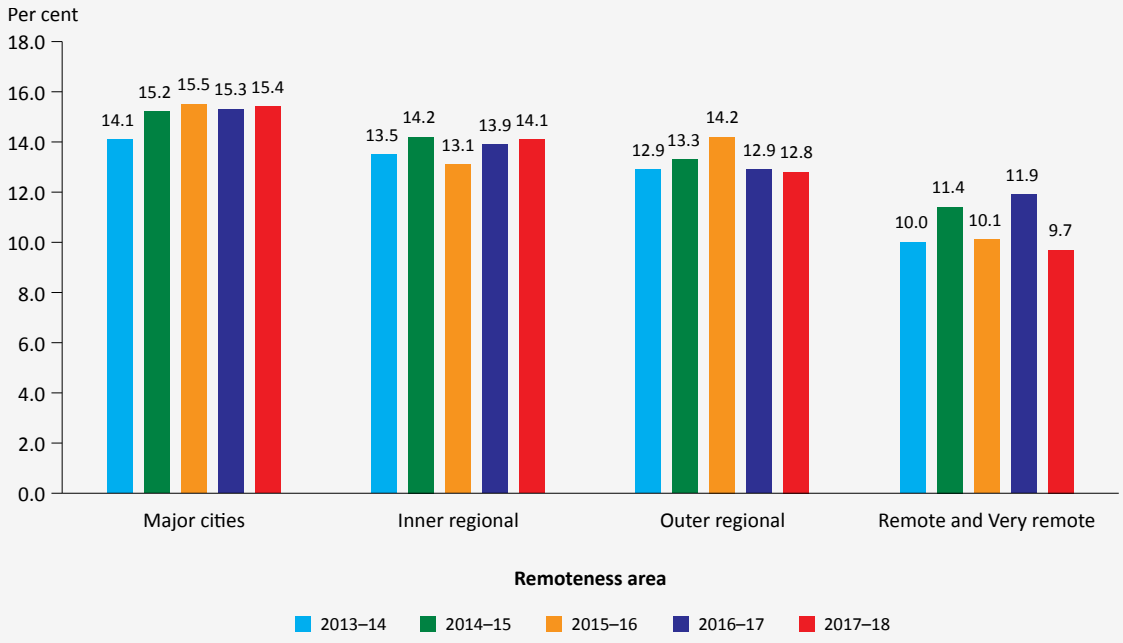
Across remoteness areas, major cities had a small upwards trend, while inner regional areas, outer regional areas, and remote and very remote areas did not show a consistent trend (Figure PI 17).

What can't the data tell us?

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

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 17: Overnight acute admitted patient mental health care separations that are followed by mental health readmissions to hospital within 28 days, by remoteness area, 2013–14 to 2017–18



Source: State and territory governments (unpublished).

Performance indicator 18:
Mental health consumer and carer workers

Consumer and carer involvement in the planning and delivery of mental health services is essential to adequately represent the views of consumers and carers, advocate on their behalf, and promote the development of consumer responsive services. As such, the rate of staff who are mental health consumer and carer workers 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.

What does the data tell us?

Nationally, the number of full-time equivalent (FTE) consumer and carer workers per 10,000 mental health care provider FTE has increased, from 28.8 and 12.0 respectively in 2007–08, to 64.3 and 24.0 respectively in 2017–18.

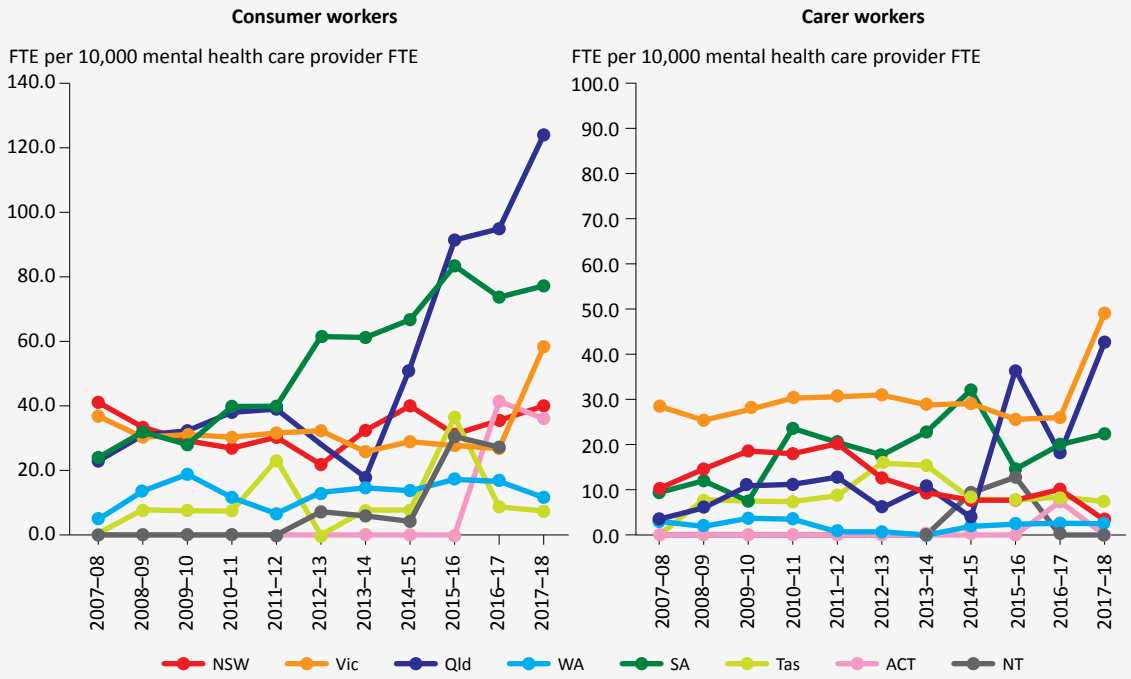
While the rate of carer workers was reasonably stable over time for all states and territories, the rate of consumer workers shows more variation (Figure PI 18). The rate of consumer workers in South Australia shows a sustained increase from 2011–12, and Queensland experienced a sharp increase from 2013–14. The rate of consumer workers in Tasmania has fluctuated, with peaks in 2011–12 and 2015–16.

What can't the data tell us?

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.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 18: Full-time equivalent mental health consumer and carer workers, states or territory, 2007–08 to 2017–18



Note: The rate of consumer workers in Northern Territory in 2017–18 increased to 339.0 per 10,000 mental health care provider FTE, and has been omitted from the figure to aid interpretation of the trends for the remaining jurisdictions. Caution is required when interpreting the increase as the Northern Territory consumer worker FTE is relatively small, and therefore small changes in these FTE numbers may have a large impact on the rate.

Source: National Mental Health Establishments Database.

Performance indicator 19:
Suicide rate

Suicide rates provide a high-level indication of community mental health and wellbeing. Higher suicide rates indicate poorer mental health and wellbeing.

What does the data tell us?

Over the 10 years from 2009 to 2018, no state or territory experienced a sustained reduction in its suicide rate (Figure PI 19). Nationally, the suicide rate has trended slightly upwards over this time.

