The Fifth National Mental Health and Suicide Prevention Plan

national
mental
health
strategy

The Fifth National Mental Health and Suicide Prevention Plan

Foreword

The release of the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan) marks a significant point in the history of the National Mental Health Strategy which commenced in 1992. Over the next five years, the Fifth Plan will build on the achievements that have occurred in the first 25 years of national mental health reform.

For the first time this plan commits all governments to work together to achieve integration in planning and service delivery at a regional level. Importantly it demands that consumers and carers are central to the way in which services are planned, delivered and evaluated.

Furthermore this plan recognises the tragic impact of suicide on the lives of so many Australians and sets a clear direction for coordinated actions by both levels of government to more effectively address this important public issue.

This plan is also the first to specifically outline an agreed set of actions to address social and emotional wellbeing, mental illness and suicide amongst Aboriginal and Torres Strait Islander peoples as a priority, as well as being 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 accompanies mental illness.

The Fifth Plan was developed at a time of considerable change in social policy in Australia. Of paramount importance has been the establishment of the National Disability Insurance Scheme which promises much for people who have psychosocial disability. In addition, Primary Health Networks have been established as new entities that provide primary and specialist mental health care and several state governments have established Mental Health Commissions that focus on a whole of government approach to mental health care and preventing suicide.

The development of the Fifth Plan built on the extensive consultation undertaken by the National Mental Health Commission in 2014 and then brought together the knowledge of people with lived experience of mental illness, the mental health sector, including mental health and suicide prevention service providers, Aboriginal and Torres Strait Islander organisations, state and territory governments and a range of stakeholders. Mental Health Australia led a comprehensive national consultation about the priority areas and provided valuable assistance that ensured the views of the broader mental health sector were captured. This plan is the culmination of those efforts.

Over the next five years, the Fifth Plan will establish a national approach for collaborative government action to improve the provision of better integrated mental health and related services in Australia. It will build on the foundation established by four previous National Mental Health Plans, existing state and territory mental health and suicide prevention plans, and national health and mental health reforms.

The Fifth Plan commits to a nationally agreed set of priority areas and actions, that are designed to achieve an integrated mental health system and that will be used to build a stronger, more transparent, accountable, efficient and effective mental health system. These actions represent what governments and the sector believe are achievable and measurable improvements to the current functioning of the mental health system.

The Fifth Plan is accompanied by an Implementation Plan that sets out who will be responsible for undertaking the actions agreed in the plan and how implementation will proceed and be coordinated across governments.

For the first time the plan also contains a set of nationally agreed indicators which can be captured and reported on to track the progress of the plan.

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. While there is still much room for improvement across the health system, the Fifth Plan is ambitious in its intent and promises to positively address the inadequacies and inefficiencies experienced by individuals currently using the mental health service system.

I would like to thank the members of the MHDAPC Writer's Group and the Commonwealth secretariat for their hard work and dedication over the last two years. Their commitment to producing the very best plan possible in the hopes of improving the mental health outcomes for all Australians is to be commended. I also wish to acknowledge representatives from Consumer and Carer organisations, Aboriginal and Torres Strait Islander organisations, Mental Health Australia, National Mental Health Commission, and other key stakeholders and external consultants who have generously given their time and knowledge for this important work.

And finally, I would like to express my gratitude to all those who contributed to the plan, from the individuals who've shared their personal experiences with mental illness to the mental health professionals who've provided their expertise. The opinions, feedback and wisdom given through the entire process have been instrumental in achieving a plan that advocates for improved mental health outcomes for everyone in the Australian community.

The Hon Jill Hennessy
Chair, COAG Health Council
August 2017

Contents

Introduction

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) is an integral part of the National Mental Health Strategy. Endorsed by the Australian Health Ministers' Conference in 1992, the National Mental Health Strategy is formed by a suite of documents, each with a specific purpose.

These documents include the National Mental Health Policy, the Mental Health Statement of Rights and Responsibilities and four successive National Mental Health Plans. The strategy has driven mental health reform over the last twenty-five years.

The National Mental Health Policy provides a strategic framework to guide coordinated government efforts in mental health reform and service delivery. Its vision, aims and policy directions provide a context for the development of national, state and territory mental health plans. The National Mental Health Policy was first endorsed in 1992 and most recently updated in 2008. The 2008 National Mental Health Policy emphasised the importance of collaboration across sectors, levels of government and government agencies to achieve improvements in mental health outcomes across the community. Its visions and aims are set out in **Figure 1**.

National Mental Health Plans set out national actions to achieve the intent of the National Mental Health Policy. The first National Mental Health Plan was a five-year document that commenced in 1993. It was renewed in 1998, in 2003, and via the Fourth National Mental Health Plan in 2009.

Previous National Mental Health Plans have prioritised particular areas of action consistent with the need and opportunity identified at that time. Like its predecessors, the Fifth Plan acknowledges that it is not possible to fix everything at once or for all population groups and that it is important to focus on significant issues that need to be addressed as part of a national approach. The Fifth Plan builds on the foundation established by previous reform efforts and sets out a national approach for collaborative government effort over the next five years. **Figure 2** outlines some of the priorities and achievements under the National Mental Health Strategy.

The Fifth Plan is underpinned by several targeted priority areas, which were developed taking into account feedback from key stakeholders, and includes supporting actions that enable change. The supporting actions are not intended to solve all problems within the five-year period of the Fifth Plan but are instead intended to set the direction for change and provide a foundation for longer-term system reform.

It also responds to calls for a national approach to address suicide prevention, acknowledging that, while considerable effort has been taken to develop strategic guidance to improve suicide prevention activity in Australia, there has not previously been a dedicated national suicide prevention plan. The Fifth Plan addresses that deficit by identifying key activities within the Health portfolio that can reduce the impact of suicide on our community. It also acknowledges that suicide prevention is the responsibility of all levels of government and government agencies and therefore provides mechanisms for the health portfolio to interact with other portfolios to drive preventive action in those domains.

The Fifth Plan also recognises that state and territory mental health and suicide prevention plans, and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, are important in terms of driving specific reform activities. It therefore seeks to complement these plans and focuses on areas where a national approach is needed and where outcomes are best achieved by governments working together.

Figure 1: Vision and aims of the 2008 National Mental Health Policy

The vision is for a mental health system that:

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

The aims are to:

- promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community
- promote recovery from mental health problems and mental illness
- assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The National Mental Health Strategy can be accessed at: http://www.health. gov.au/internet/main/publishing.nsf/content/mental-strat

Figure 2: Priorities and achievements under the National Mental Health Strategy

HEALTH MINISTERS

NATIONAL MENTAL HEALTH STRATEGY

NATIONAL MENTAL HEALTH POLICY

NATIONAL MENTAL HEALTH PLAN

MENTAL HEALTH STATEMENT OF RIGHTS AND RESPONSIBILITIES

1993–1998 FIRST NATIONAL MENTAL HEALTH PLAN

1998–2003 SECOND NATIONAL MENTAL HEALTH PLAN

2004–2008 THIRD NATIONAL MENTAL HEALTH PLAN

2009–2014 FOURTH NATIONAL MENTAL HEALTH PLAN

2017–2022 FIFTH NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION PLAN

National Mental Health Policy priorities:

- Creating mechanisms to incorporate consumer input into mental health policy
- Linking mental health services to other services such as housing, social support, income security, employment and training
- Embedding mental health promotion and prevention into services
- Implementing ongoing mental health training for health professionals
- Increasing service responsiveness and strengthening quality
- Shifting focus from process measurement to outcome measurement
- Strengthening accountability in mental health reform and service delivery
- Driving integration of planning, services and treatments and improving coordination for people with severe and complex mental illness
- Improving physical health of people living with mental illness
- Improving safety and quality of mental health services and ensuring system enablers are in place

Mental Health Statement of Rights and Responsibilities priorities:

- Defining the relationship between mental health services and the general health sector
- Increasing the quality and range of mental health services
- Enhancing education, training and support programs for carers
- Developing legislation consistent with UN Resolutions and Mental Health Statement of Rights and Responsibilities
- Creating partnerships in service reform and delivery
- Renewal of National Mental Health Policy
- Driving a social inclusion and recovery focus
- Building a coordinated national approach to suicide prevention
- Improving Aboriginal and Torres Strait Islander mental health and suicide prevention
- Reducing stigma and discrimination

Priorities in the Fifth Plan to achieve the vision of the National Mental Health Policy

The Fifth Plan sets out to achieve outcomes in eight priority areas that align with specific aims and policy directions in the National Mental Health Policy. These priority areas do not reflect all the aims and policy directions in the National Mental Health Policy but align with those that are well positioned for change in terms of both need and opportunity. The eight priority areas of the Fifth Plan are:

- 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.

Governments are committed to actions that are directed at achieving these outcomes and have identified indicators of progress that will be measured and reported on over the life of the Fifth Plan.

In achieving these outcomes, governments commit to the principle articulated in the National Mental Health Policy that acknowledges that consumers and carers have vital contributions to make and should be partners in planning and decision-making. Consumers and carers should be at the centre of, and enabled to take an active role in shaping, the way in which services are planned, delivered and evaluated. Governance and implementation of the Fifth Plan reflect the intent of the National Mental Health Policy regarding consumer and carer participation—that is, '**Nothing about us, without us**'.

Recognising diverse experiences

Mental health problems and mental illness are widespread and have a substantial social and economic impact (refer to the key facts in **Figure 3**). Mental health needs vary across population groups. It is known that mental health experiences are influenced by age, gender, sexuality, family situation and cultural background.[1] Some of the specific considerations needed for certain population groups are outlined in **Figure 4**.

The actions in the Fifth Plan, and related activity being undertaken by individual governments, require specific and appropriate application to these groups. Governments commit to responding to the mental health and suicide prevention needs of these population groups through building effective and appropriate relationships with relevant population groups, addressing the drivers of the burden of mental illness, and understanding the actions that will facilitate effective access to services and overall improvements to mental health and wellbeing.

Figure 3: Mental health in Australia key facts

1 in 5 Australians aged over 16 will experience mental ill-health each year [i]

Most early deaths of psychiatric patients are due to **physical health conditions** [iv]

Almost 50% of Australians aged over 16 will experience mental illness at some point [ii]

People living with mental illness, particularly those with severe mental illness, are more at risk of experiencing a range of adverse health outcomes, and they have a lower average life expectancy than the general population [iii]

19%

Mental health and substance use disorders are leading contributor of the burden of disease and injury in Aboriginal and Torres Strait Islander peoples, causing **19%** of total disease burden in this population group [vi]

Mental Health and substance use disorders are the **third largest** cause of total disease burden (12% of total burden in Australia in 2011) and the **leading** cause of non-fatal burden (24% of all YLD – Years with lived disability) [v]

3027

In 2015 there were **3027 deaths** by suicide, or an average of 8 deaths per day [ix]

89%   85%
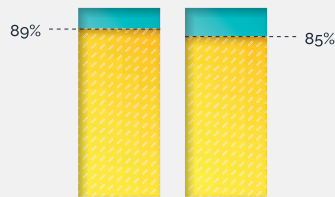
Australian findings indicate that **89%** of respondents knew someone who had attempted and **85%** knew someone who had died by suicide [viii]

$28.6b

Estimated that total direct health and non-health expenditure to support people living with mental illness is **$28.6 billion per year** (2.2% of Australia's GDP) [vii]
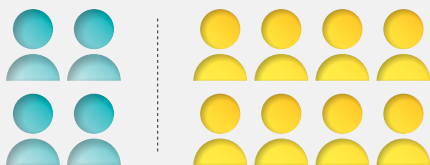
Suicide rates for Aboriginal and Torres Strait Islander peoples are **twice as high** as for non-Indigenous Australians [x]

Male suicide rate is higher for people living in rural and remote regions [xi]

Figure 4: Diversity of experience of mental illness across population groups

Australians who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) have disproportionate experiences of mental health problems and mental illness. Rates of major depressive episodes in the LGBTI community can be four to six times higher than the general population, psychological distress rates are reported as twice as high, and suicide rates are higher than in any other group in the Australian population.[2] Reducing stigma and improving the appropriateness of mental health services is critical for LGBTI communities.

Aboriginal and Torres Strait Islander peoples have higher rates of mental illness and suicide, higher rates of substance use burden, and rates of psychological distress more than twice those of the general population.[3,4,5] Stressors include discrimination, racism and social exclusion; grief and loss; removal of children; economic and social disadvantage; family and community violence; incarceration; substance use; and physical health problems.[6] Intergenerational trauma associated with these stressors can impact upon Aboriginal and Torres Strait Islander communities. Despite this, Aboriginal and Torres Strait Islander peoples do not make up a significant proportion of people attending services.

Eating disorders are complex mental disorders that result in significant physical impairment and have high rates of mortality. People with eating disorders experience higher rates of comorbid mental health problems than the general population. These include depression and anxiety disorders, substance misuse and personality disorders.[7] People with eating disorders can also experience significant physical comorbidities, such as higher levels of cardiovascular disease and neurological symptoms[8], and are likely to experience stigma and discrimination as a result of their disorder. Treatment for an eating disorder requires not only responses to the underlying pathology but also integrated responses to relevant mental and physical health comorbidities.

There is a higher burden of mental illness for people who live in rural and remote Australia due to a number of factors. While the prevalence of illness in rural and remote Australia is similar to that in major cities, the impact of mental illness is much greater. Mental health professionals are in short supply, with rates declining markedly with remoteness; with 88% of psychiatrists and 75% of psychologists employed in major cities, and only 3 psychiatrists per 100,000 population and 30 psychologists per 100,000 population employed in remote and very remote areas.[9]

Incidence of suicide is 30 per cent higher in regional/rural areas and twice as high in remote areas, while mental health hospitalisations are higher by at least 10 per cent and intentional self-harm and drug and alcohol issues are higher by up to double when compared with major cities. The lack of available services results in many people not accessing prevention, primary health care and early intervention services: they present late, are diagnosed late and often are at a more advanced stage of illness, with corresponding physical comorbidities.[10]

The Australian military are selected and trained to face highly stressful situations. Australian Defence Force (ADF) personnel have lifetime prevalence rates of mental illness that are slightly higher than those of the general population. ADF personnel have higher rates of affective and anxiety disorders and higher rates of suicidality than those in the general community.[11] However, ADF personnel have lower rates of reported deaths by suicide and lower rates of alcohol disorders than those in the general community. Responses to mental health problems for ADF personnel require sensitivity to the specific circumstances that individuals have faced.

Over recent decades there has been a growing understanding of the risk of mental health problems occurring during pregnancy and in the postnatal period. Systematic reviews in high-income countries have shown that about 10 per cent of pregnant women and 13 per cent of women who have given birth experience some type of mental illness, most commonly depression or anxiety.[12] The needs of this group, and of their children, differ significantly from those of the general population and require specific responses.

Age is a significant factor in the experience of mental health problems and mental illness, with children and adolescents having experiences of mental health problems and mental illness that are different from those of adults. One in seven Australian children are reported as likely to experience a mental illness, high proportions experience anxiety and affective disorders, and mid-to late adolescence is a common time for the onset of psychotic disorders.[13]

Trauma is widespread among those who use mental health services. It often has lasting adverse effects, so it is critical to effectively address this issue to reduce its impact and to prevent the exposure to any further trauma within services. The experience of childhood trauma, especially sexual abuse, greatly increases the risk of mental illness. The current Royal Commission into Institutional Responses to Child Sexual Abuse has highlighted the lasting impact of childhood abuse on a person's mental health, and its outcomes, expected later in 2017, will be reviewed closely by governments. The provision of therapeutic responses for those affected will need to be strongly based on the best available evidence about trauma informed care.

Older Australians often experience a combination of complex physical illness and mental health problems. It is thought that between 10 and 15 per cent of older people experience depression and about 10 per cent experience anxiety.[14] Suicide rates in men aged over 85 are disproportionately higher than those in the remainder of the population.[15] Integrated services that address both physical and mental health problems, and skills in recognising the risk factors for suicide, are central to achieving effective outcomes for older Australians.

It is widely acknowledged that there is a significant overlap of people who present with substance misuse problems in addition to their mental illness. The combination of substance misuse and mental illness makes diagnostic and treatment decision-making difficult and successful interventions are often dependent on concurrent responses to both disorders. It is therefore essential that the linkage and management of these comorbidities are considered in system and service planning. Implementation of the Fifth Plan will be progressed with reference to work committed to under the National Drug Strategy 2017-2026, which provides a framework to guide the work of governments, communities and service providers in minimising alcohol and other drug-related harms.

People with disability, particularly people with intellectual disability, experience higher rates of mental health problems and mental illness. It is estimated that people with intellectual disability are at least two to three times more likely to have a mental illness than the general population[16], yet people with intellectual disability experience significantly lower rates of treatment of mental health problems compared with the general population[17] and many encounter significant barriers which prevent timely access to appropriate supports and services.[18] People with intellectual disability also tend to be more vulnerable to the factors that can lead to the development of mental health problems. Mental illness in people with intellectual disability can also be overlooked for a range of reasons, including that the person may be unable to describe their experience and that their behaviours may be misattributed to their intellectual disability.[19] People with intellectual disability and mental illness often have complex needs that require a coordinated approach across multiple service sectors. Integrated, accessible and person-centred supports and services are key to ensuring that people with disability, particularly people with intellectual disability, can experience better mental health and realise their potential.

Roles and responsibilities

The health system as a whole is driven by coordinated action between levels of government, reflecting their legislative, policy and funding accountabilities. Coordinated change requires all levels of government to exercise their accountabilities in a synchronised way. The Commonwealth, state and territory governments, public sector agencies the private sector, community-managed organisations, and families and carers all contribute to care and support for people living with mental illness.

The Commonwealth Health portfolio provides Medicare and grant-based funding and policy direction for the delivery of primary mental health care services delivered by private psychiatrists in the community, general practitioners (GPs), private psychologists, mental health nurses and other allied health professionals, as well as providing core funding to Aboriginal Community Controlled Health Services (ACCHSs). It is also a key funder of services delivered by the community-managed sector, both directly and through grants administered by Primary Health Networks (PHNs) and aged care services. It has a central role in the infrastructure of the mental health system through funding research and telephone-based and digital service delivery initiatives, workforce initiatives in the tertiary education sector, Pharmaceutical Benefits Scheme (PBS) subsidised medicines and interfaces with key portfolio areas such as the Department of Social Services and the National Disability Insurance Scheme (NDIS). Intergovernmental funding agreements between the Commonwealth and states and territory governments are a key mechanism for achieving coordinated policy and system improvements.

State and territory governments provide funding for public sector services and set legislative, regulatory and policy frameworks for mental health service delivery within their jurisdiction. Like the Commonwealth Government, they also provide substantial funding to community-managed organisations and commission targeted research and program evaluations and workforce initiatives in the vocational education sector. Mental health laws are enacted and regulated at the state and territory level.

Over the last decade, a number of governments within Australia have established mental health commissions. These commissions vary in role and authority. Some, such as the Western Australian Mental Health Commission, have budget and performance-setting responsibilities. Others focus on strategy and community engagement. Mental health commissions have an important role in coordinating government action across portfolios and raising the profile of mental health both within and outside of government.

Activity at the local service delivery level is driven through PHNs and Local Hospital Networks (LHNs). PHNs were established by the Commonwealth Government. They plan and commission medical and health services within defined regional populations and are expected to support service integration at the regional level. LHNs were established by states and territories. They manage public hospital services; may manage other health services funded by states and territories, such as community-based health services; and support service integration at the regional level. PHNs and LHNs have strong relationships with the community-managed sector. Collective action by both PHNs and LHNs is necessary to drive effective service integration within a local region.

The community-managed sector generally operates on a not-for-profit basis. It includes both large and small organisations, some with large geographic coverage and many interrelationships and some that operate in only one locality. These organisations provide interventions for consumers and carers that include prevention and brief intervention services, psychosocial support services, advocacy, respite, and telephone and internet-based interventions. These services often have strong connections with local communities and can engage those communities to deliver better social outcomes for consumers and carers. Funding for community-managed organisations comes from both levels of government and from other entities such as PHNs and LHNs.

The private health sector provides professional fee-based services in both inpatient and office-based settings. These services can include primary care, acute management, rehabilitation, psychological interventions and other allied health based supports. Private sector professionals and organisations are substantial contributors to overall service delivery in mental health, and their funding is provided by a mix of patient fees and Commonwealth Government rebates.

ACCHSs are not-for-profit organisations that, depending on their size and complexity, deliver the range of services and programs attributed above to the community-managed and private sectors. These include comprehensive primary health care, specialist services, allied health and social support services delivered within Aboriginal and Torres Strait Islander (culturally appropriate) models of care and under Aboriginal and Torres Strait Islander governance structures. Programs delivered by ACCHSs are usually well integrated into the organisation's overall model of service delivery, which typically considers the physical, emotional and social needs of the whole person in the context of their family and community. ACCHSs are an important part of any mental health service system that is responsive to the needs of Aboriginal and Torres Strait Islander peoples and should be considered as mental health service delivery partners for both PHNs and LHNs in their work with Aboriginal and Torres Strait Islander peoples and communities.

Families and carers are the backbone of community mental health support. They can and do help consumers to recover and live well in the community and can also help to reduce episodes of acute illness and the need for hospital admissions.

It is clear there are a number of contributors to mental health and suicide prevention, meaning that policy implementation can only be successful if all parts of the system are working consistently and collaboratively to achieve system integration. The Fifth Plan identifies actions at each level of government that will improve mental health services and access to them. It also defines opportunities where better connections will be made between services at the regional level, driven by national agreement between governments, so that people living with mental illness are better supported to live a contributing life.

Figure 5: Meeting our international obligations

The Australian Government has committed to international agreements that place a responsibility on our mental health system to meet agreed international standards. International norms and standards are generally seen as the minimum acceptable standard for health policy. An example of such a set of standards to which Australia commits is the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

Australia has ratified a number of international human rights conventions. In doing so, Australia has promised the international community that it will protect and promote the human rights set out in those conventions. Australia has ratified the:

- Convention on the Rights of Persons with Disabilities (CRPD)
- International Covenant on Civil and Political Rights
- Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- Convention on the Rights of the Child
- International Covenant on Economic, Social and Cultural Rights
- Convention on the Elimination of All Forms of Discrimination Against Women
- International Convention on the Elimination of All Forms of Racial Discrimination
- United Nations Declaration on the Rights of Indigenous Peoples.

These treaties place obligations on Australia to protect and promote, among other things, the right to the enjoyment of the highest attainable standard of health, including mental health. Further, the CRPD sets out specific obligations with respect to persons with disabilities, including mental disabilities. Australia has also ratified the Optional Protocol to the CRPD, which provides a mechanism for monitoring States parties' implementation of the CRPD. A national plan is an important means of addressing these commitments, and the Fifth Plan recognises the rights described in the CRPD and seeks to support their implementation.

World Health Organization (WHO) agreements are non-binding but carry technical and moral weight through international consensus. Australia will have reporting duties related to the WHO Comprehensive Mental Health Action Plan 2013–2020 (the WHO Plan). The priority areas of the Fifth Plan link with the objectives and targets of the WHO Plan. Comprehensive implementation of the Fifth Plan will contribute to Australia meeting the objectives and targets of the WHO Plan.

Governance commitments

Governance arrangements for the Fifth Plan need to be designed to assist the Council of Australian Governments (COAG) Health Council to deliver on improved outcomes.

They need to provide 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.

The governance arrangements for the Fifth Plan are outlined in **Figure 6**.

Action i Governments will establish a **Mental Health Expert Advisory Group** that will advise the Australian Health Ministers' Advisory Council (AHMAC), through the Mental Health Drug and Alcohol Principal Committee (MHDAPC), on the implementation of the Fifth Plan and analyse progress. Membership will consist of:

- representatives from the Commonwealth and each state and territory, representing cross-portfolio interests
- cross-representation with existing governance and advisory mechanisms, where appropriate
- expert representatives from the private sector and community-managed sector
- consumers and carers.

AHMAC may request advice from the Mental Health Expert Advisory Group on broader mental health policy issues, which may include cross-portfolio consideration of issues that may arise from the implementation of mental health reforms and the NDIS for people with severe and complex mental illness and opportunities to harmonise data collection strategies. The Mental Health Expert Advisory Group will be time-limited and operate for the life of the Fifth Plan. Further detail about the role of the Mental Health Expert Advisory Group is provided in Priority Area 3.

Action ii Governments will establish a **Suicide Prevention Subcommittee** that will report to MHDAPC on priorities for planning and investment. Membership will consist of:

- representatives from the Commonwealth and each state and territory government
- expert representatives from key peak bodies, research and academia and the Aboriginal and Torres Strait Islander health sector
- consumers and carers
- cross-representation with the new Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee.

The first priority for the Suicide Prevention Subcommittee will be to develop the National Suicide Prevention Implementation Strategy for COAG Health Council endorsement. Further detail about the role of the Suicide Prevention Subcommittee is provided in Priority Area 2.
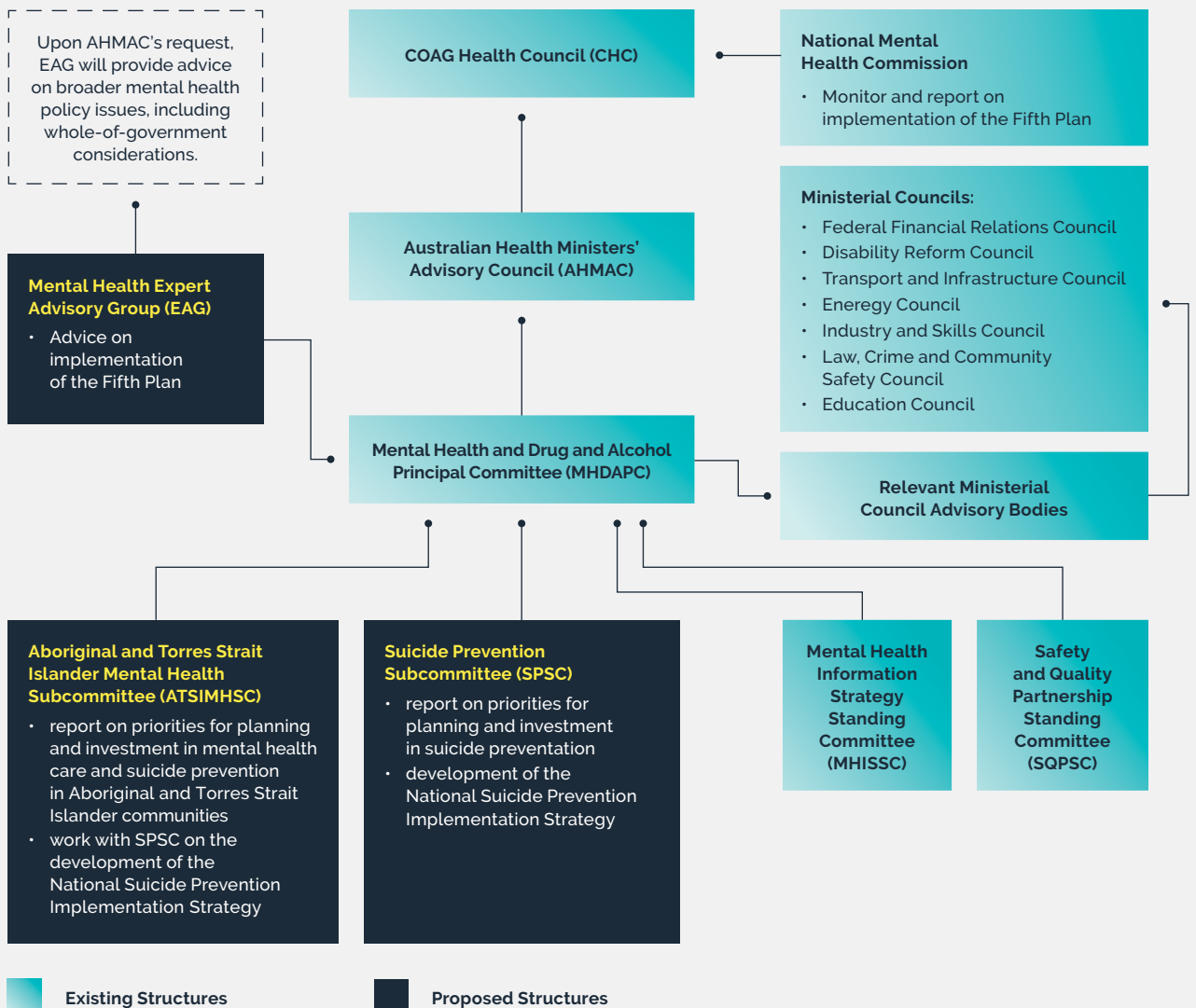
Action iii Governments will establish an **Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee** that will report to MHDAPC on priorities for planning and investment. The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will:

• be chaired by Aboriginal and Torres Strait Islander representatives

• include membership from the Commonwealth and each state and territory government

• include cross-representation with the new Suicide Prevention Subcommittee.

The Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee will work with the Suicide Prevention Subcommittee on the development of a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander peoples, for inclusion in the National Suicide Prevention Implementation Strategy. Further detail about the role of the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee is provided in Priority Area 4.

MHDAPC will meet regularly with relevant ministerial council advisory bodies on the implementation of the Fifth Plan and broader mental health policy issues that require whole-of-government consideration. This will ensure that implementation of the Fifth Plan is supported by an inclusive, whole-of-government approach.

Figure 6: Fifth Plan governance arrangements

Upon AHMAC's request, EAG will provide advice on broader mental health policy issues, including whole-of-government considerations.

COAG Health Council (CHC)

National Mental Health Commission
• Monitor and report on implementation of the Fifth Plan

Mental Health Expert Advisory Group (EAG)
• Advice on implementation of the Fifth Plan

Australian Health Ministers' Advisory Council (AHMAC)

Ministerial Councils:
• Federal Financial Relations Council
• Disability Reform Council
• Transport and Infrastructure Council
• Eneregy Council
• Industry and Skills Council
• Law, Crime and Community Safety Council
• Education Council

Mental Health and Drug and Alcohol Principal Committee (MHDAPC)

Relevant Ministerial Council Advisory Bodies

Aboriginal and Torres Strait Islander Mental Health Subcommittee (ATSIMHSC)
• report on priorities for planning and investment in mental health care and suicide prevention in Aboriginal and Torres Strait Islander communities
• work with SPSC on the development of the National Suicide Prevention Implementation Strategy

Suicide Prevention Subcommittee (SPSC)
• report on priorities for planning and investment in suicide preventation
• development of the National Suicide Prevention Implementation Strategy

Mental Health Information Strategy Standing Committee (MHISSC)

Safety and Quality Partnership Standing Committee (SQPSC)

■ **Existing Structures**   ■ **Proposed Structures**

Action iv Governments will renew the National Mental Health Policy. This review will begin in 2018 and be completed during the life of the Fifth Plan. Given the National Mental Health Policy is the foundation document for reform, the review will be completed with sufficient time to inform the development of any future National Mental Health and Suicide Prevention Plans under the National Mental Health Strategy.

Governments recognise and emphasise the role of consumers and carers in overseeing improvements to mental health care. They promote consumer and carer participation in policy and oversight, and co-design of models of care and service and program reform. Co-design has developed internationally as an inclusion principle for delivery of public services. Service recipients are seen as critical partners in service design, planning, implementation and evaluation. The Fifth Plan will ensure the principle of inclusivity is embedded in the approach to implementation, with consumers and carers involved at all levels.