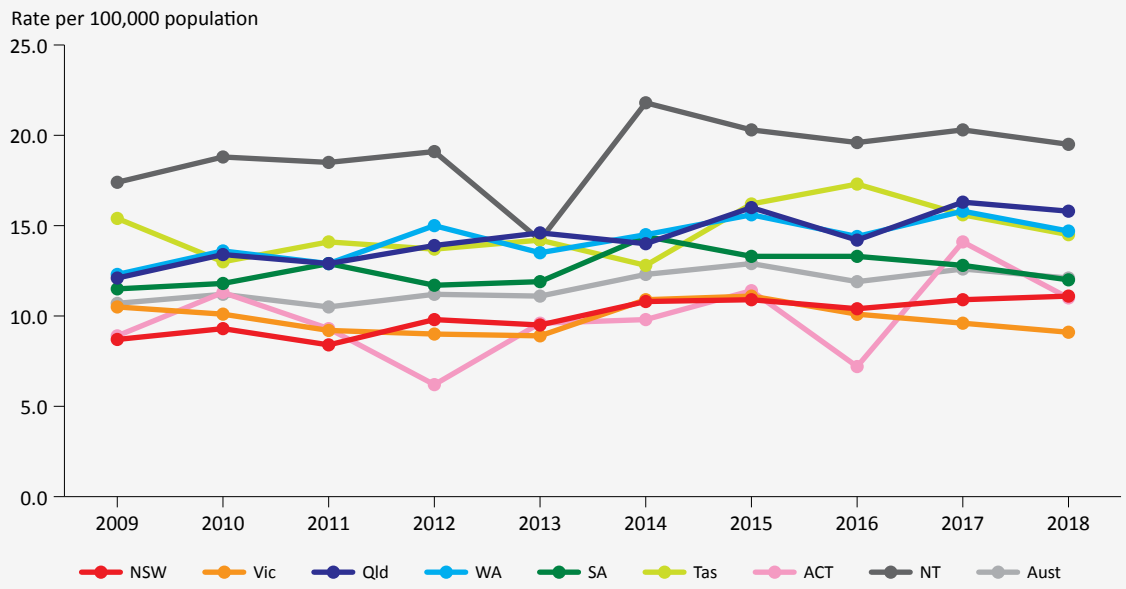
In 2009–2013 Aboriginal and Torres Strait Islander Australians had a suicide rate around double that of non-Indigenous Australians (20.2 and 10.7 per 100,000 population respectively). This disparity was stable through 2014–2018 (23.7 and 12.3 suicide deaths per 100,000 population respectively).

What can't the data tell us?

While the 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.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 19: Suicide rate, state or territory, 2009 to 2018



Source: ABS Causes of Death, Australia, 2018.

Performance indicator 22: Seclusion rate

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. Higher rates of seclusion indicate poorer performance of the mental health system.

What does the data tell us?

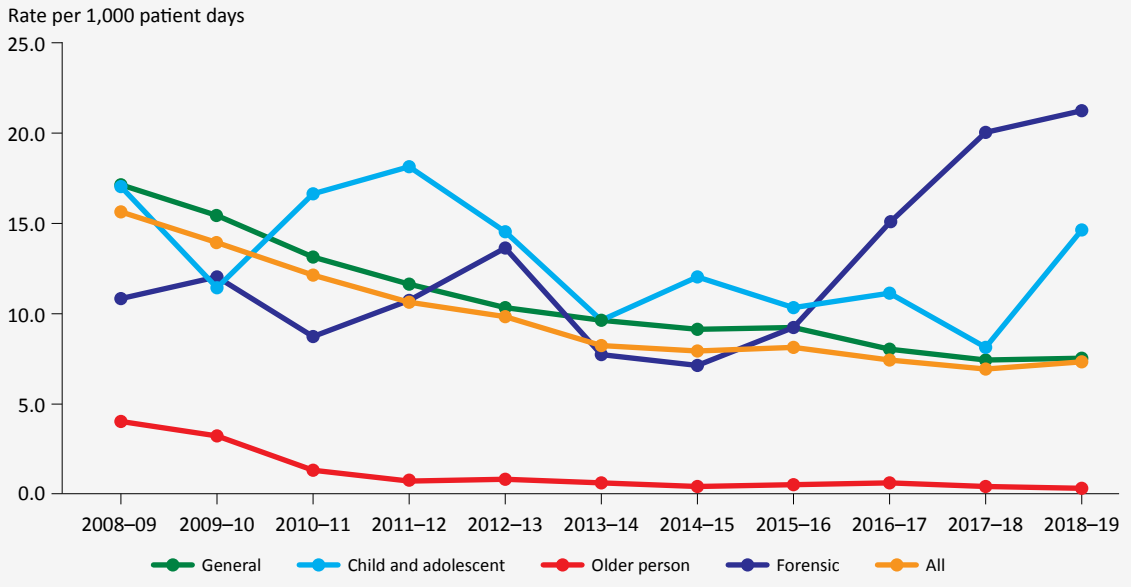
The total seclusion rate in public acute mental health hospital services showed a sustained reduction from 2008–09 to 2018–19 (Figure PI 22). Seclusion rates for public acute mental health hospital services targeted at older people and the general population also showed a sustained reduction over this period. However, seclusion rates fluctuated for services targeted at children and adolescents, while services targeted at the forensic population have experienced a sharp increase since 2015–16.

What can't the data tell us?

Seclusion rates may point to the existence of inadequacies in the functioning of the mental health care, but they do not suggest specifically where the inadequacies exist.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 22: Seclusion events per 1,000 patient days in public acute mental health hospital services, by service target population, 2008–09 to 2018–19



Source: State and territory governments (unpublished).

Performance indicator 23a:
Involuntary hospital treatment

Involuntary care is a type of restrictive and coercive practice where treatment for mental illness is provided without the person's consent. Higher rates of involuntary hospital treatment indicate that more consumers are experiencing restrictive and coercive practices in the mental health system.

What does the data tell us?

In 2017–18, the proportion of public sector acute mental health separations with specialised mental health care that were involuntary varied between states and territories (Figure PI 23a).

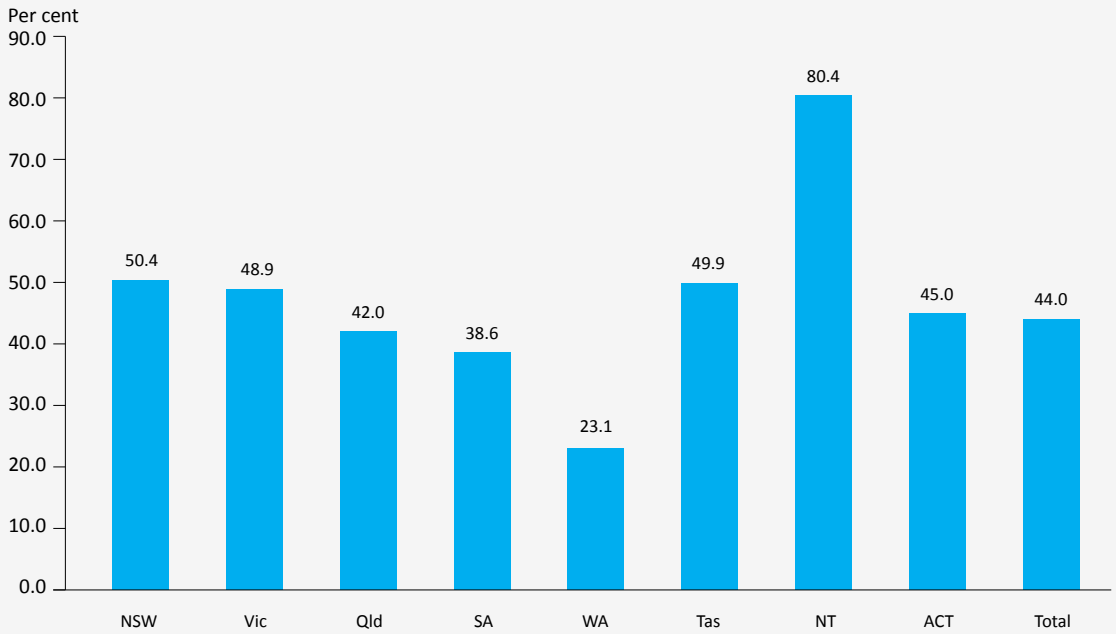
What can't the data tell us?

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.

To gain a better picture of how much involuntary care was provided in public hospital separations with specialised mental health care, data from this indicator should be interpreted in conjunction with Performance Indicator 23b: Involuntary patient days.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 23a: Public sector acute mental health separations with involuntary specialised mental health care, state or territory, 2017–18



Note: This is the first year this data has been collected. Data should be interpreted with caution.

Source: State and territory governments (unpublished).

Performance indicator 23b: Involuntary patient days

Involuntary care is a type of restrictive and coercive practice where treatment for mental illness is provided without the person's consent. Higher rates of involuntary hospital treatment indicate that more consumers are experiencing restrictive and coercive practices in the mental health system.

What does the data tell us?