Governments also recognise the importance of Aboriginal and Torres Strait Islander leadership in building better mental health services, underpinned by the Gayaa Dhuwi (Proud Spirit) Declaration (Appendix A)[20], which provides a platform for governments to work collaboratively to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.
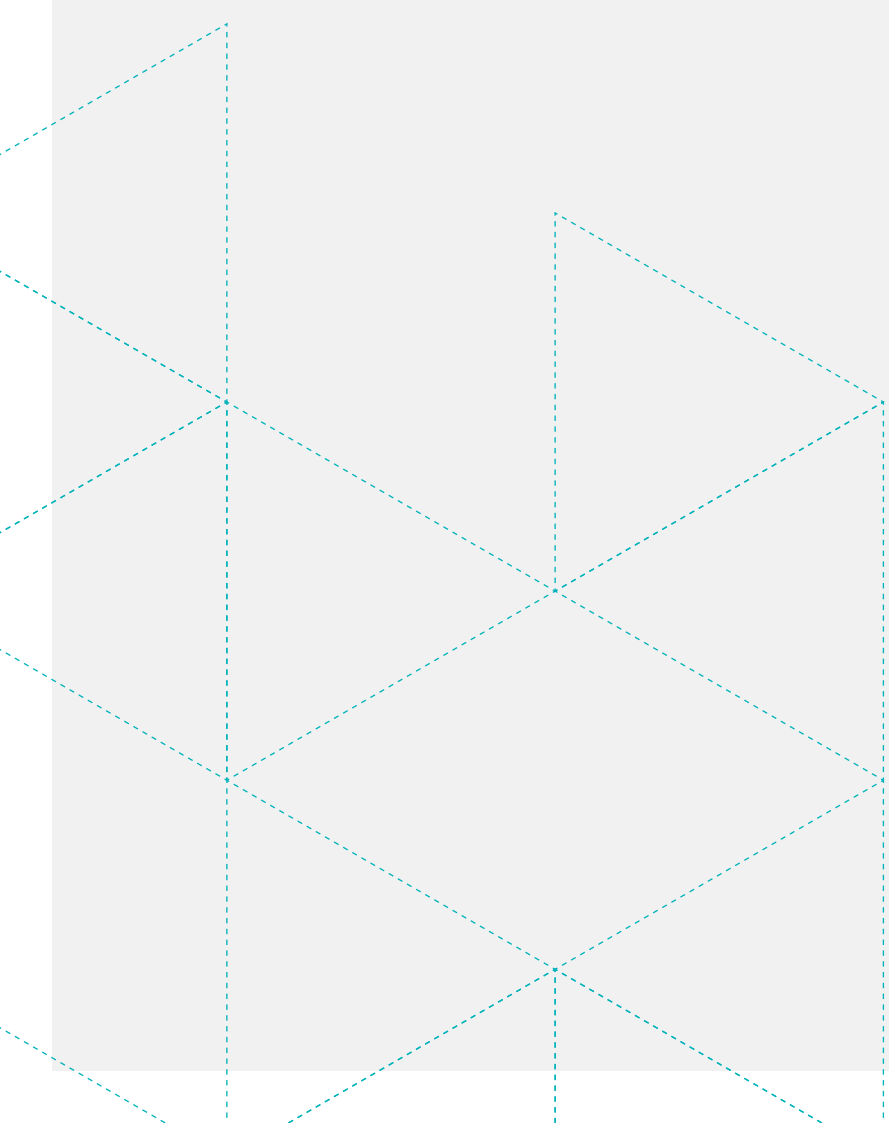
Measuring and reporting on change

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 that they are making a difference. An annual reporting process will be established that provides timely public reports on the implementation of the Fifth Plan, including progress against agreed outcomes and performance against identified indicators.

The Fifth Plan identifies 24 national key performance indicators which can currently be reported on or which could realistically be implemented within the life of the plan. Selection of these indicators was guided by the National Mental Health Commission's 2014 National Review of Mental Health Programmes and Services. Indicators from the review which can currently be measured have been included, along with additional indicators which are relevant to the commission's proposed domains. The indicator set is summarised in **Table 1** below and in Appendix B.

Table 1: Indicator set for the Fifth National Mental Health and Suicide Prevention Plan

Domain	Indicator
Healthy start to life	1. Proportion of children developmentally vulnerable in the Australian Early Development Index
Better physical health and living longer	2. Rate of long-term health conditions in people with mental illness 3. Rate of drug use in people with mental illness 4. Avoidable hospitalisations for physical illness in people with mental illness* 5. Mortality gap for people with mental illness*
Good mental health and wellbeing	6. Prevalence of mental illness 7. Proportion of adults with very high levels of psychological distress 8. Connectedness and meaning in life*

Domain	Indicator
Meaningful and contributing life	9. Rate of social/community participation amongst people with mental illness
	10. Proportion of people with mental illness in employment
	11. Proportion of carers of people with mental illness in employment*
	12. Proportion of mental health consumers in suitable housing*
Effective support, care and treatment	13. Proportion of consumers and carers with positive experiences of service*
	14. Change in mental health consumers' clinical outcomes
	15. Population access to mental health care
	16. Post-discharge community care
	17. Readmission to hospital
	18. Proportion of total mental health workforce accounted for by consumer and peer workers*
Less avoidable harm	19. Rates of suicide
	20. Suicide of persons in inpatient mental health units
	21. Rates of follow-up after suicide attempt/self-harm*
	22. Rates of seclusion in acute mental health units
	23. Rate of involuntary hospital treatment
Stigma and discrimination	24. Experience of discrimination amongst people with mental illness

* NOTE: Indicator potentially available subject to investment and data development.

These indicators focus on different levels of health status and health system performance. They range from measures of the health status of the population, such as community psychological distress, to measures of the process of mental health care, such as rates of follow-up after discharge from hospital. Whenever possible, these indicators will provide both a combined national view and a more detailed view for community groups or mental health services. Many of the proposed indicators will allow performance to be reported separately for different age groups, for men and women, and for Aboriginal and Torres Strait Islander peoples. They will also allow state and regional comparisons. However, not all of the indicators are relevant or available for all service sectors. Data and reporting are mostly available for state/territory public mental health services and through population surveys. Significant development is required to ensure comparable data is available and reported for community managed, Commonwealth funded and privately funded care.

Most of these indicators are relevant to more than one of the Fifth Plan's priority areas. Each of the eight priority areas therefore describes the range of relevant indicators and identifies issues requiring future information development.

The proposed indicator set aligns with the Fifth Plan's focus on health care and support services. Many other issues influence the mental health and wellbeing of people and communities. Any additional reporting developed to support the Fifth Plan will include measures of these broader issues where possible.

Developing a comprehensive suite of indicators requires long-term planning and investment. Better data is required to understand the mental health needs and subsequent outcomes for Australians from all walks of life, from all parts of Australia and across their life span. There should be transparency and accountability for the full range of care and support services funded or provided by Australian governments, from state and territory services and community managed organisations to private care and emerging areas, such as digital health and the NDIS. Previous National Mental Health Plans have supported significant investment in measurement and reporting and provided data on many of these issues, but gaps remain. Priorities may include:

- longitudinal outcomes data linked to service use
- data on service pathways
- use of outcomes and other data collected by the National Disability Insurance Agency (NDIA)
- measures of integration
- expanding use of the Australian Mental Health Care Classification.

Action v Governments will request the National Mental Health Commission delivers an annual report, for presentation to health ministers, on the implementation progress of the Fifth Plan and performance against identified indicators once the baselines have been established. These indicators will be disaggregated by Aboriginal and Torres Strait Islander status where possible.

Action vi Governments will evaluate the Fifth Plan, commencing in the final year of the Fifth Plan, to inform future directions in mental health policy. This evaluation will be principally informed by annual reporting on the Fifth Plan and targeted stakeholder consultation with governments, consumers and carers and the mental health sector.

Action vii Governments will develop a longer-term strategy for information and indicator development. This strategy will be published as a third edition of the National Mental Health Information Development Priorities. It will include the identification of information development priorities and the development of additional national reform and system performance measures in consultation with consumers, carers and other key stakeholders.

PRIORITY AREA 1: Achieving integrated regional planning and service delivery

Why is this a priority?

Integration is the pivotal theme underpinning the Fifth Plan. It is a priority area in its own right and is interlinked with all other priority areas of the plan. It represents the flagship of actions agreed by governments for ensuring that consumers and carers are at the centre of the way in which services are planned and delivered.

Integration is a goal of the National Mental Health Strategy and has been incorporated in all previous National Mental Health Plans, albeit each with a different focus and actions. While previous National Mental Health Plans have been strong in their intent to strengthen integration, they have been limited in their effectiveness on the ground. The exception is the First National Mental Health Plan, which targeted integration of state and territory funded clinical community and hospital services. This was largely achieved because it was in the control of a single level of government. The more complex integration objective, requiring cooperation between multiple levels of government and across portfolios, has remained elusive, and there remain calls to address the fundamental problems in the integration of services for people living with mental illness.

The National Mental Health Commission's 2014 National Review of Mental Health Programmes and Services concluded that mental health services are fragmented and delivered within a complex system that involves multiple providers and siloed funding streams, with the different parts of the service system often operating in isolation of each other and people having a poor experience of care and unmet need. It highlighted service gaps, inefficiencies, duplication and poor planning and coordination, compounded by a lack of clarity of roles and responsibilities by governments. It suggested that both levels of government too often make decisions about programs and services without proper engagement, planning and co-design, and fail to address the critical issue of system design. It called for a better integrated, person-centred service system and identified opportunities to better integrate services.[21]

Similar problems and calls for action are echoed in plans released by state and territory governments. The strategic plan released by the Mental Health Commission of New South Wales identifies a number of problems in the mental health service system and concludes that service integration is a key priority of future reform.[22] The strategic plan released by the Western Australian Mental Health Commission notes that it is essential for services to work together, across sectors, in an integrated way, to ensure that people do not fall through the gaps across the service continuum and that they receive the appropriate level of care and support to meet their needs.[23]

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

In the context of the Fifth Plan, integration is concerned with building relationships between organisations that are seeking similar aims to improve the outcomes and experiences of consumers and carers. Integration can be implemented at different levels, but integration at any level can deliver better experiences and outcomes for consumers and carers.
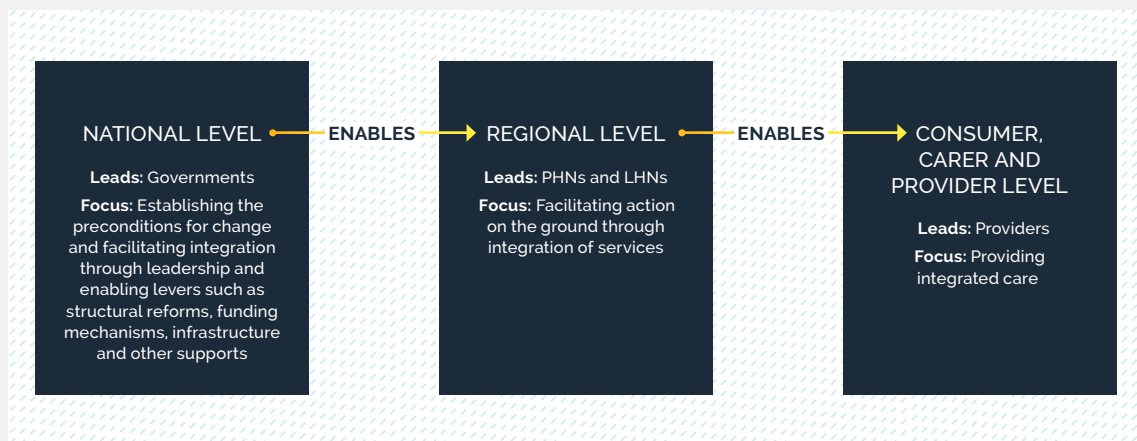
Many people living with mental illness interface with health care, social care, housing and other services. If the needs of consumers and carers are truly at the centre of the way in which services are planned and delivered, there needs to be greater integration between mental health services and other services and better recognition of the broader determinants of mental health and issues that affect people living with mental illness. This means connecting health and areas such as disability, housing, education and employment. It also means extending integration into prevention and early intervention.

Since the Fourth National Mental Health Plan, both levels of government have devolved identified service delivery responsibilities to regional entities. The establishment of these entities (PHNs and LHNs) has aligned Commonwealth and state and territory health planning and operational boundaries for the first time, providing an unprecedented opportunity to align efforts at a regional level. The Fifth Plan recognises that PHNs and LHNs provide the core architecture to support integration at the regional level. They will lead regional integration activities and work in partnership with regional stakeholders to build a consensus around what needs to change and when. Critical to success will be the involvement of consumers and carers and the building of relationships with community-managed organisations, Aboriginal and Torres Strait Islander health services, GPs and private sector providers.

The precondition for strengthening integration is for governments to provide leadership and create the conditions that will foster high-quality decision-making at the regional level. This will involve identifying opportunities and areas that need to be a focus for regional integration. It will also involve providing guidance, tools and other key information to support integration efforts.

This approach represents a fundamental re-conceptualisation of the role of a National Mental Health Plan as one that sets an enabling environment for regional action instead of dictating change from the top down. The Fifth Plan reflects the shared interest of governments in pursuing joint regional planning and initiatives, setting national directions and priorities, and establishing the framework for regions to undertake the work required (**Figure 7**).

Figure 7: National and regional roles in strengthening integration

NATIONAL LEVEL

Leads: Governments

Focus: Establishing the preconditions for change and facilitating integration through leadership and enabling levers such as structural reforms, funding mechanisms, infrastructure and other supports

ENABLES →

REGIONAL LEVEL

Leads: PHNs and LHNs

Focus: Facilitating action on the ground through integration of services

ENABLES →

CONSUMER, CARER AND PROVIDER LEVEL

Leads: Providers

Focus: Providing integrated care

Nationally developed tools will strengthen regional planning and decision-making. The National Mental Health Service Planning Framework (NMHSPF) was an action from the Fourth National Mental Health Plan and has been developed to guide evidence-based decision-making about the right mix and level of services and the workforce needed to meet local circumstances. The NMHSPF can soon be applied at a regional level to support planning and resource allocation in a nationally consistent manner. This will be important in undertaking regional needs assessment, identifying service gaps and targeting resources to best respond to local need.

To complement the NMHSPF, regions will be provided with a range of supports on stepped care approaches to service planning. These will be a guide on the range of service delivery options of varying intensity to match a person's level of need. Stepped care approaches define the various levels of need, based on best available epidemiological evidence, along with the services required at each level (see **Figure 8**). They also take into account linkages between clinical and non-health supports required by people living with mental illness. All of these factors need to be comprehensively considered in the development of regional mental health and suicide prevention plans and are best guided by a nationally consistent approach.

Figure 8: Mental health stepped care levels of need and services

WELL POPULATION

Mainly publically available information and self-help resources

AT RISK GROUPS (early symptoms, previous illness)

Mainly self-help resources, low intensity interventions including digital mental health

23.1%
of population

MILD MENTAL ILLNESS

Mix of self-help resources including digital mental health and low intensity face-to-face services

Psychological services for those who require them

9.0%
of population

MODERATE MENTAL ILLNESS

Mainly face-to-face clinical services through primary care, backed up by psychiatrists where required

Self-help resources, clinician-assitsted digital mental health services and other low intensity services for a minority

4.6%
of population

SEVERE MENTAL ILLNESS

Clinical care using a compination of GP care, psychiatrists, mental health nurses, and allied health.

Inpatient services
Pharmacotherapy
Psychosocial support services
Coordinated, multiagency services for those with severe and complex illness

3.1%
of population

* Adapted from Australian Government Response to Contributing Lives, Thriving Communities—Review of Mental Health Programmes and Services (November 2015).

* Estimates of prevalence derived from National Mental Health Service Planning Framework modelling (unpublished).

What will we do?

Action 1 Governments will support integrated planning and service delivery at the regional level by:

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

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

1.3. developing a plan for ongoing development, refinement and application of the NMHSPF

1.4. developing and releasing planning tools based on the NMHSPF and an evidence-based, stepped care model

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

Action 2 Governments will work with PHNs and LHNs to implement integrated planning and service delivery at the regional level. This will include:

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

2.2.   engaging with the local community, including consumers and carers, community-managed organisations, ACCHSs, NDIS providers, the NDIA, private providers and social service agencies

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

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

2.5.   developing joint regional mental health and suicide prevention plans and commissioning services according to those plans

2.6.   identifying and harnessing opportunities for digital mental health to improve integration

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

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

How will we know things are different?

What will be different for consumers and carers?

- You will be at the centre of care and will be included in shaping the way in which services are planned and delivered.
- Services will work with you in a coordinated way to understand and holistically meet your needs and achieve the outcomes that are important to you.
- Treatment, care and support will be personalised and provided by the right service, at the right place and at the right time.
- Your journey through services will be smoother.

System improvements

- The service system works in an integrated way at the regional level to plan and deliver services that are tailored to the needs of consumers and carers is easier for consumers and carers to navigate and is delivered in the most effective and efficient way possible.

Measuring change

The progress made by PHNs and LHNs in developing regional mental health and suicide prevention plans and partnerships will be regularly reviewed and reported on. This will include reporting on the inclusion of consumers and carers in service development and the implementation of evidence-based, stepped mental health care.

Systems will be developed to allow mental health indicators to be analysed and reported at a regional level. This will allow PHNs and LHNs to monitor local variation in health needs, care and outcomes, including differences in:

- health status and needs, such as the proportion of the local population with high levels of psychological distress (PI 7) and rates of suicide (PI 19)

- the quality of mental health care, including the proportion of consumers and carers reporting a positive experience of service (PI 13) and the effectiveness of services in changing clinical outcomes (PI 14) or increasing social participation (PI 9)

- the accessibility and integration of health care, including population access to care (PI 15) and rates of follow-up after hospital discharge (PI 16) or after suicide attempts (PI 21).