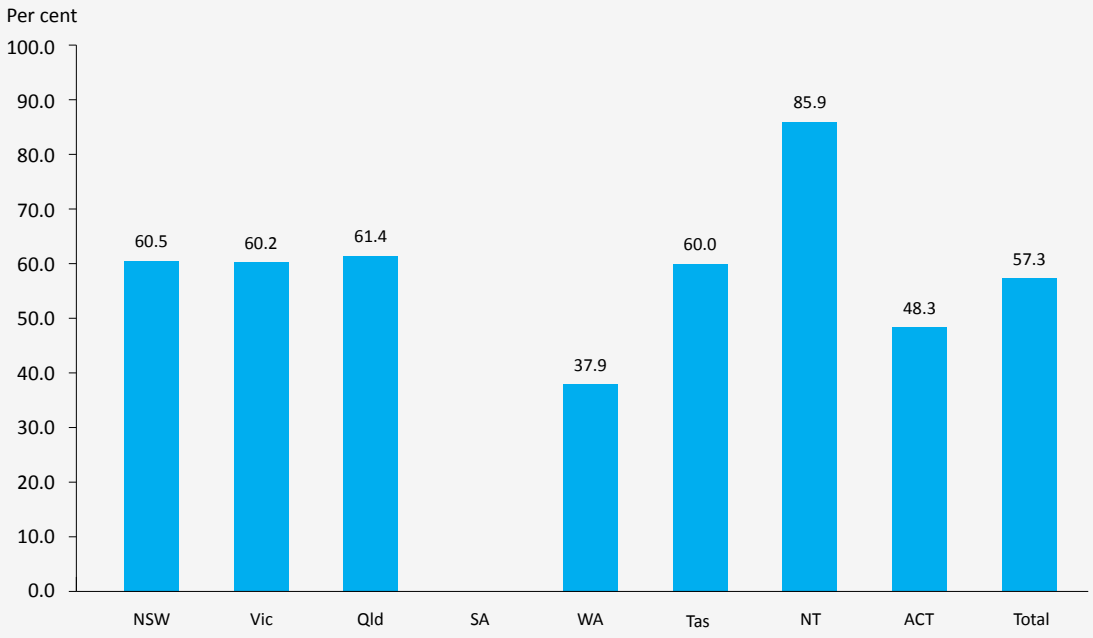
In 2017–18, the proportion of public sector acute mental health patient days with specialised mental health care that were involuntary varied between states and territories (Figure PI 23b).

What can't the data tell us?

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.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 23b: Public sector acute mental health patient days with involuntary specialised mental health care, state or territory, 2017–18



Notes: South Australia was unable to provide data for the mental health care days in the first year of collection. This is the first year this data has been collected. Data should be interpreted with caution.

Source: State and territory governments (unpublished).

Performance indicator 24: Experience of discrimination in adults with mental illness

For people with mental illness, experiencing discrimination can increase feelings of isolation and create barriers to seeking help. Higher proportions of people with mental illness who have experienced discrimination in the past 12 months suggest lower levels of wellbeing.

What does the data tell us?

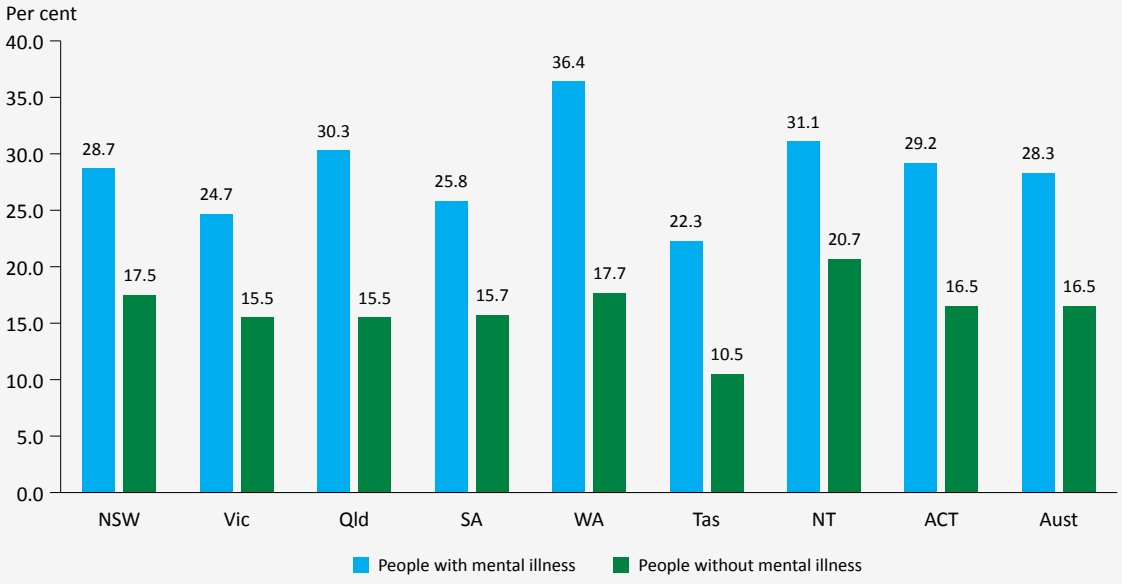
In 2014, in every state and territory, more people with mental illness experienced discrimination compared to people without mental illness (Figure PI 24). Nationally, the proportion of people with mental illness who experienced discrimination was nearly double that of people without mental illness (28.3% and 16.5% respectively). There is a similar pattern in Aboriginal and Torres Strait Islander people; 44.5% of Indigenous people with mental illness experienced discrimination in the past 12 months, compared to 29.2% of Indigenous people without mental illness.

What can't the data tell us?

The data show 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 or not the discrimination was the result of the person's mental illness.

Additional information about the scope of this indicator can be found in Appendix D.

Figure PI 24: Adults who have experienced discrimination in the past 12 months, by mental illness status, state or territory, 2014



Source: ABS General Social Survey, 2014.

Appendices

Appendix A:
Overview of action status

Action	Status	Coordination Point	Milestone data in Implementation Plan
Governance			
i	Complete	MHPC	December 2017, first meeting before June 2018.
ii	Complete	MHPC	First meeting mid-2018.
iii	Complete	MHPC	First meeting mid-2018.
iv	Commenced – not on track	AHMAC (progress reported by the MHPC)	Commence January 2018, completed December 2020.
Measuring and reporting on change			
v	Commenced – on track	MHPC	Negotiations commence January 2018 and implementation will be ongoing
vi	Yet to commence	AHMAC (progress reported by the MHPC)	Evaluation plan agreed December 2018. Evaluation completed June 2022.
vii	Commenced – on track (as per Action 24)	MHISSC	Published by December 2018
Priority Area 1: Achieving integrated regional planning and service delivery			
1.1	Commenced – on track	MHPC	Progressively from December 2017.
1.2	Commenced – on track	MHPC	Completed mid-2018.
1.3	Commenced – on track	NMHSPF Steering Committee	December 2017.
1.4	Commenced – on track	NMHSPF Steering Committee	Progressively to June 2018.
1.5	Commenced – on track	MHISSC	Completed June 2018.
2.1	Commenced – on track	AHMAC (progress reported by the MHPC)	Commencing early 2018.
2.2	Commenced – on track	AHMAC (progress reported by the MHPC)	Commencing early 2018.
2.3	Commenced – on track	MHPC	Progressively from June 2018.
2.4	Not scheduled to commence until mid-2020	MHPC	Commencing mid-2020.
2.5	Commenced – on track	MHPC	Commencing late 2017. Completed mid-2020.
2.6	Commenced – on track	MHPC	Commencing 2017. Completed mid-2020.
2.7	Commenced – on track	MHPC	Mid-2021.
2.8	Commenced – on track	MHPC	Mid-2021.

Action	Status	Coordination Point	Milestone data in Implementation Plan
Priority Area 2: Suicide Prevention			
3	Commenced – on track	MHPC	December 2017, first meeting early 2018.
4	Commenced – on track	MHPC	Commence 2018. Release of strategy for public consultation by mid-2019. Release of final strategy by 2020.
5	Commenced – on track	MHPC	Commence 2019 and ongoing .
Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness			
6	Complete	No coordination point	Commence in 2017. Finalised by the end of 2018.
7	Complete	No coordination point	Completed mid-2018.
8	Part 1 of this action is complete as per Action i, Governance	No coordination point	2019.
	Part 2 of this action is not scheduled to commence until late 2021		Commence late 2021.
9	Commenced – not on track	No coordination point	Commence in 2018. Release in 2020.
Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention			
10	Commenced – on track	MHPC	Commence mid-2018.
11	Complete (as per action iii)	MHPC	First meeting mid-2018.
12.1	Yet to commence	ATSIMHSPPRG	Commence 2018. Completed 2020.
12.2	Yet to commence	MHPC	Commence 2018 and ongoing.
12.3	Commenced – on track	MHPC	Commence 2018 and ongoing.
12.4	Yet to commence	MHPC	Commence 2018 and ongoing.
13.1	Yet to commence	MHPC	Commence 2018 and ongoing.
13.2	Commenced – on track	MHISSC	Commence 2018. Completed 2021.
13.3	Yet to commence	MHPC	From 2017 and ongoing.
13.4	Commenced – on track	MHISSC	Commencing 2018 and ongoing.
13.5	Yet to commence	MHISSC	Commence 2018. Completed 2021.
Priority Area 5: Improving the physical health of people living with mental illness and reducing early mortality			
14	Commenced – on track	All jurisdictions	From 2017 following release of Equally Well.
15	Commenced – on track	MHPC	Commence mid-2018. Completed late 2019. Annually from 2020.
16.1	Commenced – on track	MHPC	June 2018. By mid-2020.
16.2	Commenced – on track	MHPC	June 2018
16.3	Not scheduled to commence until mid-2020	MHPC	From mid-2020.
17	Commenced – on track	MHISSC	Commence October 2017. Completed 2022.

Action	Status	Coordination Point	Milestone data in Implementation Plan
Priority Area 6: Reducing stigma and discrimination			
18	Commenced – not on track	MHPC	Completed mid-2018. Completed late 2018. Completed early 2019.
19.1	Commenced – not on track	AHMAC (progress reported by the MHPC)	Completed by mid-2021.
19.2	Yet to commence	MHPC	Completed by mid-2018.
19.3	Yet to commence	MHPC	Completed by mid-2018.
20	Commenced – on track (as per Action 29)	MHPC	Commence mid-2018. Completed 2021.
Priority Area 7: Making safety and quality central to mental health service delivery			
21.1	Commenced – not on track	SQPSC	Commence 2018. Completed 2021.
21.2	Complete	MHISSC	Commence 2019. Completed 2020.
21.3	Commenced – on track	SQPSC	Commence 2018. Completed 2020.
21.4	Commenced – not on track	SQPSC	Commenced 2019. Completed 2021
21.5	Commenced – on track	SQPSC	Commence 2018. Completed 2020.
22	Yet to commence	SQPSC	Commence 2019. Completed 2021.
23	Commenced – on track	MHISSC	Commence 2018. Completed 2021.
24	Commenced – on track	MHISSC	Published by December 2018.
25	Commenced – on track	SQPSC (reassigned to the MHISSC)	Completed end 2021.
26	Commenced – on track	MHPC	Commence 2017 and ongoing.
27	Yet to commence	SQPSC (reassigned to all jurisdictions)	Commence 2018 and ongoing.
Priority 8: Ensuring that the enablers of effective system performance and system improvement are in place			
28	Commenced – on track	MHPC	Commence mid-2018. Completed 2021.
29	Commenced – on track	MHPC	Commence mid-2018. Completed 2021.
30	Commenced – on track	MHISSC	Commence mid-2018 and ongoing.
31	Commenced – on track	AHMAC (progress reported by the MHPC)	Commence early-2018. Completed 2022.
32	Commenced – on track	AHMAC (progress reported by the MHPC)	Commence mid-2018. Framework completed 2020.

Appendix B:
Case studies

Priority Area 1: Achieving integrated planning and service delivery

Achieving integrated health systems by regional collaboration

North Coast Collective is a regional collaboration between North Coast PHN, the Mid North Coast Local Health District and the Northern NSW Local Health District. The North Coast Collective is currently focused on planning and delivering a range of services that will improve the lives of people living with mental illness and alcohol and other drug issues. The North Coast Collective's work will be driven by the shared regional strategy and be informed by system dynamics and investment optimisation modelling.

To guide investment optimisation in the future, the North Coast Collective is engaging with government, non-government organisations, Aboriginal and Torres Strait Islander community members, people with lived experience, and consumers and carers. Through shared investment and making joint decisions, North Coast PHN, Mid North Coast Local Health District and Northern NSW Local Health District will be able to provide an optimal range of services for the community, instead of delivering services in silos.

Improving the lives of people living with mental illness and alcohol and other drug issues was identified by the North Coast community as their highest priority, and is therefore the first area of focus for the North Coast Collective. During the next phases, membership of the North Coast Collective will expand to include partners outside the health sector to deliver a regional strategy that considers all the known social determinants of health.

In another example, Murrumbidgee PHN has established the Murrumbidgee Mental Health Drug and Alcohol Alliance. The alliance provides a forum for key stakeholders from the health, community and social sectors, and consumers and carers, to develop a strategic approach to meet the mental health, and drug and alcohol needs and expectations of consumers in the Murrumbidgee population.

The principles of the alliance include focusing on consumer outcomes and recognising the value that the community and social sectors contribute to addressing the needs of consumers. Other principles include communicating and working together in a collaborative, open and transparent manner that recognises the values, skills and expertise that members bring to the alliance. The alliance meets monthly to develop, design, and improve services and service delivery while advocating for the consumer in the system. The alliance also ensures appropriate communication of available services to consumers across the Murrumbidgee population.

In direct response to consumer feedback that the service system was considered to be fragmented, complex and difficult to navigate, the alliance implemented the Alliance Service Integration Project. This Project has identified a number of priorities for improvement, including development of an online, interactive mental health and drug and alcohol service map; a common referral and consent form shared across all member agencies; and a consumer-led care and wellness plan app that will be available on consumers' devices and can be shared by the consumer with the agencies they are working with.

Achieving service integration through consultation workshops

In April 2018, Central Queensland, Wide Bay and Sunshine Coast PHN, and the Hospital and Health Services held a Mental Health and Alcohol and Other Drug Service Provider Workshop to build on the strengths and abilities of local communities and foster collaboration in the design and implementation of the region's future health system landscape. The workshop brought together key representatives from the region's PHNs, LHNs, and other stakeholders, including those with lived experience, to develop and progress the region's joint planning activities, with a specific focus on the development of the joint regional plan.

The workshop has played an instrumental role in the development of the joint regional plan and supported opportunities for networking, relationship building, stakeholder buy-in, and identification and discussion of emerging issues and concerns within the sector. The success of this activity has been enabled by the commitment, transparency and contributions of all stakeholders within the region. The activity has assisted the development of a firm foundation upon which the joint regional plan and its objectives can be achieved.

Key outcomes of the workshop include identification of issues relevant to the region, improved service literacy and understanding, improved interface between tertiary and primary health services for consumers, and improved referral fluidity between services.

Co-designing youth mental health services

Hunter New England and Central Coast PHN received funding to commission a new service type for young people with, or at risk of, developing severe and enduring mental illness. As this was a new service, the service delivery model needed to be co-designed to ensure that the clinical care, case management, and collaborative care (such as specialist mental health care and psychological therapies) were aimed at meeting the needs of the young person, and to ensure that the model built on existing services and acknowledged local characteristics.

Orygen facilitated four co-design workshops in each region identified through the Mental Health and Suicide Prevention Needs Assessment. The purpose of the workshops was to discuss and gather feedback on how each region could design a local primary care model that provided the best possible outcome for young people with complex presentations. Before the workshops, participants received a briefing paper that outlined models of mental health services for young people experiencing severe and complex mental ill health, to provide context to the workshop, and key questions for consideration and discussion.

The workshops were attended by more than 200 local consumers, carers, community members, young people, service providers, school teachers, GPs, specialist mental health clinicians from Local Health Districts, private providers, service providers, representatives from ACCHSs, Department of Education, Family and Community Services, and Disability Services. Stakeholders were also able to provide input and feedback to the co-design process via the PHN online social media tool, 'Peoplebank'. In addition to the co-design workshops, a young person with a lived experience was part of tender evaluation panel. The services developed through the co-design process are providing local solutions to young people to facilitate easier access and better pathways to the right care, at the right time, to suit a young person's needs.