A priority is to develop better information on the integration of care between primary care and specialist care, and between Commonwealth and state/territory funded services. Currently, data is limited to measuring the integration of mental health care within health systems, such as follow up by state/territory government community mental health teams after discharge from a public hospital. Additional priorities for information development include indicators of service efficiency for all mental health service types and of consumer and carer involvement in service development across the whole spectrum of mental health services.
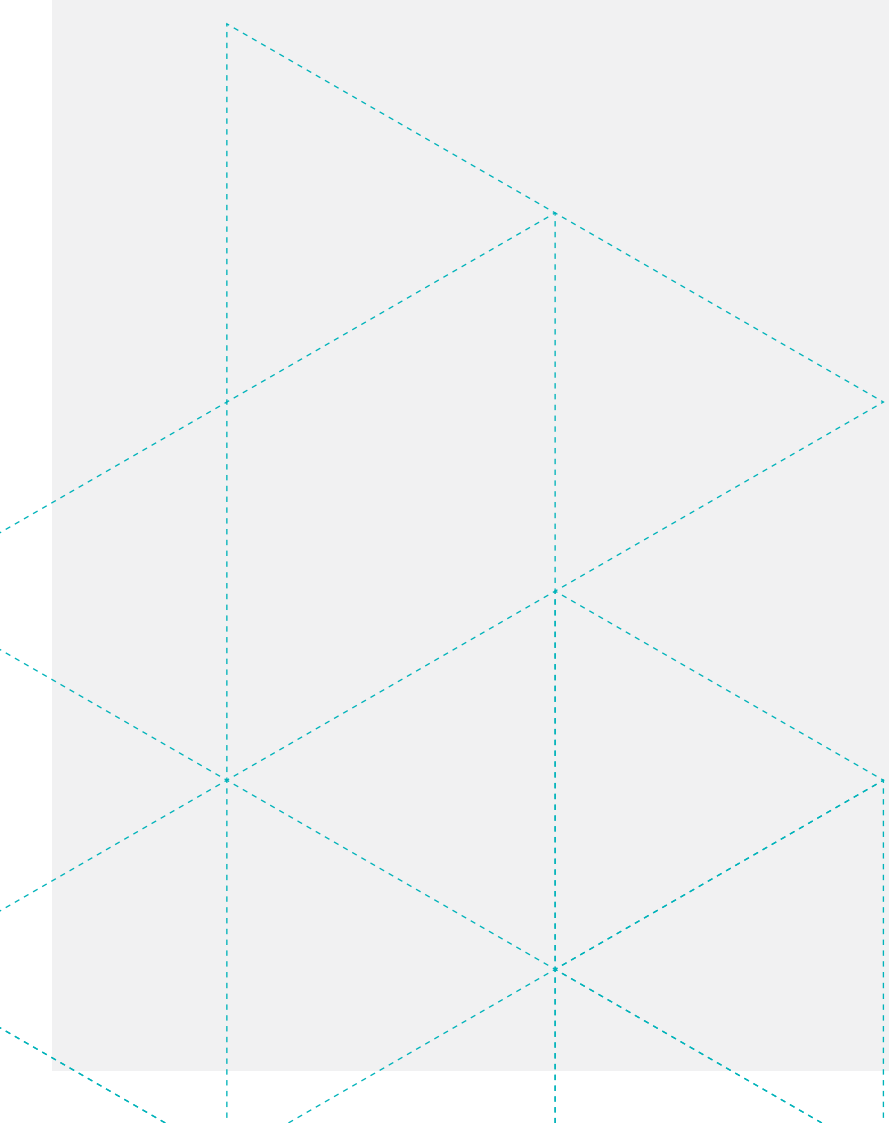
PRIORITY AREA 2: Suicide prevention

Why is this a priority?

Suicide is a significant health and social policy issue. 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. An effective suicide prevention response may require concerted action by law enforcement agencies, planning and infrastructure developers, transport providers, social support agencies, housing providers and health agencies. While governments have a pivotal role to play in addressing suicide, effective community engagement and action is central to improving outcomes.

Despite ongoing work to improve suicide prevention efforts in Australia, there has been no significant reduction in the suicide rate over the last decade.[24] In 2015, there were 3027 deaths by suicide, or an average of eight deaths by suicide each day.[25]

Approximately 75 per cent of people who die by suicide are male.[26] Suicide is the leading cause of death for people aged 15 to 44 years and the third leading cause of death for people aged 45 to 55 years. It accounts for one in three deaths among people aged 15 to 24 years and over one in four deaths among people aged 25 to 34 years.[27]

The number of people who are hospitalised due to self-harm is more than twenty times the number who lose their life to suicide, with females much more likely than males to plan or attempt suicide.[28] A previous suicide attempt is the most reliable predictor of a subsequent death by suicide.[29,30] In addition, people who have attempted suicide and those who are experiencing mental illness are at a higher risk of suicide immediately following discharge from mental health care or emergency departments.[31] This is of particular concern when treatment involves involuntary admission.

The personal impact of suicide is profound. It has a significant impact on families, communities and society. There is a clear need to reduce the number of people who die by suicide or attempt suicide each year and to reduce the human suffering associated with these actions. It has been estimated that the total economic cost of deaths by suicide in 2012 was $1.7 billion, noting that this amount excludes costs associated with attempted suicide.[32]

The causes of suicide and suicide attempts can be complex and multifaceted. While some mental illnesses can be linked to an increased risk of suicide, not everyone who dies by suicide will have a mental illness. Suicide attempts are often linked to feelings of helplessness or being overwhelmed by a situation. These stressful life events can include relationship difficulties, social isolation, loss of a job or income and financial or housing stress.

Some population groups have consistently higher rates of suicide attempts or deaths due to suicide. These groups may experience a combination of risk factors that make them particularly vulnerable, and consideration should be given to how they can be provided with extra support. This includes suicide among Aboriginal and Torres Strait Islander peoples. Among this population, suicide was almost unheard of prior to the 1960s[33], yet in 2014 it was the fifth leading cause of death among Aboriginal and Torres Strait Islander peoples, and the age-standardised completed suicide rate was around twice as high as the non-Indigenous rate.[34]

Suicide prevention efforts need to consider how services respond to people who have attempted suicide or are at risk of suicide. By providing intensive follow-up care during the days and weeks after a suicide attempt, or following discharge from inpatient psychiatric care, it is possible to reduce the risk of future suicide attempts. Health services should aim for zero suicides within health care settings.

The current approach to suicide prevention has been criticised as being fragmented, with unclear roles and responsibilities across governments.[35] This has led to duplication and gaps in services for consumers. Where there are competing or overlapping services, there is a lack of clarity about which services are most effective or efficient.

These issues have led to calls to develop a national approach to address suicide prevention that brings together agreed goals and strong national planning and collaboration. A national approach would draw on existing strategic guidance, including the Living Is For Everyone Framework, the Report of the Aboriginal and Torres Strait Islander Suicide Prevention Project, Suicide Prevention Australia's Strategic Framework for Suicide Prevention, the LifeSpan model, Mindframe's National Media Initiative and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, that was developed in 2013 by the Commonwealth Government.

What will we do?

Consistent with the WHO's *Preventing suicide: A global imperative*, the Fifth Plan commits all governments to a systems-based approach which focuses on the following 11 elements:

1. **Surveillance**—increase the quality and timeliness of data on suicide and suicide attempts.
2. **Means restriction**—reduce the availability, accessibility and attractiveness of the means to suicide.
3. **Media**—promote implementation of media guidelines to support responsible reporting of suicide in print, broadcasting and social media.
4. **Access to services**—promote increased access to comprehensive services for those vulnerable to suicidal behaviours and remove barriers to care.
5. **Training and education**—maintain comprehensive training programs for identified gatekeepers.
6. **Treatment**—improve the quality of clinical care and evidence-based clinical interventions, especially for individuals who present to hospital following a suicide attempt.
7. **Crisis intervention**—ensure that communities have the capacity to respond to crises with appropriate interventions.
8. **Postvention**—improve response to and caring for those affected by suicide and suicide attempts.
9. **Awareness**—establish public information campaigns to support the understanding that suicides are preventable.
10. **Stigma reduction**—promote the use of mental health services.
11. **Oversight and coordination**—utilise institutes or agencies to promote and coordinate research, training and service delivery in response to suicidal behaviours.

Many activities, plans and strategies that governments, peak bodies, commissioning agencies and service providers currently have under way align with the elements above. Therefore, the critical step that needs to be taken is to bring into alignment all of these individual actions into a consolidated national suicide prevention implementation strategy with a national, cross-jurisdictional body responsible for governance and oversight.

Action 3 Governments will establish a new Suicide Prevention Subcommittee of MHDAPC, as identified in the Governance section of this Fifth Plan, to set future directions for planning and investment.

Action 4 Governments will, through the Suicide Prevention Subcommittee of MHDAPC, develop a National Suicide Prevention Implementation Strategy that operationalises the 11 elements above, taking into account existing strategies, plans and activities, with a priority focus on:

- providing consistent and timely follow-up care for people who have attempted suicide or are at risk of suicide, including agreeing on clear roles and responsibilities for providers across the service system

- providing timely follow-up support to people affected by suicide

- improving cultural safety across all service settings

- improving relationships between providers, including emergency services

- improving data collections and combined evaluation efforts in order to build the evidence base on 'what works' in relation to preventing suicide and suicide attempts.

Action 5 Governments will support PHNs and LHNs to develop integrated, whole-of-community approaches to suicide prevention:

- This will include engaging with local communities to develop suicide prevention actions as part of a joint regional mental health and suicide prevention plan.

- These regional plans will be consistent with the 11 elements above and informed by the National Suicide Prevention Implementation Strategy as it is developed.

- At a regional level, PHNs and LHNs will work together to map providers across the service system, develop stronger referral pathways and build community knowledge of the range of available services and how to access them.

How will we know things are different?

What will be different for consumers and carers?

- If you are at risk of suicide, you will have timely access to support and be clear about which services in your area are responsible for providing you with care and support.

- Services will actively follow up with you if you are at a higher risk of suicide, including after a suicide attempt.

- There will be improved postvention support for carers, families and communities affected by suicide.

System improvements

- There is a reduction in the incidence of suicide and more effective follow-up support for people who have attempted suicide.

- There is a whole-system approach to suicide prevention, with government, business and the community working together towards the one outcome, beyond a traditional health perspective.

- There is an integrated and efficiently resourced suicide prevention system, with people trained to deliver quality services to prevent suicide.

- There is a whole-of-community support and engagement model, with the sharing and exploration of ideas within the suicide prevention community and the wider community in general.

- There is a person-centred and integrated approach to service delivery.

- There is high-quality services through standards and the regulatory framework.

- There is a robust knowledge-to-practice system to ensure research is applied.

Measuring change

Effective suicide prevention strategies aim to contribute to a reduced rate of suicide (PI 19) in the Australian community. The Fifth Plan also aims to see a further reduction in the rare occurrence of suicide deaths within inpatient mental health units (PI 20).

Several other indicators are important in planning and monitoring suicide prevention strategies. More effective care during high-risk periods will be reflected in increased rates of follow-up for people seen in emergency departments after a suicide attempt (PI 21) or people discharged from hospital after care for a mental health condition (PI 16).

Improved data on care and outcomes following suicide attempts is a priority for future information development. The commitments in the Fifth Plan will support the development of better identification of suicide attempts in routine health data collections and better measurement of integrated care and follow-up after suicide attempts. Priority will be given to using data linkage to report on rates of suicide in the high-risk period following discharge from hospital.

Providing effective care and support for mental health conditions, including depression, is one essential strategy for preventing suicide. Better measures of access to and effectiveness of treatment and support services are therefore needed, particularly for people at high risk. Enhanced measures are also required to accurately measure the rate of suicide amongst people receiving community mental health care and support.
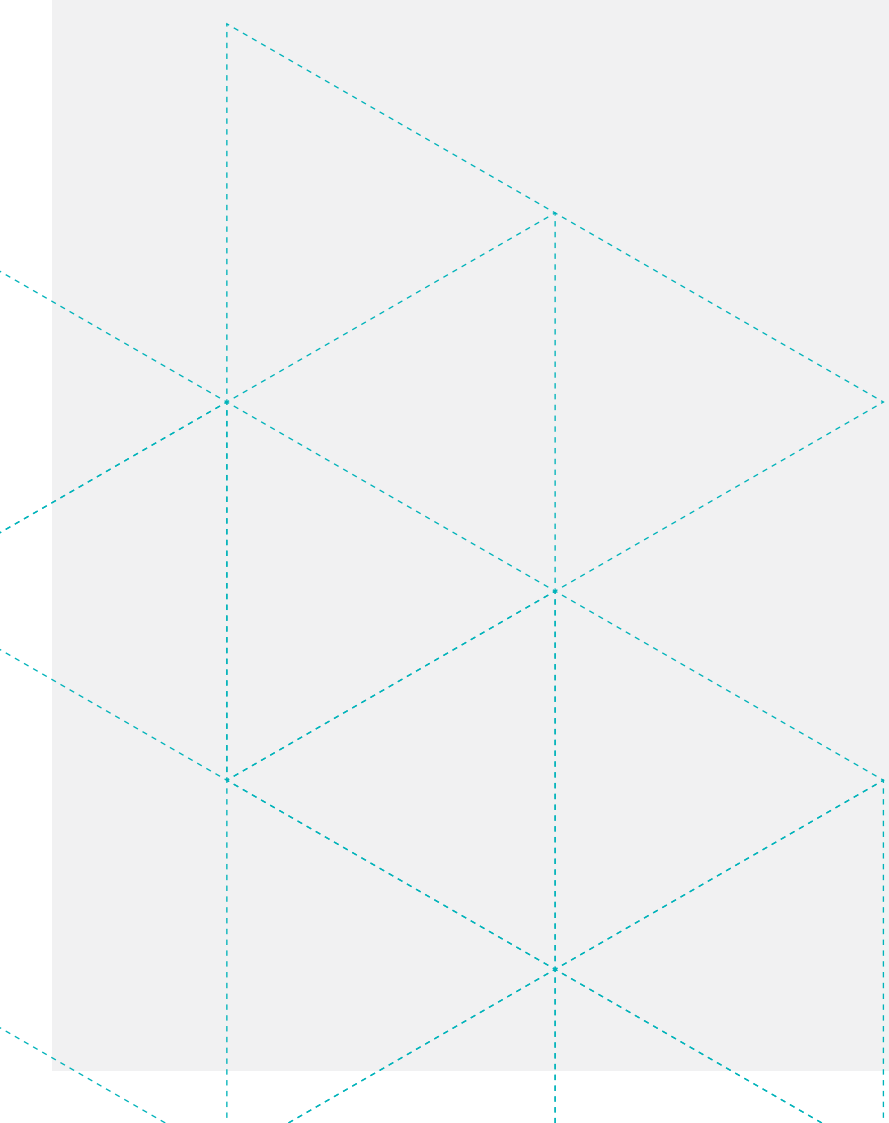
PRIORITY AREA 3: Coordinating treatment and supports for people with severe and complex mental illness

Why is this a priority?

Approximately 690 000 people (3 per cent of the population) have a severe mental illness.

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

The diversity and fractured coordination of government funding, policy frameworks and service systems can hinder the ability of services to adequately address need. This may leave consumers and carers to navigate a system that is often complex, uncoordinated and not tailored to their needs. This can result in vulnerable people being caught in cycles of prolonged illness and dependence, with serious repercussions for a person's relationships, education, housing and employment, and an over-reliance on support from families and carers to fund and resource recovery-based care. The cost to families, carers and the wider community, both in direct service provision and in lost productivity, can be very high.[36]

The general workforce does not always have the knowledge, experience or tools to effectively treat severe mental illness in an Aboriginal and/or Torres Strait Islander cultural context. Language barriers can hinder communication and accurate assessment, and gaps in cultural knowledge and understanding can lead to misdiagnosis or mental disorders remaining undiagnosed. A lack of cultural competency and the attitudes of staff can have a significant impact on the cultural safety of Aboriginal and Torres Strait Islander consumers and co-workers, resulting in lower rates of access to services and fractured care. Cultural competence should be considered a core clinical competence capability, as it can determine the effectiveness of a service for Aboriginal and Torres Strait Islander peoples.