Improving regional service consistency by rationalising funding models

Use of different funding models by different stakeholders can present a barrier to achieving integration. This can be confusing to service providers, and consumer and carers, particularly, when a regional service provider has multiple funders, resulting in inconsistency of service delivery. Organisationally, adopting a co-funding model demonstrates significant commitment and trust between organisations, and focuses on improving consumer and carer experience rather than organisational benefits.

The Active Life Enhancing Intervention (ALIVE) program is a service for people aged 17 years and older who are at medium to high risk of suicide. ALIVE aims to decrease the incidence of suicide and self-harm behaviour in the community by providing a safe, non-judgmental support service for those at risk. It offers up to three months of intensive therapeutic support as needed, with the aim of linking people to ongoing counselling services and programs, where necessary. Before the 2018–19 financial year, the program received separate funding from the WA Primary Health Alliance and the Western Australian Mental Health Commission for separate arms of the service. During 2018–19 the WA Primary Health Alliance and the Western Australian Mental Health Commission agreed to jointly fund and manage the contract for the ALIVE program.

The decision to align service schedules was based on reducing confusion around accessibility and improving the operational performance of the service, by providing a consistent pathway to receive the service across the Perth-metropolitan area. The changes to the model of co-commissioning ALIVE have led to a well-connected and integrated system that services the most vulnerable people and ensures that individuals at risk receive the care and support required.

Reducing the impact of suicide by early intervention for bereaved

As part of the Perth South Suicide Prevention Trial Site, the WA Primary Health Alliance has contributed to the Peel and Rockingham Kwinana Community Postvention Response pilot. This pilot includes support for the immediate family affected by suicide, such as an immediate notification service following a critical incident involving a suspected suicide, ensuring a rapid response and allowing support services to reach out to the family to offer counselling.

The pilot has been achieved through a partnership of government and nongovernment agencies, groups and community members, and in collaboration with the WA Primary Health Alliance, the Western Australian Police, and the Rockingham Peel Group. The 6-month pilot builds on a comprehensive postvention plan developed by local agencies in response to several suicides in the Rockingham and Mandurah area in 2016.

During the past year, the postvention plan has allowed local agencies to support a number of families, along with friends and community members.

The recent addition of the immediate notification service and the rapid response means that services can reach out to more people even earlier – offering support in the critical period immediately following a sudden loss. The impact has been immediately identifiable. In the first three months of the immediate notification pilot, 100% of losses by suspected suicide were identified, and families were offered support. The pilot highlights that suicide prevention is everyone's business and that meaningful outcomes can result from better integration.

Mental health services mapping in Tasmania

At the simplest level, service mapping can be used to portray demographic, socio-economic and health characteristics, and display physical features such as health facilities. This function directly supports the implementation of Priority Area 1 of the Fifth Plan and particularly Action 2.3 – to undertake a joint regional mental health needs assessment to identify gaps, duplication and inefficiencies to make better use of existing resources and improve sustainability.

Mapping the current mental health services across Tasmania was seen as a critical first step in understanding the gaps, duplications, and future services needs that would be addressed through the regional plan. The service mapping is jointly funded and led by Primary Health Tasmania and the Department of Health Tasmania.

The University of Queensland has been contracted by the Australian Government Department of Health to undertake this work, which includes mapping existing mental health services against the National Mental Health Service Planning Framework taxonomy, reporting to the Regional Plan Steering Committee on current and future service needs, and working with staff from Primary Health Tasmania and the Department of Health Tasmania to build capacity to enable future service mapping to happen locally.

Priority Area 2: Effective suicide prevention

Peer-led suicide attempt aftercare service

In consultation with the community, Nepean Blue Mountains PHN identified a high priority need within the region to provide assertive, consistent, coherent, and timely aftercare for people discharged from hospital mental health units after a suicide attempt.

The peer-led suicide aftercare service was established in partnership with the Nepean Blue Mountains Local Health District and is based at Nepean Hospital, providing services to the four local government areas across the Nepean Blue Mountains region. The service uses a peer workforce to facilitate access and link people to their GP, and other support services, after discharge from hospital following a non-fatal suicide attempt.

It is expected that the aftercare service will better support people who have attempted suicide to connect with a GP or community support services post-hospitalisation, and reduce rates of re-admission. Additional benefits will include GPs being more engaged with this vulnerable group, and that a trained peer-led workforce will be available and maintained.

Integrating clinical and psychosocial aftercare services following suicide attempt

To meet the complex needs of people discharging from hospital following a suicide attempt, it is important to ensure that any clinical and psychosocial services are integrated. Gippsland PHN and Latrobe Regional Hospital have been working together since 2018 with Beyond Blue to establish and deliver The Way Back Support Service in Gippsland.

The Way Back Support Service is a non-clinical support service providing practical psychosocial support to people who are experiencing a suicidal crisis or who have attempted suicide. Gippsland PHN has been selected for rollout of The Way Back Service. In conjunction with the Hospital Outreach Post-Suicidal Engagement (HOPE) team at Latrobe Regional Hospital, The Way Back Service will provide an integrated suicide prevention service for the region.

In response to the high representation of the Darling Downs and Western Moreton region in Queensland suicide statistics, and the urgent need for support services in the region, the Darling Downs and Western Moreton PHN has committed to funding The Way Back Support Service in Ipswich and Toowoomba base hospital areas. This initiative is in the final phase of rollout. It is expected that it will achieve a coordinated response for one of the most vulnerable cohorts experiencing mental health and alcohol and other drug impacts in the region.

Integration of services for hospital aftercare

In recognition of the need for appropriate aftercare following a suicide attempt, Western Sydney PHN commissioned a program for follow-up care. The program targets people living with mental illness and those who have self-harmed or attempted suicide who are leaving acute mental health units and do not have sufficient support to reintegrate into the community.

The program uses peer workers who, with consumers' agreement, meet with consumers and their carers and family during the discharge planning process to discuss the support that can be provided and identify the goals each person wants to achieve.

At the time of reporting, the program had received more than 170 referrals from acute units in the Western Sydney local government area, with an acceptance rate of more than 50%. The program is helping to bridge the service gap and reduce the re-hospitalisation rate in the community.

Preventing suicide by Connecting with People

SA Health has implemented Connecting with People training to improve the capability of the health workforce to support people at risk of suicide. This program supports clinicians to improve their capacity to connect with people who have had suicidal thoughts or attempted suicide. Through this training, SA Health has also increased knowledge and improved consistency in skills and practice across the clinical workforce. The program will also see for the first time, the development of an Aboriginal specific mental health module for the Connecting with People Suicide Prevention Training for clinicians, delivered by 4Mental Health.

New suicide prevention initiatives under the ACT LifeSpan trial

In partnership with Capital Health Network, ACT Health Directorate has implemented a three year trial of the Black Dog Institute's LifeSpan Integrated Suicide Prevention Framework, which supports the coordination of the various suicide prevention initiatives occurring across the ACT. A key component of the ACT LifeSpan is the Question, Persuade, Refer (QPR) program, which teaches lay and professional gatekeepers to recognise and respond positively to someone exhibiting suicide warning signs and behaviours.

QPR training is designed to detect people who are in the ideational phase of a suicide plan. QPR training may also enable individuals to identify people at risk who have already made one or more non-lethal attempts. QPR training is delivered online. At the time of reporting more than 350 people had undertaken the training.

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

Anticipating change in the psychosocial sector

A recent significant change in the mental health sector was the introduction of the NDIS, and the transition of a number of national psychosocial programs into new psychosocial funding streams. Eastern Melbourne PHN led three large Partners in Recovery programs across east and northeast Melbourne, and took a number of actions in its approach to transition planning.

In 2018, before the transition from Partners in Recovery to the NDIS, the Eastern Melbourne PHN ran a 'psychosocial support pilot'. The pilot enabled consumers to access psychosocial support with a one-to-one worker in addition to the usual service provided by Partners in Recovery. To enhance transition success, the pilot also provided an opportunity for the system to retain and build a strong and knowledgeable psychosocial support workforce.

Eastern Melbourne PHN also commenced early transition planning for the new psychosocial support program with neighbouring PHNs, North Western Melbourne PHN and South East Melbourne PHN. The collaboration resulted in early agreement on the psychosocial support specifications, aiding service system consistency for both providers and consumers and carers.