Current and unfolding reforms provide significant opportunities to address the fragmentation and lack of coordination of services for people with severe and complex mental illness and ensure that care is based on their needs. Regional planning and decision-making will support the development of tailored and coordinated care for people with severe and complex mental illness. Implementation of the NDIS will give people with severe and ongoing psychosocial disability tailored and coordinated access to the services and supports they need. These reforms have also resulted in significant changes to policy and funding arrangements, and concerns have been raised about needing to monitor implementation and put safeguards in place to ensure that all people with severe and complex mental illness have access to the services and supports they need.

Governments recognise that the implementation of the NDIS requires the development of agreed approaches to defining the relationship between the NDIS and existing service systems, which is provided through the 2013 COAG agreed *NDIS Mainstream Interface Principles*[37] that provide the framework for making decisions on the respective roles and responsibilities of agencies for service delivery in the context of the NDIS. This includes specific interface principles with the mental health system.

However, a particular concern is about continuity of psychosocial supports for people with severe and complex mental illness who will not be eligible for the NDIS. Governments have committed to ensuring that people with disability who are currently receiving services are not disadvantaged in the transition to the NDIS. It will therefore be important for governments to monitor the impact of mental health reforms and implementation of the NDIS to identify and respond to issues that may emerge.

What will we do?

Action 6 Governments will negotiate agreements that prioritise coordinated treatment and supports for people with severe and complex mental illness. This will include planning for the community mental health support needs of people who do not qualify to receive supports under the NDIS, including fulfilment of agreed continuity of support provisions and ensuring any mainstream capacity is not lost for the broader population as a result of transition to the NDIS.

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.

Action 8 Governments will establish a time-limited Mental Health Expert Advisory Group, as identified in the Governance section of this Fifth Plan, that will:

• advise on the implementation of the Fifth Plan and analyse progress

• where requested by AHMAC, provide advice on broader mental health policy issues, which may include cross-portfolio consideration of issues that may arise from the implementation of mental health reforms and the NDIS for people with severe and complex mental illness and opportunities to harmonise data collection strategies.

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. These guidelines will:

• clarify roles and responsibilities across the health and community support service sectors

• be consistent with the COAG Mainstream Interface Principles (which determine the responsibilities of the NDIS and other service providers)

• specify criteria to guide the targeting of service delivery to consumers, including identifying pathways for culturally competent services

• promote the roles of multi-agency care plans, care pathways and information-sharing protocols

• identify opportunities for the use of digital mental health and electronic health records in coordinating care

• highlight the role of data in supporting these activities.

How will we know things are different?

What will be different for consumers and carers?

- If you have severe and complex mental illness, you will have access to the clinical and community services you require to live a more contributing life.

System improvements

- An integrated, culturally competent and sustainable service system provides the right amount of tailored clinical and community supports, at the right time, for people with severe and complex mental illness.

Measuring change

A well-integrated, effective and sustainable mental health service system for people with severe and complex illness will be reflected by:

- better-quality of care and support, including better consumer and carer experience of service (PI 13), reduced need for involuntary hospital admission (PI 23) and reduced use of restrictive practices such as seclusion (PI 22)

- better personal and clinical outcomes, including a greater sense of meaning and connectedness in life (PI 8), greater social and family connectedness (PI 9), greater involvement in study or employment (PI 10) and improvement in clinical outcomes (PI 14)

- better continuity of care, including improved follow-up after hospital admission (PI 16)

- more effective care for physical health problems reflected in reduced prevalence of long-term physical health conditions in people reporting long-term mental health conditions (PI 2) and a reduced mortality gap when compared with other Australians (PI 5)

- better support for carers, leading to increased carer participation in employment (PI 11).

There are priorities for information development in this area. Data is needed to monitor the support received by people with severe and complex mental illness as the NDIS is implemented. Systems are needed to measure continuity of care between primary care and specialist services, the quality of physical health care for people with severe and complex mental illness, and experiences of stigma or discrimination in general health settings. Better information is needed on the full range of clinical and community supports which underpin a connected and contributing life. New data collections established by PHNs and the NDIS may allow development of additional indicators on these issues, and priority will be given to ensuring that these collections align with existing state and territory data collections.

PRIORITY AREA 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention

Why is this a priority?

Aboriginal and Torres Strait Islander adults are almost three times more likely to experience high or very high levels of psychological distress than other Australians[38,39], are hospitalised for mental and behavioural disorders at almost twice the rate of non-Indigenous people[40], and have twice the rate of suicide than that of other Australians.[41] The breadth and depth of such high levels of distress on individuals, their families and their communities is profound.

It is estimated that mental illness and substance use disorders comprise 14 per cent of the overall health gap and 29 per cent of the health gap for 15–44-year-olds. The high rates of chronic disease in Aboriginal and Torres Strait Islander peoples mean that many people are likely to experience coexisting physical and emotional health problems. Governments have recognised that achieving the COAG Closing the Gap targets will require simultaneous action to address chronic disease and mental illness in Aboriginal and Torres Strait Islander peoples, families and communities.

Despite having greater need, Aboriginal and Torres Strait Islander peoples have lower than expected access to mental health services and professionals. In 2012–2013, the most common Closing the Gap service deficits reported by ACCHSs related to mental health and social and emotional wellbeing services.[42] The 2012 National Prisoner Health Census reports that incarcerated Aboriginal and Torres Strait Islander peoples were less likely than non-Indigenous people to report a history of mental health problems, to be taking mental health related medication and to be referred to prison mental health services for observation and further assessment.[43]

Barriers faced by Aboriginal and Torres Strait Islander peoples in accessing mental health care include the cost of health services, the cultural competence of the service, remoteness and availability of transport, and the attitudes of staff. Many Aboriginal and Torres Strait Islander peoples continue to experience high levels of exclusion, victimisation, discrimination and racism at personal, societal and institutional levels. 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.[44]

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

Aboriginal and Torres Strait Islander peoples embrace a holistic concept of health, which inextricably links mental and physical health within a broader concept of social and emotional wellbeing. A whole-of-life view, social and emotional wellbeing recognises the interconnectedness of physical wellbeing with spiritual and cultural factors, especially a fundamental connection to the land, community and traditions, as vital to maintaining a person's wellbeing.

The impact of intergenerational trauma and social and economic disadvantage at individual, family and community levels continues to challenge the mental and physical health and wellbeing of Aboriginal and Torres Strait Islander peoples, who can present to mental health services with a complex and interrelated mix of problems. In addition to symptoms of mental illness, these problems could include cultural disconnection and multiple stressors such as substandard housing, poverty, physical ill health, trauma, abuse and loss. To close the health gap, attention is required to address the determinants of social and emotional wellbeing problems at the community level and to ensure early identification and treatment of mental illness at the individual level.

The challenge for mental health clinicians in assessing, diagnosing and treating mental illness in this complex socio-cultural context is compounded by cultural interpretations of experiences and of verbal and non-verbal communication. For example, experiences which may be seen as indicators of mental health problems in non-Indigenous communities may not have these associations in Aboriginal and Torres Strait Islander communities and vice versa. Non-Indigenous clinicians need to be able to interpret presenting 'symptoms' within the cultural context in which they occur rather than viewing the presenting person solely through the lens of Western clinical practice. However, few non-Indigenous clinicians are trained to understand this, and these gaps in cultural knowledge can lead to misdiagnosis or to mental illness remaining undiagnosed. The skills, knowledge and behaviours of non-Indigenous mental health staff can be enhanced through training that encourages the embedding of cultural capability into clinical practice. In addition, many non-Indigenous clinicians would benefit from understanding how to incorporate culture into therapy, as culture can be both a protective factor that promotes and builds resilience and a therapeutic tool that can aid recovery.

Aboriginal and Torres Strait Islander leadership in mental health services is fundamental to building culturally capable models of care. Governance, planning processes, systems and clinical pathways will be more effective if they include Aboriginal and Torres Strait Islander workers at key points in the consumer journey, such as assessment, admission, case conferencing, discharge planning and development of mental health care plans.

Strong ACCHSs are an important component of a culturally responsive mental health service system. These organisations can play a vital role in:

- prevention and early intervention to address risk of developing mental health problems
- enabling access to primary and specialist mental health services and allied health
- facilitating the transition of consumers across the primary and specialist/acute interface
- connecting consumers with the range of community-based social support services
- working with mainstream community mental health and hospital services to enhance cultural capability through provision of cultural mentorship, advice and training placements for non-Indigenous staff
- working as part of multi-agency and multidisciplinary teams aimed at delivering shared care arrangements.

Building a culturally competent service system also requires a well-supported Aboriginal and Torres Strait Islander mental health workforce. Aboriginal and Torres Strait Islander mental health workers require opportunities and support to attain advanced qualifications and recruitment and retention processes that maximise opportunities for Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander organisations and workforces should be complemented by mainstream services and clinicians that are responsive to the needs of Aboriginal and Torres Strait Islander peoples.

Mental health staff in all service settings should also be trained in the delivery of recovery-oriented and trauma informed care. In 2013, AHMAC endorsed the *National framework for recovery-oriented mental health services guide for practitioners and providers*, which describes the values, knowledge, skills, behaviours, practice characteristics and leadership required to assess, treat and support the recovery of Aboriginal and Torres Strait Islander peoples living with mental illness. Likewise the need for a comprehensive and consistent approach to providing care in mental health services, based on trauma informed principles, is vital to ensure people have the greatest opportunity of recovery.

In 2016, COAG endorsed the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026, which has significant application in efforts to enhance the cultural capability of mental health services. Given the widespread transgenerational trauma that exists in Aboriginal and Torres Strait Islander communities, trauma-informed models of mental health services delivery and staff that are able to deal directly with trauma and its effects are an essential part of a culturally competent service model.

One of the most critical connections in Aboriginal and Torres Strait Islander mental health care is between the primary and acute care sectors. Many key stakeholders are involved at various points throughout the Aboriginal and Torres Strait Islander mental health pathway—these include family, community support networks/services, general practitioners, emergency department clinicians, ambulance officers, multidisciplinary care teams, mental health clinical and non-clinical staff, allied health staff and Aboriginal and Torres Strait Islander hospital liaison officers.

Any one or more of these staff can be involved in providing care to an Aboriginal and Torres Strait Islander person with mental illness, as Aboriginal and Torres Strait Islander peoples may connect with the health system at various points. The concept of coordinated carers can complement the notion of coordinated care, making up a care team from the consumer's perspective. Rather than considering the discharge of a consumer from acute care as the end of a hospital's responsibility, the mental health system would benefit from considering discharge from hospital as a handover to another care provider involved in that person's health care team.

Aboriginal and Torres Strait Islander peoples have regularly informed governments that much more could be done to improve both the way in which services are structured and the range of services available. There is a need to better coordinate efforts and focus on achieving improved integration of culturally appropriate mental health, social and emotional wellbeing, suicide prevention, and alcohol and other drug services. Efforts to encourage culturally appropriate care can have widespread effect, as evidenced by the recent apology to Aboriginal and Torres Strait Islander people by the Australian Psychological Society.

Substantial work is under way to identify appropriate responses to mental health problems for Aboriginal and Torres Strait Islander peoples, and this work provides a critical policy foundation for identifying actions to improve outcomes. Governments commit to the principles of this work in the Fifth Plan. The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) evaluated the effectiveness of existing suicide prevention services and programs with a final report, *Solutions that work: What the evidence and our people tell us*, presented to the Commonwealth Government in late 2016. This work informs approaches adopted in the Fifth Plan. The National Strategic Framework for Aboriginal and Torres Strait Islander People's Mental Health and Social and Emotional Wellbeing 2017–2023 is a guiding document in the implementation of the Fifth Plan, and its principles underpin this priority area.

In 2016, AHMAC held a national forum to advise on priority approaches to improving mental health care for Aboriginal and Torres Strait Islander peoples. The forum focused on expanding and strengthening the existing Aboriginal and Torres Strait Islander mental health workforce; strengthening the capacity of the primary health care sector to deliver social and emotional wellbeing programs and support specialist mental health services; strengthening the accessibility, effectiveness and cultural competence of mainstream mental health services; and integrating the pathways between primary and acute care. These are all priorities in the Fifth Plan.

What will we do?

Action 10 Governments will work with PHNs and LHNs to implement integrated planning and service delivery for Aboriginal and Torres Strait Islander peoples at the regional level. This will include:

- engaging Aboriginal and Torres Strait Islander communities in the co-design of all aspects of regional planning and service delivery
- collaborating with service providers regionally to improve referral pathways between GPs, ACCHSs, social and emotional wellbeing services, alcohol and other drug services and mental health services, including improving opportunities for screening of mental and physical wellbeing at all points; connect culturally informed suicide prevention and postvention services locally and identify programs and services that support survivors of the Stolen Generation
- developing mechanisms and agreements that enable shared patient information, with informed consent, as a key enabler of care coordination and service integration
- clarifying roles and responsibilities across the health and community support service sectors
- ensuring that there is strong presence of Aboriginal and Torres Strait Islander leadership on local mental health service and related area service governance structures.

Action 11 Governments will establish an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Subcommittee of MHDAPC, as identified in the Governance section of this Fifth Plan, that will set future directions for planning and investment and:

- provide advice to support the development of a nationally agreed approach to suicide prevention for Aboriginal and Torres Strait Islander peoples for inclusion in the National Suicide Prevention Implementation Strategy
- provide advice on models for co-located or flexible service arrangements that promote social and emotional wellbeing incorporating factors, including a person's connection to country, spirituality, ancestry, kinship and community
- identify innovative strategies, such as the use of care navigators and single care plans, to improve service integration, support continuity of care across health service settings and connect Aboriginal and Torres Strait Islander peoples with community-based social support (non-health) services
- provide advice on suitable governance for services and the most appropriate distribution of roles and responsibilities, recognising that the right of Aboriginal and Torres Strait Islander communities to self-determination lies at the heart of community control in the provision of health services
- oversee the development, dissemination and promotion in community, hospital and custodial settings of a resource that articulates a model of culturally competent Aboriginal and Torres Strait Islander mental health care across the health care continuum and brings together (a) the holistic concept of social and emotional wellbeing and (b) mainstream notions of stepped care, trauma-informed care and recovery-oriented practice
- provide advice on workforce development initiatives that can grow and support an Aboriginal and Torres Strait Islander mental health workforce, incorporate Aboriginal and Torres Strait Islander staff into multidisciplinary teams and improve access to cultural healers
- provide advice on models of service delivery that embed cultural capability into all aspects of clinical care and implement the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016–2026 in mental health services
- provide advice on culturally appropriate digital service delivery and strategies to assist Aboriginal and Torres Strait Islander peoples to register for My Health Record and to understand the benefits of shared data.

Action 12 Governments will improve Aboriginal and Torres Strait Islander access to, and experience with, mental health and wellbeing services in collaboration with ACCHSs and other service providers by:

12.1. developing and distributing a compendium of resources that includes (a) best-practice examples of effective Aboriginal and Torres Strait Islander mental health care, (b) culturally safe and appropriate education materials and resources to support self-management of mental illness and enhance mental health literacy and (c) culturally appropriate clinical tools and resources to facilitate effective assessment and to improve service experiences and outcomes

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

12.3. recognising and promoting the importance of Aboriginal and Torres Strait Islander leadership and supporting implementation of the Gayaa Dhuwi (Proud Spirit) Declaration (Appendix B)

12.4. training all staff delivering mental health services to Aboriginal and Torres Strait Islander peoples, particularly those in forensic settings, in trauma-informed care that incorporates historical, cultural and contemporary experiences of trauma.

Action 13 Governments will strengthen the evidence base needed to improve mental health services and outcomes for Aboriginal and Torres Strait Islander peoples through:

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, including the use of cultural healing and trauma-informed care

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

13.3. ensuring that future investments are properly evaluated to inform what works

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

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

How will we know things are different?

What will be different for Aboriginal and Torres Strait Islander consumers and carers?

- Both your clinical and social and emotional wellbeing needs, and the needs of your community, will be addressed when care is planned and delivered.

- Your care will be coordinated, and you will be supported to navigate the health system.

- You will receive culturally appropriate care.

- Services will actively follow up with you if you are at a higher risk of suicide, including after a suicide attempt.

- If you are at risk of suicide, you will have timely access to support and be clear about which services in your area are responsible for providing you with care and support.

System improvements

- Culturally competent care is provided through integrating social and emotional wellbeing services with a range of mental health, drug and alcohol and suicide prevention services.
- The incidence of suicide in Aboriginal and Torres Strait Islander peoples is reduced and there is effective follow-up support for people who have attempted suicide.