Eastern Melbourne PHN commissioned the Psychosocial Support Service in January 2019, using National Psychosocial Support and Continuity of Service funding. The service is delivered by Neami National. It was important for the Psychosocial Support Service to appear as a single program offering services 'on the ground' to reduce consumer and carer confusion and enhance continuity of care during the transition period.

As a result of this planning approach, in March 2019, Eastern Melbourne PHN was able to respond quickly to the new National Psychosocial Support Transition funding to improve the continuity of care while consumers transitioned into NDIS services. The response included the design and implementation of psychosocial transition supports for consumers who were previously Partners in Recovery, Day to Day Living or Personal Helpers and Mentors Service participants. The service commenced in July 2019.

Eastern Melbourne PHN is currently planning to develop a 'regional psychosocial interface', ensuring that psychosocial services provided by PHNs, the Victorian Government and the NDIS are easy to navigate for consumers and carers, as well as for GPs and other health providers.

Meeting the needs of young people with moderate to severe mental illness

As a result of commissioning for services for young people with severe and complex mental illness, Northern Sydney PHN identified a service gap for young people who experience moderate to severe mental illness. These young people present with symptoms too severe and/or complex for headspace services but do not meet eligibility criteria for the Child and Youth Mental Health Service provided by the Northern Sydney Local Health District.

Following extensive consultation and co-design, a model was developed, and Parramatta Mission was contracted to establish the Karrikin program. Karrikin provides intensive clinical case management support, individual and group psychological therapies, and access to psychiatry. Services are delivered by a multidisciplinary team, including a psychiatrist, psychologists, social workers and youth peer workers, at accessible locations across the region and using assertive outreach. At intake, the young person receives a comprehensive assessment by a mental health clinician and psychiatrist and a treatment plan is developed. A peer worker will also work with the young person to address psychosocial needs and will link with other services, including vocational support where required. Karrikin staff are trained in family systems therapy and where consent is provided, will work with the young person's broader family unit to address communication issues and support recovery.

To ensure service integration, communication, and shared care pathways, Northern Sydney Primary Health Network has facilitated collaboration between the Karrikin program and other local services including headspace, the Child and Youth Mental Health Service, and youth drug and alcohol services. Karrikin staff regularly liaise with these services to undertake joint assessment where consumer needs are shared across the services and Karrikin staff also provide secondary consultation to local service providers working with young people. Karrikin have partnered with the local Lifeline service,

also commissioned by Northern Sydney PHN, to deliver Dialectical Behavioural Therapy-based skills development groups for young people with mood disorders and emotional dysregulation.

Uptake for the Karrikin program has been strong and feedback from consumers, carers and local service providers has been highly positive, noting in particular the value of psychiatry and peer support in the model. Young people accessing the service have demonstrated improvement across a number of domains relating to their psychological wellbeing and personal recovery.

headspace Early Intervention Team

In Central and Eastern Sydney PHN, the headspace Early Intervention Team was co-designed and commissioned due to fill the gap in service availability for young people who do not meet the headspace criteria of mild to moderate mental health needs or the threshold for community health teams. The headspace Early Intervention Team provides early identification, care coordination, assertive outreach and targeted interventions, enabling young people who are experiencing, or are at risk of, complex or severe mental illness to be assessed, treated, and supported to recover. It is delivered by Sydney Local Health District out of the primary health care locations of headspace Ashfield and headspace Camperdown.

The program has so far supported 190 young people. It has also provided additional support to headspace centres, ensuring greater coordination for young people stepping up and down between primary mental health services and Local Health District services.

No wrong door – improved access to services through shared intake model

Northern Queensland PHN has implemented a regional clinical intake assessment and triage model of service delivery. The service model supports the concept of 'no wrong door'. This means that a person referred, usually by a GP, to a service where a clinical intake process is undertaken, leading to improved system navigation to the right level and type of care.

As an example, for a person in suicidal crisis, the service conducting the intake process will create a safety plan and facilitate access to an acute care team, a suicide prevention counsellor, and a suicide call back service, based on identified need. Additionally, the service conducting the intake process may identify needs not met by the clinical stepped care suite of service delivery, such as interpersonal and family violence. The service may then include the Queensland Police Service and the Women's Domestic Violence Service, as well as psychological therapy providers.

The service that provided the intake process will conduct a follow-up to ensure that the person is engaged, and feeling safe and supported. This model has been used by a range of providers, including primary health providers, police services, education services, and tertiary mental health providers.

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

Kumpa Kiira Suicide Prevention Project

Coomealla Health Aboriginal Corporation provides health services to address the health needs of Aboriginal people in the Wentworth and Balranald regions of New South Wales. The communities serviced experience a range of complex issues, including domestic violence, drug and alcohol issues, and mental and physical health concerns. The communities have also lost a number of Aboriginal and Torres Strait Islander people to suicide.

In response, Coomealla Health Aboriginal Corporation developed a suicide prevention project as part of the NSW Suicide Prevention Fund. Kumpa Kiira is an innovative health promotion program that seeks to prevent suicide by engaging Aboriginal and Torres Strait Islander people across the lifespan through activities grounded in culture and community connection. The project employs a team leader and two Aboriginal and Torres Strait Islander suicide prevention workers. They are supported in their roles by a dedicated Social and Emotional Wellbeing Worker, who provides one-on-one support and counselling to clients.

Community engagement has been a key component of the work. The project engages Aboriginal and Torres Strait Islander youth with culture through youth groups for men and for women, using art, music and other. This engagement supports connection to community and to local schools. Kumpa Kiira has also

engaged Elders to run regular groups that focus on culture, intergenerational exchange and connection. Program promotional materials include messaging to increase understanding of mental illness and suicide risk in at-risk groups, including aged people.

The project has also engaged local GPs, through formal up-skilling and advice on identifying and managing suicide risk, and postvention support. Since 2017, Kumpa Kiira has brought its community together and promoted culture as healing which is a critical component of suicide prevention in Aboriginal and Torres Strait Islander communities.

Addressing lateral violence as a barrier to help-seeking

As part of the National Suicide Prevention Trial, Western New South Wales PHN supports local providers to deliver a hybrid model of suicide prevention, using the LifeSpan model and recommendations from the 2016 Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project report.

As part of the community consultation for the suicide prevention trial in the shires of Lachlan and Weddin, Western Plains Regional Development found that Aboriginal community members in the town of Condobolin saw lateral violence as a major issue in community suicide. Lateral violence has its origins in colonisation and the consequent discrimination, disempowerment, and disconnection from land and cultural practices and supports that have been experienced by Aboriginal and Torres Strait Islander communities. These effects in turn create environments of insecurity and reduced safety, where individuals are less likely to seek assistance for suicidal thoughts for fear that support will not be provided, or there is a risk of being attacked and dismissed as 'attention seeking.'

The Condobolin community reported that, although a majority of members had witnessed, been the victim of, or perpetrated, lateral violence, very few knew of any strategies to address it. As a result, the project staff arranged for Kooreen Enterprises to deliver a 2-day Lateral Healing workshop. The workshop was attended by 27 Aboriginal community leaders and members, and included discussion about the nature and causes of lateral violence and strategies to address it.

The majority of participants subsequently reported that they had the skills and confidence to respond to lateral violence in their community. As a result of the success of this initiative, Western New South Wales PHN is currently working with project staff to gauge interest from other Aboriginal and Torres Strait Islander communities in conducting similar work in their communities.

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

Improving the physical health of people living with severe mental illness

In early 2019, based on insights gained through community engagement and analysis of regional data, North Western Melbourne PHN invited tenders for a locally based and integrated approach to supporting the physical health needs of people with severe mental illness.

The Integrated Chronic Care service is a two-year trial that seeks to improve health outcomes for people living with severe mental illness through delivery of recovery focused mental health support and support for chronic conditions using a self-management approach. The service is targeted at people with severe and persistent mental illness, and a diagnosis of one or more chronic physical health conditions such as diabetes and cardiovascular disease.

The service uses a multi-disciplinary workforce, including peer workers, to deliver a flexible and person-centred model that enhances the coordination of care. The service supports people to participate in and connect with their community and to increase their confidence to self-manage their health care. The service was recently implemented and will use consumer self-reported experience and outcome indicators to continually improve.