Measuring change

The commitments in the Fifth Plan aim to result in better mental health and wellbeing for Aboriginal and Torres Strait Islander peoples, including reduced rates of:

- psychological distress (PI 7)
- drug use in people with mental health conditions (PI 3)
- suicide (PI 19).

In addition, wherever possible, all mental health indicators will be analysed and reported to show rates for Aboriginal and Torres Strait Islander peoples and to identify gaps in access, quality or outcomes when compared with other Australians. This includes indicators of:

- access to mental health care (PI 15)
- quality and continuity of care as reflected in experience of care (PI 13), rates of involuntary hospital care (PI 23), change in consumer clinical outcomes (PI 14), post-hospital follow-up (PI 16) and readmission to hospital (PI 17)
- follow-up after suicide attempts (PI 21)
- rates of long-term physical health conditions (PI 2) and mortality gap (PI 5).

There are many priorities for information development in this area. Better information is needed on the prevalence of mental health conditions amongst Aboriginal and Torres Strait Islander peoples. Data collections also need to be updated to capture data on the Aboriginal and Torres Strait Islander workforce in mental health care and support services, whether in clinical, support or peer roles. Evaluation and publication of effective outcomes is also intended. The Fifth Plan's information development activities will include integration of data collected by ACCHSs. Reporting in this area will be supported by ongoing work to improve the accuracy of Aboriginal and Torres Strait Islander identification in all relevant data collections.

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

Why is this a priority?

People living with mental illness have poorer physical health than other Australians, as their physical health needs are often overshadowed by their mental health condition. Physical health treatment rates for people living with mental illness are reported to be around 50 per cent lower than for people with only a physical illness.[45] This leads to physical conditions being undiagnosed and untreated, which can prove fatal.

Studies indicate that people living with mental illness are more likely to die early[46,47] and their life expectancy can be shortened by up to 30 per cent.[48] Most of the causes of early death relate to physical illnesses such as cardiovascular disease, respiratory disease, diabetes and cancer. Compared with the general population, people living with mental illness are[49]:

- twice as likely to have cardiovascular disease
- twice as likely to have respiratory disease
- twice as likely to have diabetes
- twice as likely to have metabolic syndrome
- twice as likely to have osteoporosis
- 50 per cent more likely to have cancer
- 65 per cent more likely to smoke
- six times more likely to have a dental health issue.

The presence of serious physical conditions affects quality of life and impedes recovery from mental illness.[50]

Some population groups living with mental illness are at a greater risk of physical ill health. For example, cardiovascular disease is the leading cause of death for people with a severe mental illness, such as schizophrenia.[51] An Australian national survey of people living with a psychotic illness found that over 25 per cent had heart or circulatory conditions.[52] This is five times the rate in the general population. Additionally, the burden of disease for Aboriginal and Torres Strait Islander peoples is two and a half times greater than that of the general community[53], with mental illness and cardiovascular disease being the two leading causes.

Often these outcomes are system driven, with unnecessary barriers within health services and unclear delineation between professional roles hindering a consumer's ability to get the care they need.

This breakdown has significant flow-on costs for the health system and broader society. For example, in addition to the personal cost of physical illness for people living with severe mental illness, the total cost to the Australian economy has been estimated at $15 billion per annum.[54] This includes the cost of health care, lost productivity and other social costs. For each person living with a long-term physical health condition and a mental illness, the interaction between conditions raises the health care costs.[55] Statistics show that 13.3 per cent of people living with mental illness have an additional two or more medical illnesses.[56] Multiple illnesses increase the cost of health care significantly, yet much of this cost is avoidable. Improved systems, screening and care pathways could have a substantial impact on these costs.

There is also evidence that people diagnosed with a substantial physical illness are at greater risk of mental illness as a result.[57] This suggests that the interface between physical and mental illness, and the factors that drive them, are not always clear.

Effective mental health care, in conjunction with quality physical health care provided early, improves life expectancy and quality of life for consumers and reduces the pressure on the health system. The National Mental Health Commission has recently developed a National Consensus Statement for improving the physical health and wellbeing of people living with mental illness in Australia. The elements underpinning the statement are:

- a holistic, person-centred approach to physical and mental health and wellbeing

- effective promotion, prevention and early intervention

- equity of access to all services

- improved quality of health care

- care coordination and regional integration across health, mental health and other services and sectors which enable a contributing life

- the monitoring of progress towards improved physical health and wellbeing.

These elements provide strong guidance in how governments can work together to better address the physical health of people living with mental illness, while also considering the mental health needs of people experiencing chronic or debilitating physical 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, will be critical to improving the long-term physical and mental health outcomes for people living with mental illness and people with a chronic or debilitating illness who may be at a higher risk of a mental illness. This will lead to improved health outcomes, including better management of coexisting mental and physical health conditions, reduced risk factors and improved life expectancy.

What will we do?

Action 14 Governments commit to the principles of Equally Well—The National Consensus Statement for improving the physical health and wellbeing of people living with mental illness in Australia.

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. Implementation of the guidelines and resources will be monitored and reported. These guidelines and resources will:

- provide advice on how to ensure physical health checks are part of the routine care of individuals with mental illness

- provide advice on screening, detection, treatment and early medical intervention for people known to be at high risk of physical ill health

- define the roles of GPs, other primary care providers and specialist health providers in supporting integrated physical and mental health care.

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:

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

16.2. including it as part of joint clinical governance activity

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

Action 17 Governments will commence regular national reporting on the physical health of people living with mental illness. This will include:

• building on existing datasets and reporting mechanisms

• identifying and addressing data gaps

• seeking opportunities to share data across traditional boundaries.

How will we know things are different?

What will be different for consumers and carers?

• You will have appropriate access to, and quality of, physical health care.

• Your physical health care needs will be discussed and addressed.

• Better coordination of services at the local level will support you to address physical health care needs and improve your quality of life.

• Services at the regional level will be integrated, person-centred and easier for you to navigate.

System improvements

• The physical health care of people living with mental illness is identified as a national service delivery priority, and the life expectancy gap is reduced.

• Management of illicit drug use in those with a mental illness is improved.

• Better screening and early detection will help to identify the people in need so that health professionals can intervene and provide appropriate care, including better medication management and advice on reducing smoking and other risk factors.

Measuring change

The commitments in the Fifth Plan aim to result in better physical health for Australians with mental illness, including reducing:

• the rate of long-term health conditions in people with mental illness (PI 2)

• the rate of substance use in people with mental illness (PI 3)

• avoidable hospitalisations for physical illness in people with mental illness (PI 4)

• the mortality gap for people with a mental illness (PI 5).

A priority of future information development will be to improve data on physical health issues for Australians with mental illness. Risk factors such as smoking, diet or medicines may take many years to cause health problems, so reducing risk factors and mortality require long-term efforts. Interim measures of change in risk factors or health care processes will be needed to measure progress along the way. Smoking rates in people with self-reported long-term mental health conditions can provide an indicator of change in one important risk behaviour. The rapidly developing capacity of electronic medical records and data linkage will make it possible to develop additional measures of physical health care and outcomes in people living with mental illness. These may include measures of access to GP and specialist care, the quality of care received and the rate of avoidable hospital admission for physical health problems.

PRIORITY AREA 6: Reducing stigma and discrimination

Why is this a priority?

Stigma is a complex social process that excludes, rejects, shames or devalues someone on the basis of a particular characteristic.[58] It can be conceptualised as including problems of knowledge (ignorance or misunderstanding), problems of attitudes (prejudice) and problems of behaviour (discrimination).[59] Stigma exists on levels that are interconnected and mutually reinforcing. It includes self-stigma (the stigmatising views that people living with mental illness hold about themselves), social stigma (individual and collective stigmatising attitudes and beliefs about mental illness) and structural stigma (the policies and practices of social institutions that restrict opportunities for people living with mental illness).[60]

Stigma against people living with mental illness is prevalent in Australia, with almost three out of four people with mental illness experiencing stigma.[61] People living with mental illness may be perceived or represented as violent, unpredictable, prone to criminality, incompetent, undeserving or weak in character. Discriminatory behaviours may include avoidance, withholding opportunities or withholding support.[62,63] Stigmatising views about mental illness may be more entrenched in rural and remote regions and culturally and linguistically diverse populations.[64,65]

The impact of stigma and discrimination against people living with mental illness is far-reaching and is compounded for groups who are already marginalised and who experience other forms of discrimination[66,67,68,69], such as Aboriginal and Torres Strait Islander peoples and people who identify as LGBTI.

Stigma and discrimination may lead to feelings of shame, helplessness, fear, worthlessness and self-doubt. They may discourage people from disclosing their mental health problem or mental illness, decrease the likelihood of seeking support and create additional distress. They may result in exclusion and isolation, adversely affect personal relationships and affect opportunities for social interaction and community involvement. They may also create significant barriers to participating in employment and adversely affect promotional opportunities and housing outcomes. Importantly, they can hamper the promotion of mental health and wellbeing, exacerbate mental ill health and impede recovery. The impact of stigma and discrimination extends to broader communities and society due to lost productivity[70] and increased costs to the health system.[71]

Reducing stigma and discrimination is critical to improving the wellbeing of people living with mental illness and their carers and families and promoting better mental health within society. While there have been some improvements in knowledge about mental illness, there is still widespread misunderstanding, and people living with mental health illness still experience significant stigma.[72] It will take a sustained and collective effort to dispel the myths associated with mental illness, change ingrained negative attitudes and behaviours and, ultimately, support social inclusion and recovery.

People with a lived experience of mental illness are a central part of effectively tackling stigma and discrimination. Providing effective role models and using peer-based interventions can be helpful in improving a person's capacity to respond to stigma and discrimination. Peer workers must be empowered to take on these roles through access to meaningful contact with consumers and opportunities for grassroots advocacy. Certificate IV training provides an opportunity to build peer worker skills for this purpose.

People living with mental illness may experience stigma and discrimination by the health workforce, as well as by the broader community. This may include being advised by a health professional to lower their expectations for accomplishments in life, being shunned or avoided by a health professional, a health professional behaving differently after discovering that a person has a mental illness or a health professional not being comfortable talking to a person with mental illness.[73] A particular issue is diagnostic overshadowing, where a health professional misattributes physical symptoms to a person's mental illness and subsequently provides inadequate diagnosis or treatment.[74]

Stigma and discrimination by the health workforce can have a significant impact on the wellbeing of people living with mental illness and people who experience suicidal behaviour and their recovery, resulting in poorer outcomes. It may decrease the likelihood of seeking help, exacerbate psychological distress and decrease the likelihood of adhering to treatment.[75,76] It may also impede early intervention efforts, exacerbate the progression of mental illness and have a cascading impact on broader health and social outcomes.

The majority of action taken to reduce stigma and discrimination against people living with mental illness has focused on people with mild to moderate mental illness, such as depression and anxiety. While there has been some improvement in community understanding of mental illness, there is still widespread misunderstanding and ignorance. Severe mental illness, such as schizophrenia and bipolar disorder, tends to be poorly understood, and attitudes towards people with severe mental illness are less positive.

A number of interventions can help to reduce stigma and improve supportive behaviours. The Mental Health First Aid training has been shown to decrease negative attitudes and increase supportive behaviours towards people living with mental illness.[77] Positive role modelling and multiple forms of social contact from people in recovery can also be effective in reducing stigma.[78] Peer workers are well placed to assist in progressing these interventions.

What will we do?

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 will:

- involve consumers and carers, community groups and other key organisations
- build on existing initiatives, including the evidence base of what works in relation to reducing stigma and discrimination
- account for the specific experience of groups already at high risk of stigma, including Aboriginal and Torres Strait Islander peoples and people who identify as LGBTI.

Action 19 Governments will reduce stigma and discrimination in the health workforce by:

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

19.2. responding proactively and providing leadership when stigma or discrimination is seen

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

Action 20 Governments will ensure that the Peer Workforce Development Guidelines to be developed in Priority Area 8:

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

How will we know things are different?

What will be different for consumers and carers?

- You will be more supported in your recovery.
- There will be a better understanding of mental illness and improved attitudes towards people living with mental illness.
- There will be more widespread understanding and adherence to the principles of your rights.

System improvements

- There is less experience of stigma and discrimination when attending services and greater responsiveness to consumer and carer rights.

Measuring change

Reduced mental health stigma will be associated with a reduction in the proportion of people with mental health conditions who report experiences of discrimination (PI 24).

Several additional measures can provide indirect evidence of reduced stigma and discrimination against people with mental illness. Reducing stigma and discrimination is an important factor contributing to increases in the proportion of people with mental illness reporting connectedness and meaning in life (PI 8) and the proportion of people with mental illness participating in employment or study (PI 13).

Reducing stigmatising attitudes in the health workforce will also contribute to an increased proportion of consumers reporting positive experiences of care (PI 12).

A priority for further information development is the development of measures of stigma and discrimination that cover the broadest range of individuals, from the general population to people in contact with specialist mental health services. Key national population surveys have the potential to provide further measures of discrimination when accessing health professionals or amongst people with disability. Work is also required to develop data sources to better understand the impact of stigma and discrimination as barriers for consumers and carers in seeking care and support and to develop measures of awareness of consumer rights. This includes information on the extent and impact of stigma in vulnerable communities, including Aboriginal and Torres Strait Islander peoples, people who identify as LGBTI and people from culturally and linguistically diverse or rural and remote communities.

PRIORITY AREA 7: Making safety and quality central to mental health service delivery

Why is this a priority?

Safety and quality are cornerstones of Australia's health system. 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.[79] The National Safety and Quality Framework defines three core principles for safe and high-quality care: that care is consumer centred, driven by information and organised for safety.[80] When combined, the concepts of safety and quality promote a focus on the things that are right, as well as looking at what goes wrong, in health care.

Safety and quality have been integral to mental health reform over the past three decades and the subject of significant collaboration between governments. Work undertaken early in the National Mental Health Strategy focused on concerns about consumer rights. Later work progressed to a broader focus on quality, including the development of standards for services and practitioners and targeted action to improve the safety of mental health care in nationally agreed priority areas, including the reduction of seclusion and other restrictive practices that are of utmost concern to consumers and carers.

Any work to improve the safety and quality of health care is dependent on the right information being available. A Mental Health Information Strategy was developed under the First National Mental Health Plan. The strategy was designed to gather basic data on what services were delivered to whom and progressively expanded to provide information about the outcomes of services received by consumers. This put Australia at the forefront of international developments.

Later work established systems to support health services to use information to review and compare their performance, learn and improve. A national performance framework was developed specifically for public sector mental health services and formed the basis of regular public reporting against key performance indicators. National information development recently moved to incorporate measures of the experiences of consumers and carers, who are in the best position to report on the quality and outcomes of the services that they receive.

Many of the early developments in safety and quality that commenced under the National Mental Health Strategy predated comparable initiatives in the broader health system. However, the past decade has seen significant change in the priority given to advancing safety and quality in the broader health system, with national structures established specifically for this purpose. These developments have introduced a level of complexity for the mental health sector in relation to progressing mental health specific initiatives, given there are many competing priorities in the broader health environment.

A significant development was the establishment of the Australian Commission on Safety and Quality in Health Care (ACSQHC) by all governments in 2006. The ACSQHC's role is to lead and coordinate national improvements in safety and quality in health care, with all governments jointly funding and endorsing the ACSQHC's work program annually.

Australia currently has two sets of national standards that apply to mental health service provision, each developed independently to provide health services with a framework for the implementation of systems to deliver safe care and continuously improve the quality of the services that they provide:

- The National Standards for Mental Health Services (NSMHS) were first released in 1996 and updated in 2010. They were designed to be implemented across the full range of mental health services, including those in the public, private and community-managed sectors. While endorsed by health ministers, accreditation against the NSMHS is not mandatory for mental health services nationally. However, some jurisdictions require this of their publicly funded services.

- The National Safety and Quality Health Service (NSQHS) Standards (first edition) were developed by the ACSQHC with the Commonwealth, states and territories. The standards aim to protect the public from harm and improve the quality of health service provision. They were released in 2011 and endorsed by health ministers for mandatory implementation in all public and private hospitals, including mental health services managed by those hospitals. However, they do not apply to mental health services in the community-managed sector or the private office based sector, and a method of integrating the standards across sectors is required.

The ACSQHC has set the authoritative national framework for improving the safety and quality of health care and has commenced work to specifically address safety and quality issues in mental health care. This has included updating the NSQHS Standards to include a greater focus on key safety issues in mental health, work on recognising and responding to deterioration in a person's mental state and examining variation in interventions for mental health as part of the Australian Atlas of Healthcare Variation. The revised NSQHS Standards (second edition), to be released in November 2017, focus on implementation in hospital services in the public and private sectors, community services provided by LHNs and prison health services.

Each state and territory also has different mental health legislation, and greater consistency is needed to ensure seamless and safe care for consumers, particularly for consumers who move between states and territories.

Future work by the mental health sector to advance safety and quality must align with the work of the ACSQHC, while acknowledging that additional work is needed to continue building a recovery-oriented culture across all health services involved in the delivery of mental health care.

What will we do?

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:

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

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

21.3. a guide for consumers and carers that outlines how they can participate in all aspects of what is undertaken within a mental health service so that their role in ongoing safety and quality initiatives is strengthened

21.4. a process for revising the NSMHS that accounts for interfaces with other relevant standards, such as the National Disability Standards

21.5. coverage of all relevant service delivery sectors.

Action 22 Governments will develop a mental health supplement to the NSQHS Standards (second edition) which will align the NSQHS Standards and the NSMHS:

- The NSQHS Standards (second edition) and its mental health supplement will guide implementation of the standards for all mental health services in public and private hospitals and community services provided by local health networks to ensure a single set of standards for these services.

- The NSMHS will be maintained as the authoritative reference point on quality mental health care for continuing use by those organisations not subject to the NSQHS Standards.

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. Efforts should be made to ensure groups that are historically poorly represented in these surveys, such as Aboriginal and Torres Strait Islander peoples, are properly represented and that survey tools are appropriately adapted to allow for this.

Action 24 Governments will develop an updated statement on National Mental Health Information Priorities for information developments over the next ten years.

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.

Action 26 Governments will improve consistency across jurisdictions in mental health legislation. This will be based on an understanding of their impacts on consumer and carers and consistent with the 1 July 2016 United Nations Human Rights Council Resolution on Mental Health and Human Rights and the 2006 CRPD.

Action 27 Governments will make accessible the WHO QualityRights guidance and training tools to build awareness amongst consumers and carers, community managed organisations and other health services of consumer rights under the CRPD.

How will we know things are different?

What will be different for consumers and carers?

- The treatment, care and support you receive will be safe and of a high quality.

- Information about the safety and quality of services will be available so that you are able to make informed decisions about treatment, care and support.

System improvements

- A safe and high-quality service system is tailored to the needs of consumers and carers, is underpinned by continuous monitoring and improvement and reports on outcomes in a transparent manner.

Measuring change

Reporting will be established to monitor progress in implementing the safety and quality commitments of the Fifth Plan, including the revision of National Safety Priorities, the updating of Key Performance Indicators for Mental Health Services, and the alignment of the NSQHS Standards (second edition) and NSMHS.

Australia's Key Performance Indicators for Mental Health Services currently includes indicators of quality and safety that are reported at the national, state and local level. The Fifth Plan commits to greater transparency in reporting of these indicators through enhanced public reporting. The safety and quality indicators highlighted in this Fifth Plan include measures of:

- effectiveness of care as measured by the proportion of consumers and carers with positive experiences of service (PI 13), change in consumer clinical outcomes (PI 14) and hospital readmission (PI 16)

- continuity of care as measured by follow-up after hospital admission (PI 16) or following a suicide attempt (PI 21)

- rates of restrictive practices, including seclusion in acute mental health units (PI 22)

- care for physical health problems as reflected in mortality rates for people with long-term mental health conditions (PI 5).

Currently, these indicators are primarily reported by state and territory specialised mental health services. A priority for future information development is to ensure that relevant quality and safety measures are developed and reported in all service settings, including community-managed and Commonwealth-funded services such as PHNs. This could include measures which address the linkage and integration between services and allow comparison of care across all service settings. Work to align the NSQHS Standards (second edition) and NSMHS will highlight additional areas requiring measurement, including measures of service adherence to relevant standards. Further refinement of existing measures, such as hospital readmission, should occur to identify differences in performance for different groups of mental health consumers. Options for measuring hospital-acquired complications during mental health hospital care should be explored.

PRIORITY AREA 8: Ensuring that the enablers of effective system performance and system improvement are in place

Why is this a priority?

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

The National Mental Health Commission's 2014 National Review of Mental Health Programmes and Services identified substantial problems with the mental health research framework in Australia. These problems included a major disconnection between the research sector and the mental health services and supports sector, no clear pathway for the translation of research into practice, and no national mechanism for prioritisation and oversight of mental health research to ensure it is aligned with policy priorities and the challenges faced by frontline practitioners.

A strategic approach to research is necessary to ensure better treatment options are available in the future and the best outcomes are achieved from care. Involving consumers and carers in the prioritisation of research objectives, targeting research funding to high priority areas and improving data collection tools are potential improvements that could translate to better services.

The mental health workforce is in need of growth and development. There is a looming shortage of mental health nurses and limited capacity for effective care of low-prevalence mental disorders in the primary care sector. Peer workers, or workers with a lived experience of mental health, play an important role in building recovery-oriented approaches to care, providing meaningful support to people and modelling positive outcomes from service experiences. However, the peer workforce is sporadically utilised and poorly supported.

It is critical that the existing Aboriginal and Torres Strait Islander workforce within mental health services is expanded and strengthened and that Aboriginal and Torres Strait Islander peoples are employed at all levels of the mental health system.

Transitions to digital mental health platforms are not occurring in a structured way. Telephone helplines proliferate and new internet models are funded by different commissioning agencies without visibility of what is being funded elsewhere. There is an urgent need for an integrated approach to this activity that prevents duplication and unnecessary spending on product development. The workforce needs to be supported to adapt to digital mental health platforms, and the community needs to be aware of their availability. Sharing clinical records amongst treating practitioners is best practice, and the technical tools to facilitate this need to be available and effective.

Digital mental health services are an emerging area of the service delivery system where developments have been fast-paced and not guided by an overarching framework. There is an opportunity to achieve a more cohesive and user-friendly approach to digital mental health services that can be supported as a legitimate component of a stepped care model. This could include reducing inconsistency in data systems and overcoming issues with the interoperability of systems.

What will we do?

Action 28 Governments will request the National Mental Health Commission to work in collaboration with the National Health and Medical Research Council, consumers and carers, states and territories, research funding bodies and prominent researchers to develop a research strategy to drive better treatment outcomes across the mental health sector.

Action 29 Governments will develop Peer Workforce Development Guidelines, consistent with the recommendation made by the National Mental Health Commission's 2014 National Review of Mental Health Programmes and Services and the commitment made at Action 20.

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.

Action 31 Governments will use the outputs from the NMHSPF, and other relevant data, to develop a Workforce Development Program that will guide strategies to address future workforce supply requirements and drive recruitment and retention of skilled staff.

Action 32 Governments will develop a National Digital Mental Health Framework in collaboration with the National Digital Health Agency that will include:

- an analysis of available research on new technology-driven platforms that are already operational
- an analysis of interoperability considerations relevant to future data developments
- cohesive guidance on the structure of digital mental health services
- recommendations on the development of new digital service delivery platforms
- actions for addressing access to new digital service delivery platforms for people from culturally and linguistically diverse communities and others who have limited engagement with these platforms
- guidance on clinical governance for digital mental health services where appropriate safety and quality mechanisms are built into service delivery and links into traditional face-to-face services are provided
- workforce development priorities to improve use and uptake of digital mental health services.

How will we know things are different?

What will be different for consumers and carers?

- Your services will continue to improve over time, responding to changing needs and the actual outcomes of service delivery.
- More effective and more accessible services will become available.
- There will be improved opportunities to translate your experiences into helping others to work through their own experience of recovery.

System improvements

- A responsive service system has a continual improvement culture. The workforce is attuned to the needs of consumers and carers and available to meet the demand for services.

Measuring change

Increasing the national mental health peer workforce will be demonstrated by an increased proportion of total mental health workforce accounted for by the mental health peer workforce (PI 18). An effective mental health peer workforce should also be associated with a more positive overall experience of service (PI 12). A priority for future information development will be to review and update current mental health workforce data collections to ensure that these accurately capture the range of current participation arrangements and diversity of consumer and carer roles in the mental health peer workforce. This could include data on Aboriginal and Torres Strait Islander representation in the clinical, support and peer workforce.

Developing indicators of the accessibility, quality and safety of telephone and digital mental health services will be an important priority for future information development. Systems are needed to measure implementation of digital health programs, including rates of access to specific government-funded programs. Indicators should also be developed to quantify the uptake and impact of electronic health records in individual clinical care, including their role in enabling service improvement.
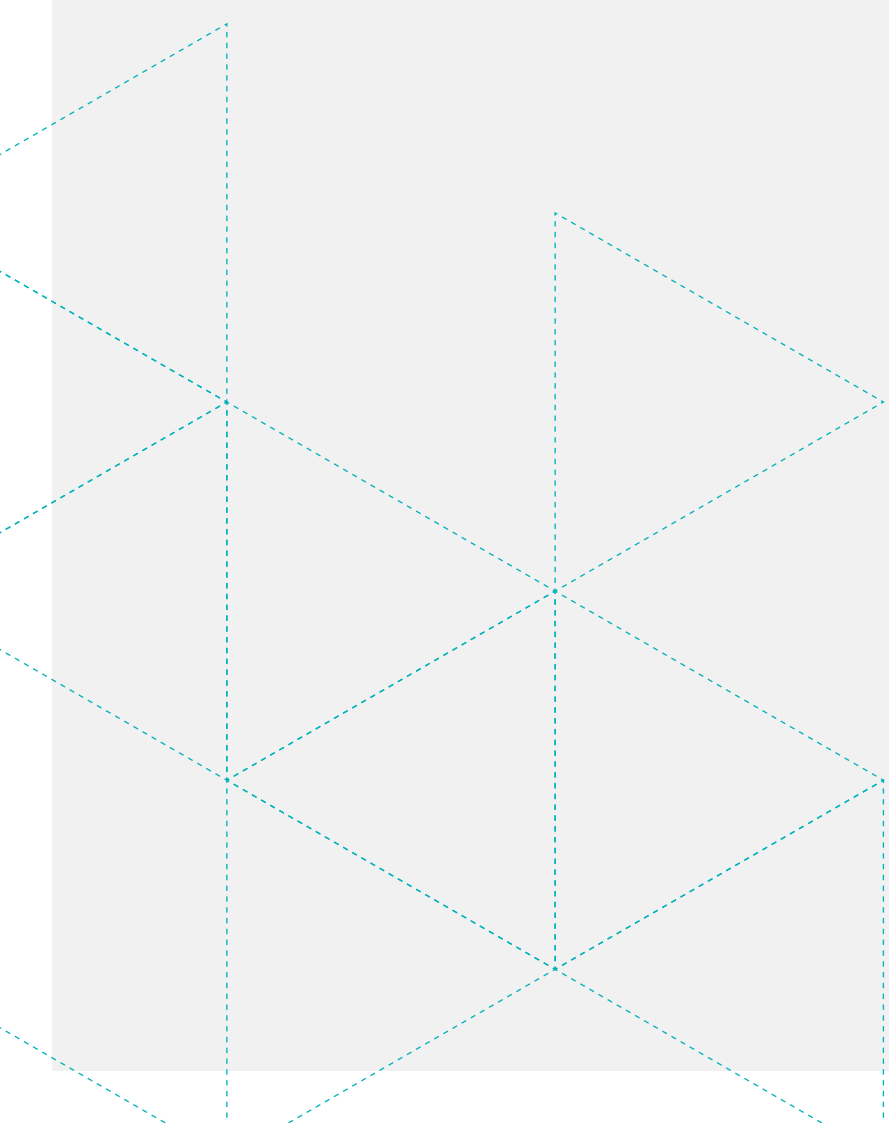
Implementation

Who will take responsibility?

Responsibility for implementation of the Fifth Plan will lie with AHMAC and its relevant Principal Committees and will be built on agreements between governments. The COAG Health Council will monitor implementation of the Fifth Plan and have ultimate accountability for its performance. Implementation needs to occur at the national level, within individual governments and at the local level, with the continued inclusion and involvement from consumers, carers and service providers. Each Commonwealth, state and territory government will drive activity within its own area of responsibility and will agree to coordinated action where responsibilities overlap.

All governments have identified relevant actions, under way or planned, that will contribute to achieving Fifth Plan outcomes. Identifying these actions assists in isolating necessary national activity and prioritising on the basis of intergovernmental agreements. These actions also contribute to improving global system measures of the national mental health program.

Governments are committed to equitable, practical, authentic co-design with consumers and carers in the implementation of Fifth Plan actions. Collaborative partnerships with consumers and carers are integral to successfully implementing changes that improve outcomes for people with, or at risk of, mental illness and/or suicide. Examples of supporting on-going and active involvement of consumers and carers include collaboration on design and planning, implementation, monitoring and evaluation of policies and actions, as well as capacity building among organisations that support consumer and carer participation and recognition of the contribution of consumers and carers to the Fifth Plan implementation supported by paid participation. A strength of the National Mental Health Strategy has been the routine development of plans within the states and territories over the last two decades that seek to drive improvements in mental health service delivery and mental health outcomes. The National Mental Health Strategy, and its constituent parts, recognises the separation of roles and responsibilities across governments. It recognises the importance of states and territories taking action within their own domains, in addition to agreed national actions, to implement the intentions of the National Mental Health Policy. Relevant state and territory plans are identified on the following page.

The final component of the implementation approach is an implementation plan that responds to the priority areas and commitments of the Fifth Plan. Governments commit to ensuring a key role for consumers and carers in all aspects of implementation of the Fifth Plan to ensure future mental health services are person-centred and meet the needs of people with mental illness and the community.

This implementation plan will be publicly released as an accompanying document to the Fifth Plan and will allow AHMAC and its Principal Committees to plan activity and ensure coordination of implementation efforts. The National Mental Health Commission will have a key role in monitoring and reporting on implementation of the Fifth Plan and governments have committed to requesting an annual report from the Commission on implementation progress and performance against identified indicators. The implementation plan for the Fifth Plan may be updated based on annual reporting from the Commission to ensure it remains a pertinent resource.

Existing activity and plans

Commonwealth plans and commitments

Australian Government response to the National Mental Health Commission report *Contributing lives, thriving communities: National review of mental health programmes and services* 2014

http://www.health.gov.au/internet/main/publishing.nsf/content/mental-review-response

Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project report *Solutions that work: What the evidence and our people tell us*

http://www.atsispep.sis.uwa.edu.au/__data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf

National Aboriginal and Torres Strait Islander Suicide Prevention Strategy

http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pub-atsi-suicide-prevention-strategy

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing Framework (publication pending)

Strengthening mental health care measure

http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2016-leySL109.htm

State/territory plans and commitments

New South Wales

Mental Health Commission of New South Wales, *Living well: A strategic plan for mental health in NSW 2014–2024*

https://nswmentalhealthcommission.com.au/sites/default/files/141002%20Living%20Well%20-%20A%20Strategic%20Plan%20(1).pdf

Victoria

10 Year Mental Health Plan (10YMHP)

https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan

Victorian Suicide Prevention Framework 2016–2025

https://www2.health.vic.gov.au/mental-health/prevention-and-promotion/suicide-prevention-in-victoria

Queensland

Connecting Care to Recovery 2016—2021

https://cabinet.qld.gov.au/documents/2016/Aug/CareRec/Attachments/Plan.PDF

Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016–2021

https://www.health.qld.gov.au/__data/assets/pdf_file/0030/460893/qhatsi-mental-health-strategy.pdf

Western Australia

The *Western Australian mental health, alcohol and other drug services plan 2015–2025*

https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf

Suicide prevention 2020: Together we can save lives

https://www.mhc.wa.gov.au/media/1220/suicide-prevention-2020-strategy-final.pdf

South Australia

The South Australian Government is currently developing a Mental Health Strategic Plan through its recently established Mental Health Commission.

Tasmania

Rethink Mental Health: A long-term plan for mental health in Tasmania 2015–2025

http://www.dhhs.tas.gov.au/mentalhealth/rethink_mental_health_project

Tasmanian Suicide Prevention Strategy (2016–2020)

http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0014/214412/151152_DHHS_Suicide_Prevention_Strategy_Final_WCAG.pdf

Youth Suicide Prevention Plan for Tasmania (2016–2020)

http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0015/214413/151152_DHHS_Youth_Suicide_PPT_WCAG-1.pdf

Suicide Prevention Workforce Development and Training Plan for Tasmania (2016–2020)

http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0013/214411/151152_DHHS_Suicide_Prev_WD_Training_Plan_Final_WCAG-1.pdf

Australian Capital Territory

The Australian Capital Territory Government is currently developing a Mental Health Services Plan; a Mental Health & Wellbeing Framework; a Suicide Reduction Strategy; and an Aboriginal and Torres Strait Islander Health Plan.