General practice centred model for integrated mental health care

South Western Sydney PHN has commissioned the Integrated Subspecialty Clinic to ensure better quality care, improved continuity of care, and more effective care of physical health problems for people with severe and complex mental illness.

Provided through Tahmoor Medical Centre and South Western Sydney Local Health District, the clinic provides coordinated, wrap around care for people with severe and persistent mental illness in a general practice setting. The clinic supports people living with a severe and persistent mental illness to address their mental health, physical health, and psychosocial needs through access to a range of services, coordinated by a dedicated South Western Sydney Local Health District Care Coordinator.

The service acts as a proof of concept for an integrated mental health service model targeting people with severe mental illness within a general practice setting. This model could be replicated in other regions.

Priority Area 6: Reducing stigma and discrimination

A charter to address the stigma of mental illness

The Fifth Plan identifies reducing the stigma and discrimination surrounding mental illness as a significant priority. This issue was reflected as a primary concern by the participants of a Partners in Recovery program in Murray PHN. As a result, Murray PHN initiated a co-design working group consisting of program participants, carers, and other stakeholders to develop strategies to address stigma.

An outcome of the working group was the development of a charter that demonstrates the commitment of organisations to addressing the stigma of mental illness. The Stop Mental Illness Stigma Charter includes seven commitments that are proven strategies to address the stigma of mental illness.

A signatory organisation commits for their staff to increase their understanding of mental illness, the myths and stereotypes that surround mental illness, and how to support people who are experiencing mental ill health. A requirement of signing the charter is that the organisation displays the charter and the signed pledge in a prominent location. This ensures all visitors, customers, and consumers are aware that the signatory organisation is committed to addressing the stigma of mental illness and that their interaction with staff will be free from stigma.

At the time of reporting, more than 70 organisations from a variety of sectors across Australia have adopted the charter. Implementation of the charter within these organisations has had a positive impact, with 83% of attendees at regional Stop Stigma workshops indicating that the charter had made a difference within their organisations.

Priority Area 7: Making safety and quality central to delivery of mental health services

Making safety and quality central to delivery of mental health services

In March 2019, Queensland Health released the Violence Risk Assessment and Management Framework – Mental Health Services. State-wide implementation of the framework was completed by July 2019. The framework was developed in response to recommendations arising from the 2016 report 'When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services'.

The Framework provides mental health services with a structured three-tiered approach. Tier 1 involves a brief risk screen undertaken by frontline clinical staff for all mental health service consumers. Tier 2 involves a comprehensive risk assessment undertaken by senior clinicians and consultant psychiatrists for consumers identified at tier 1 as having an elevated risk for violence. Tier 3 involves a targeted response by forensic mental health services for consumers assessed at tier 2 as having a significantly elevated risk profile and complex forensic behaviours requiring specialist input. Each tier is supported by clinical documentation and training modules to build clinical capability to undertake the required response.

An evaluation of a six month pilot of the framework demonstrated several benefits. The evaluation showed that the framework had improved the quality of information gathered pertaining to violence risk; encouraged discussion of risk during multidisciplinary team reviews; increased senior clinician input into risk assessment and management planning; enhanced the ability of clinicians and mental health services to manage risk; and improved liaison with, and referrals to, specialist forensic mental health services.

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

Community-of-practice approach supports peer workers in grassroots-based advocacy

As identified in the Fifth Plan, creating opportunities for peer workers to advocate within a system at a grassroots level supports the reduction of stigma and discrimination. In support of grassroots advocacy, Brisbane South PHN worked with lived experience practitioners to establish a community of practice for people working from a lived experience perspective within community services.

The community of practice was developed through a series of co-design workshops to support the lived experience practitioners to create an environment of learning from their shared experiences. The design process also aimed to build capability for emerging leaders in the lived experience workforce. The co-design facilitators taught and modelled decision making, groundwork for hosting meetings, and project design techniques. Members of the community of practice named the group, the Community of Lived Experience Workers (CLEW), and developed a slogan, 'If you don't have a CLEW, then you don't have a CLUE!'.

In total, 67 individuals attended the workshops, with the majority of participants reporting that they felt more connected. By creating a sense of belonging, and a safe supportive space, participants felt more supported in their lived experience role. Participants also reported that they felt more comfortable speaking up and that they would sustain the connections that they made through the CLEW. A participant noted 'knowing I have an external support in the Community of Lived Experience Workers, I am more confident about bringing my whole self and advocating for mental health awareness in the workplace'.

Improving the peer workforce through networking

South Eastern NSW PHN recognises the roles of the region's peer workforce across numerous parts of the public mental health service– from in-patient to community – as well as roles in community managed organisations and commissioned services. As a result, South Eastern NSW PHN established the position of Mental Health Peer Coordinator who developed Peer Networks across the regions in partnership with Local Health Districts, non-government organisations, and service providers.

The Illawarra Shoalhaven, the South Coast, and the Southern Tablelands Peer Networks meet quarterly. They provide peer workers with a safe environment, and an opportunity to share professional knowledge and learning opportunities through a combination of informal support, mentoring and co-reflective practice, and professional development activities. Since the program launched in 2017, the region's 75 peer workers have participated in over 26 network meetings.

Upskilling general practitioners on mental health contextually in the Northern Territory

The Northern Territory PHN recognises that the rates and management of mental illness and suicide in the Northern Territory are complicated by poor access to services, a complex and overstretched public mental health service, and a transient workforce.

A needs assessment in 2017–18 examined the interface between general practice and community mental health services. It identified a mismatch between the support and skillset needed by GPs in the Northern Territory and the available training, which can often result in limited GP confidence and potentially suboptimal consumer outcomes.

In response, Northern Territory PHN made up-skilling the GP workforce a priority – both in general practices and in the specific context of the Northern Territory. A mapping exercise was conducted across the Northern Territory to understand the mental health learning and education needs of GPs. Input was also sought from a wide range of health professionals and providers, and consumers and carers.

The result of this exercise will be implemented in October 2019. It includes the localisation of Mental Health HealthPathways to guide management and service availability across each of the six regions in the Northern Territory; a cyclical training package for GPs, looking at the essentials of mental health in the Northern Territory; and the identification of a group of GPs with a special interest in further developing their skills.

Appendix C:
Status of Fifth National Mental Health and Suicide Prevention Plan performance indicators

Domain	Related Fifth Plan priority area(s)	Indicator number and name	Current reporting status
Healthy start to life	N/A	PI 1: Children who are developmentally vulnerable	Included for the first time in the 2019 report
Better physical health and living longer	Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Improving the physical health of people living with mental illness and reducing early mortality.	PI 2: Long-term health conditions in people with mental illness	Included for the first time in the 2018 report
	Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Improving the physical health of people living with mental illness and reducing early mortality.	PI 3: Tobacco and other drug use in adolescents and adults with mental illness	Included for the first time in the 2018 report
	Improving the physical health of people living with mental illness and reducing early mortality.	PI 4: Avoidable hospitalisations for physical illness in people with mental illness	Requires further development
	Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Improving the physical health of people living with mental illness and reducing early mortality. Making safety and quality central to mental health service delivery.	PI 5: Mortality gap for people with mental illness	Requires further development
Good mental health and wellbeing	Achieving integrated regional planning and service delivery. Effective suicide prevention. Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Improving the physical health of people living with mental illness and reducing early mortality. Reducing stigma and discrimination. Making safety and quality central to mental health service delivery. Ensuring that the enablers of effective system performance and system improvement are in place.	PI 6: Prevalence of mental illness	Included for the first time in the 2018 report
	Achieving integrated regional planning and service delivery.	PI 7: Adults with very high levels of psychological distress	Included for the first time in the 2018 report
	Coordinating treatment and supports for people with severe and complex mental illness. Reducing stigma and discrimination.	PI 8: Connectedness and meaning in life	Requires further development

Domain	Related Fifth Plan priority area(s)	Indicator number and name	Current reporting status
Meaningful and contributing	Achieving integrated regional planning and service delivery. Coordinating treatment and supports for people with severe and complex mental illness.	PI 9: Social participation in adults with mental illness	Included for the first time in the 2019 report
	Coordinating treatment and supports for people with severe and complex mental illness.	PI 10: Adults with mental illness in employment, education or training	Included for the first time in the 2018 report
	Coordinating treatment and supports for people with severe and complex mental illness.	PI 11: Adult carers of people with mental illness in employment	Included for the first time in the 2019 report
	Reducing stigma and discrimination. Ensuring that the enablers of effective system performance and system improvement are in place.	PI 12: Proportion of mental health consumers in suitable housing	Requires further development
Effective support, care and treatment	Achieving integrated regional planning and service delivery. Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Reducing stigma and discrimination. Making safety and quality central to mental health service delivery.	PI 13: Mental health consumer experience of service	Included for the first time in the 2019 report
	Achieving integrated regional planning and service delivery. Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Making safety and quality central to mental health service delivery.	PI 14: Change in mental health consumers' clinical outcomes	Included for the first time in the 2018 report
	Achieving integrated regional planning and service delivery. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.	PI 15: Population access to clinical mental health care	Included for the first time in the 2018 report
	Achieving integrated regional planning and service delivery. Effective suicide prevention. Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Making safety and quality central to mental health service delivery.	PI 16: Post-discharge community mental health care	Included for the first time in the 2018 report
	Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.	PI 17: Mental health readmissions to hospital	Included for the first time in the 2018 report
	Ensuring that the enablers of effective system performance and system improvement are in place.	PI 18: Mental health consumer and carer workers	Included for the first time in the 2018 report

Domain	Related Fifth Plan priority area(s)	Indicator number and name	Current reporting status
Less avoidable harm	Achieving integrated regional planning and service delivery. Effective suicide prevention. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.	PI 19: Suicide rate	Included for the first time in the 2018 report
	Effective suicide prevention.	PI 20: Suicide of people in inpatient mental health units	Requires further development
	Achieving integrated regional planning and service delivery. Effective suicide prevention. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention. Making safety and quality central to mental health service delivery.	PI 21: Rates of follow-up after suicide attempt/self-harm	Requires further development
	Coordinating treatment and supports for people with severe and complex mental illness. Making safety and quality central to mental health service delivery.	PI 22: Seclusion rate	Included for the first time in the 2018 report
	Coordinating treatment and supports for people with severe and complex mental illness. Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.	PI 23: Involuntary hospital treatment • PI 23a: Involuntary hospital treatment (separations) • PI 23b: Involuntary patient days	Included for the first time in the 2019 report
Stigma and discrimination	Reducing stigma and discrimination.	PI 24: Experience of discrimination in adults with mental illness	Included for the first time in the 2018 report

Appendix D:
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.

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

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 three 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 three 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 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.

'Another long-term health condition' is defined as any of the following conditions, which has lasted six months or more, or is expected to last six 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?

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.[7]

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.[8]

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

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

All ages are in scope for this indicator.

Due to historical limitations of the data collection, equivalent data for Aboriginal and Torres Strait Islander people are not currently available for reporting. However, due to recent developments it is expected that this disaggregation will be 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 is published in the 2019 Progress Report. Source data for this indicator is published approximately every three years and was most recently conducted in 2017–18. 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 and PI 2.2 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.

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

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

Why is it important?

There is a strong association between illicit drug use and mental illness. However, it can be difficult to isolate to what degree drug use causes mental illness, and to what degree mental illness gives rise to drug use, often in the context of self-medication.[9]

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.[10] In Australia, lung cancer is responsible for a reduction in life expectancy of six years. Tobacco use is responsible for 80% of lung cancer burden.[11]

Caveats

This data includes people aged 14 and over.

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

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report. Source data for this indicator are collected approximately every three years and was most recently collected in 2016. It is likely 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.

'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?

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

Caveats

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

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.

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

Why is 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 includes people aged 18 and over.

Data are 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 is published in the 2019 Progress Report. Psychological distress data for non-Indigenous Australians is published approximately every three years, and data for Indigenous Australians is published approximately every four 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.

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

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

Data includes people aged 15 and over.

Experience of mental illness is self-reported.

Data for Aboriginal and Torres Strait Islander people and non-Indigenous people are 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 four 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.

'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 people are 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

Experience of mental illness is collected by self-report.

Respondents reporting current study were required to be 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 are limited to people aged 15-64.

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report, and updated data is published in the 2019 Progress Report. Source data for this indicator are collected approximately every three years for non-Indigenous people and approximately every four years for Aboriginal and Torres Strait Islander people. 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.

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.

Caveats

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 are 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 are collected approximately every three 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.

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

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. Source data for this indicator are collected annually, and was most recently collected in 2016–17. 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.

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

Why is it important?

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

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

Caveats

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

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report and updated data is published in the 2019 Progress Report. Source data for this indicator are collected annually and was most recently collected in 2017–18. Updated data 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 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.

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?

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.[12]

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

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

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

Caveats

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report and updated data is published in the 2019 Progress Report. Source data for this indicator are collected annually, and were most recently collected in 2017–18. Updated data 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 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, in which the consumer participated, was recorded in the seven days following that separation.

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

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 (for example, children and adolescents), follow-up with the consumer's carer represents best practice.

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 are published in 2019 Progress Report. Source data for this indicator are collected annually and were most recently collected in 2017–18. Updated data 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 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 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

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 are published in the 2019 Progress Report. Source data for this indicator are collected annually and were most recently collected in 2017–18. Updated data 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 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.

'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.

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

Caveats

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

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

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

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report, and updated data are published in the 2019 Progress Report. Source data for this indicator are collected annually and were most recently collected in 2017–18. Updated data 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 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.

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

Why is it important?

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 achieve a decrease in 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

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 are published in the 2019 Progress Report. Source data for this indicator are collected annually, and were most recently collected in 2017. Updated data 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 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.

Seclusion is defined as the confinement of the 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.[13] The use of seclusion in public sector mental health service organisations is regulated under the legislation and/or policy of each jurisdiction.

Caveats

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

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

Reporting under the Fifth Plan

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

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?

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

Involuntary care is considered a type of restrictive practice, so monitoring involuntary care is an important component of understanding and reducing the use of restrictive practices in Australian public hospitals.

Caveats

Separations with specialised mental health care days that include one or more days of involuntary care are counted as involuntary separations, regardless of how many days of voluntary care occurred within the separation.

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 are collected annually, and was most recently collected in 2017–18. Updated data 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 23a.1 and PI 23a.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.

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?

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

Involuntary care is considered a type of restrictive practice, so monitoring involuntary care is an important component of understanding and reducing the use of restrictive practices in Australian public hospitals.

Caveats

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 are collected annually and were most recently collected in 2017–18. Updated data 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 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.

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

Why is it important?

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

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

Caveats

Experience of mental illness is collected by self-report.

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

Data include people aged 18 years and older.

Reporting under the Fifth Plan

This indicator was first published in the Fifth Plan 2018 Progress Report. Source data for this indicator is published approximately every four years and was most recently published in 2014. Updated data is likely to 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 and PI 24.3 in the accompanying Excel workbook for all data available for this indicator.

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.

Another long-term health condition

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

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

Community mental health care

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

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.

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.

Postvention

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

Psychological distress

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

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

Separation

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

Specialised mental health services

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

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*
2019 Consumer and Carer Report	*Fifth National Mental Health and Suicide Prevention Plan, 2019: The consumer and carer perspective*
ACCHS	Aboriginal Community Controlled Health Service
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
ATSIMHSPPRG	Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group
COAG	Council of Australian Governments
EWIC	Equally Well Implementation Committee
Fifth Plan	Fifth National Mental Health and Suicide Prevention Plan
FPTAG	Fifth Plan Technical Advisory group
GP	General Practitioner
Implementation Plan	Fifth National Mental Health and Suicide Prevention Plan Implementation Plan
LHN	Local Health Networks
MBS	Medicare Benefits Schedule
MHERP	Mental Health Expert Reference Panel
MHISSC	Mental Health Information Strategy Standing Committee
MHPC	Mental Health Principal Committee
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework
NSMSHS	National Standards for Mental Health Services
NSQHS Standards	National Safety and Quality Health Service Standards
NSW Health	New South Wales Ministry of Health
PHN	Primary Health Network
Queensland Health	Queensland Department of Health
SA Health	South Australia Department for Health and Wellbeing
SQPSC	Safety and Quality Partnership Standing Committee
WHO	World Health Organisation
YES survey	Your Experience of Service survey

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Australian Government

National Mental Health Commission