Northern Territory

Northern Territory Mental Health Service Strategic Plan 2015–2021

http://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/988/1/Mental%20Health%20Service%20Strategic%20Plan%202015%20-%202021.pdf

NT Suicide Prevention Strategic Action Plan 2015–2018

http://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/1036/1/Northern%20Territory%20suicide%20prevention%20action%20plan%202015-2018.pdf

Appendix A: Gayaa Dhuwi (Proud Spirit) Declaration

The five themes of the Gayaa Dhuwi (Proud Spirit) Declaration, set out below, are central to the development and implementation of actions in the Fifth Plan.

1. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing should be recognised across all parts of the Australian mental health system, and in some circumstances support specialised areas of practice.

2. Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing combined with clinical perspectives will make the greatest contribution to the achievement of the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

3. Aboriginal and Torres Strait Islander values-based social and emotional wellbeing and mental health outcome measures in combination with clinical outcome measures should guide the assessment of mental health and suicide prevention services and programs for Aboriginal and Torres Strait Islander peoples.

4. Aboriginal and Torres Strait Islander presence and leadership is required across all parts of the Australian mental health system for it to adapt to, and be accountable to, Aboriginal and Torres Strait Islander peoples for the achievement of the highest attainable standard of mental health and suicide prevention outcomes.

5. Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

Appendix B: Indicators

PI 1: Proportion of children developmentally vulnerable in the Australian Early Development Index

What does this measure?

Proportion of children vulnerable on one or more domains of the Australian Early Development Index.

Domain

Healthy start to life.

Links to plan priority areas

Data source

Australian Early Development Census (AEDC).

Availability

The AEDC is conducted approximately every 3 years. It was most recently conducted in 2015.

Who is included?

Australian children in their first year of full-time school. Data breakdowns are available by state/territory, and sex. Data are available for lower levels of geographic analysis.

Data limitations

Mental illness is identified through self-report and is limited to a specific set of illnesses.

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

What does this measure?

Proportion of people with mental illness with another long-term health condition.

Domain

Better physical health and live longer.

Links to plan priority areas

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 health issues and reducing early mortality.

Data source

National Health Survey (NHS) and National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), Australian Bureau of Statistics (ABS).

Availability

The NHS is conducted approximately every 3 years; most recently 2014–15. The 2018–19 NATSIHS will provide data for the Aboriginal and Torres Strait Islander population.

Who is included?

People with a mental health condition. Data breakdowns are available by state/territory, sex and age. Some data are available for lower levels of geographic analysis.

Data limitations

Mental illness is identified through self-report.

PI 3: Rate of drug use in people with mental illness

What does this measure?

Proportion of people with mental illness who report the use of licit and illicit drugs.

Domain

Better physical health and live longer.

Links to plan priority areas

Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.

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

Data source

National Drug Strategy Household Survey (NDSHS).

Availability

The NDSHS has been conducted approximately every 3 years since 1985, most recently in 2016.

Who is included?

People with a mental health condition. Data breakdowns are available by state/territory, sex, age, Indigenous status and type of drug.

Data limitations

Mental illness is identified through self-report. Data are available for Australians 14 and over.

PI 4: Avoidable hospitalisations for physical illness in people with mental illness

What does this measure?

The number and proportion of people with a mental illness who have been hospitalised for an avoidable physical illness in the previous 12 months.

Domain

Better physical health and live longer.

Links to plan priority areas

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

Data source

Data linkage of state and territory clinical mental health and patient administration systems.

Availability

This indicator requires developmental work to confirm methodology and feasibility.

Who is included?

People using mental health services. Data breakdowns are likely to be available by state/territory, sex, age groups and Indigenous status. The amount of activity may not support lower levels of geographic analysis.

Data limitations

Data systems can only identify consumers in touch with state and territory community mental health services and will not include people with a mental illness who receive services through primary care or private providers.

PI 5: Mortality gap for people with mental illness

What does this measure?

The average life expectancy for a person with mental illness compared with the life expectancy of all Australians.

Domain

Better physical health and live longer.

Links to plan priority areas

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 health issues and reducing early mortality.

Making safety and quality central to mental health service delivery.

Data source

Data linkage of state and territory clinical mental health and patient administration systems.

Availability

This indicator requires developmental work to confirm methodology and feasibility.

Who is included?

People using mental health services. Data breakdowns are likely to be available by state/territory, sex, age groups and Indigenous status. The amount of activity may not support lower levels of geographic analysis.

Data limitations

Data systems can only identify consumers in touch with state and territory mental health services and will not include people with a mental illness who receive services through primary care or private providers.

PI 6: Prevalence of mental illness

What does this measure?

Proportion of Australians who experienced a mental disorder in the previous 12 months.

Domain

Good mental health and wellbeing.

Links to plan priority areas

Prevalence is relevant to all priority areas.

Data source

National Survey of Mental Health and Wellbeing (NSMHWB).

Availability

The NSMHWB is composed of three prevalence surveys: adults (most recent data from 2007), high-impact psychosis (2010) and children and adolescents (2013–14).

Who is included?

The Australian population. Data are available by sex and diagnoses.

Data limitations

Large-scale, population-based surveys are the most reliable measures of prevalence, but they take time and are expensive. Australian surveys have been conducted approximately every ten years.

PI 7: Proportion of adults with very high levels of psychological distress

What does this measure?

Proportion of adults reporting very high levels of psychological distress.

Domain

Good mental health and wellbeing.

Links to plan priority areas

Achieving integrated regional planning and service delivery.

Data source

National Health Survey (NHS) and National Aboriginal and Torres Strait Islander Health Survey (NATSIHS), Australian Bureau of Statistics (ABS).

Availability

The NHS is conducted approximately every 3 years, most recently 2014–15. The most recent NATSIHS data are 2012–13.

Who is included?

All Australians. Data breakdowns are available by state/territory, sex and age. Some data are available for lower levels of geographic analysis.

Data limitations

None.

PI 8: Connectedness and meaning in life

What does this measure?

Proportion of mental health consumers reporting connectedness and meaning in life.

Domain

Good mental health and wellbeing.

Links to plan priority areas

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

Reducing stigma and discrimination.

Data source

Living in the Community Questionnaire (LCQ).

Availability

The LCQ is not yet implemented in mental health services. This indicator requires developmental work to confirm methodology and feasibility.

Who is included?

People using mental health services. Data breakdowns are likely to be available by state/territory, sex, age groups and Indigenous status.

Data limitations

It is unclear when the LCQ will be implemented and whether sufficient data will be available to support reporting of a national indicator.

Implementation of the LCQ is likely to occur mainly within state and territory mental health services.

PI 9: Rate of social/community/family participation amongst people with mental illness

What does this measure?

The proportion of people with a mental illness reporting participation with family, social and community groups.

Domain

Meaningful and contributing life.

Links to plan priority areas

Achieving integrated regional planning and service delivery.

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

Data source

General Social Survey (GSS), Australian Bureau of Statistics.

Data for this indicator could also be sourced from the LCQ following implementation.

Availability

The GSS is conducted approximately every 4 years, most recently in 2014.

Who is included?

People with a mental health condition. Data breakdowns are likely to be available by state/territory, sex, age groups and Indigenous status.

Data limitations

Mental illness is identified through self-report in the GSS.

It is unclear when the LCQ will be implemented and whether sufficient data will be available to support reporting of a national indicator.

Implementation of the LCQ is likely to occur mainly within state and territory mental health services.

PI 10: Proportion of people with mental illness in employment

What does this measure?

The proportion of adults with a mental illness who are in employment, education or training.

Domain

Meaningful and contributing life.

Links to plan priority areas

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

Data source

National Health Survey (NHS) and the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS).

Availability

The NHS is conducted approximately every 3 years, most recently 2014–15. The 2018–19 NATSIHS will provide data for the Aboriginal and Torres Strait Islander population.

Who is included?

People with a mental health condition. Data breakdowns are likely to be available by state/territory, sex, age groups and Indigenous status.

Data limitations

Mental illness is identified through self-report.

PI 11: Proportion of carers of people with mental illness in employment

What does this measure?

The proportion of people who identify as carers of people with mental illness who are in employment.

Domain

Meaningful and contributing life.

Links to plan priority areas

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

Data source

Survey of Disability, Ageing and Carers (SDAC), Australian Bureau of Statistics.

Availability

The SDAC is conducted approximately every 3 years; most recently in 2015.

Who is included?

Carers of people with a psychosocial disability, which includes nervous or emotional conditions that restrict everyday activities, mental illness or conditions requiring help or supervision, memory problems or periods of confusion that restrict everyday activities, and/or social or behavioural difficulties that restrict everyday activities. Data breakdowns are likely to be available by state/territory, sex and age groups.

Data limitations

Data are available for primary carers only. A primary carer is a person who provides the most informal assistance, in terms of help or supervision, to a person with disability. Data are available for people aged 15 and over, for carers living in the same household as the recipient of care.

PI 12: Proportion of mental health consumers in suitable housing

What does this measure?

The proportion of people using mental health services who report suitable housing.

Domain

Meaningful and contributing life.

Links to plan priority areas

Reducing stigma and discrimination.

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

Data source

Living in the Community Questionnaire (LCQ).

Data from the National Outcomes and Casemix Classification may be available as an interim data source.

Availability

The LCQ is not yet implemented in mental health services. This indicator requires developmental work to confirm methodology and feasibility.

Who is included?

People using mental health services. Data breakdowns are likely to be available by state/territory, sex, age groups and Indigenous status.

Data limitations

It is unclear when the LCQ will be implemented and whether sufficient data will be available to support reporting of a national indicator.

Implementation of the LCQ is likely to occur mainly within state and territory mental health services.

PI 13: Proportion of consumers and carers with positive experiences of service

What does this measure?

The proportion of mental health consumers and their carers who report a positive experience of their care.

Domain

Effective support, care and treatment

Links to plan priority areas

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.

Data source

For consumers: Your Experience of Service (YES) survey.

For carers: Carer Experience Survey (CES).

Availability

Rollout of the YES survey in state and territory mental health services is currently under way, as is work to develop a nationally consistent data collection. Versions of the YES survey have been developed that may be suitable for some CMO services and services commissioned by PHNs.

Implementation of the CES is yet to be finalised. This indicator requires developmental work to confirm methodology and feasibility.

Who is included?

People using mental health services. Data breakdowns are likely to be available by state/territory, sex, age groups, Indigenous status and involuntary status.

Data limitations

Survey methodologies for the YES survey differ between jurisdictions. It is unknown what impact that will have on whether the data are nationally comparable.

PI 14: Change in mental health consumers' clinical outcomes

What does this measure?

The proportion of episodes of mental health care where significant improvement was identified between admission and review or discharge.

Domain

Effective support, care and treatment.

Links to plan priority areas

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.

Data source

National Outcomes and Casemix Collection.

Availability

Data are updated annually. Most recent data are from 2014–15.

Who is included?

People using mental health services. Data breakdowns are available for age groups, sex, service setting (admitted, ambulatory or residential care) and state and territory.

Data limitations

Data are only available for services run by states and territories. Considerable work would be required to develop a collection for outcomes from other service providers (e.g. private psychiatrists, non-government organisations).

PI 15: Population access to mental health care

What does this measure?

Proportion of people who receive clinical mental health care from a GP, private psychiatrist, private hospital or public specialised mental health service.

Domain

Effective support, care and treatment.

Links to plan priority areas

Achieving integrated regional planning and service delivery.

Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.

Data source

Medicare Benefits Scheme, Department of Veteran's Affairs, Private Psychiatric Hospitals Data Reporting and Analysis Service, state and territory clinical mental health systems.

Availability

Data are updated annually. Most recent data are from 2014–15.

Who is included?

People using mental health services. Data breakdowns are available for age groups, sex, service setting, Indigenous status, remoteness and state and territory.

Data limitations

Mental health care by GPs and private providers is sourced from the Medicare Benefits Scheme. Care that is delivered outside the specified mental health schedule items is not included.

PI 16: Post-discharge community care

What does this measure?

Proportion of discharges from an acute admitted specialised mental health unit for which there was a follow-up by a community mental health service within 7 days.

Domain

Effective support, care and treatment.

Links to plan priority areas

Achieving integrated regional planning and service delivery.

Suicide prevention.

Coordinating treatment and support 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.

Data source

State and territory clinical mental health data systems.

Availability

Data are updated annually. Most recent data are from 2014–15.

Who is included?

People using state and territory mental health services. Data breakdowns are available for age groups, sex, service setting, Indigenous status, remoteness and state and territory.

Data limitations

Data are only available for services run by states and territories. Considerable work would be required to develop data linkages to other forms of care in the community, such as GPs and private office-based care providers.

PI 17: Readmission to hospital

What does this measure?

The proportion of admissions to a specialised mental health unit that are followed by readmission within 28 days of discharge.

Domain

Effective support, care and treatment.

Links to plan priority areas

Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.

Data source

State and territory clinical mental health data systems.

Availability

Data are updated annually. Most recent data are from 2014–15.

Who is included?

People using admitted mental health services. Data breakdowns are available for age groups, sex, Indigenous status and state and territory.

Data limitations

Data are only available for admissions to public hospitals.

PI 18: Proportion of total mental health workforce accounted for by the mental health peer workforce

What does this measure?

The proportion of staff employed in state and territory administered specialised mental health services who are peer workers.

Domain

Effective support, care and treatment.

Links to plan priority areas

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

Data source

Mental Health Establishments National Minimum Data Set.

Availability

Data are updated annually. Most recent data are from 2014–15.

Who is included?

Staff employed in state and territory administered specialised mental health services. Data are available by state and territory.

Data limitations

Data are only available for services run by states and territories. Work has been undertaken to develop an equivalent collection for non-government organisations, but considerable work and resourcing would be required to implement it.

PI 19: Rates of suicide

What does this measure?

The number of suicides per 100 000 Australians.

Domain

Less avoidable harm.

Links to plan priority areas

Achieving integrated regional planning and service delivery.

Suicide prevention.

Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.

Data source

Causes of Death, Australian Bureau of Statistics.

Availability

Data are updated annually. Most recent data are from 2015.

Who is included?

All Australians. Data breakdowns are available for age groups, sex, Indigenous status and state and territory.

Data limitations

It can be difficult to establish a cause of death as having an intent of suicide, and coroners may be cautious in making a finding of suicide. Circumstances surrounding suicide deaths can be complex, and it may therefore take time for the coroner to make a finding and close the case.

PI 20: Suicide of persons in inpatient mental health units

What does this measure?

The number of suicides that occur in admitted patient specialised mental health services.

Domain

Less avoidable harm.

Links to plan priority areas

Suicide prevention.

Data source

State and territory data systems.

Availability

Data are updated annually. Most recent data are from 2014–15.

Who is included?

All people using admitted patient specialised mental health services. The small numbers do not support any data breakdowns.

Data limitations

Data are only available for public hospitals.

PI 21: Rates of follow-up after suicide attempt/self-harm

What does this measure?

Proportion of presentations to hospital for which there was a follow-up in the community within an appropriate period.

Domain

Less avoidable harm.

Links to plan priority areas

Achieving integrated regional planning and service delivery.

Suicide prevention.

Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.

Making safety and quality central to mental health service delivery.

Data source

Data linkage of state and territory clinical mental health and patient administration systems.

Availability

This indicator requires developmental work to confirm methodology and feasibility.

Who is included?

People using mental health services. Data breakdowns are likely to be available by state/territory, sex, age groups and Indigenous status. The amount of activity may not support lower levels of geographic analysis.

Data limitations

Data systems can only identify consumers in touch with state and territory mental health services and cannot currently identify people who receive follow-up care through primary care or private providers.

PI 22: Rate of seclusion in acute inpatient mental health units

What does this measure?

Number of seclusion events per 1000 patient days within public acute admitted patient specialised mental health service units.

Domain

Less avoidable harm.

Links to plan priority areas

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

Making safety and quality central to mental health service delivery.

Data source

National Seclusion and Restraint Data Collection.

Availability

Data are updated annually. Most recent data are from 2015–16.

Who is included?

People using admitted patient specialised mental health services. Data breakdowns are available for state and territory, remoteness of the hospital and target population. Current data does not support analysis by smaller geographic areas.

Data limitations

Seclusion events occurring in non-specialised mental health service settings, for example, emergency departments, are not included in currently available data. Considerable work would be required to expand this dataset.

PI 23: Rate of involuntary hospital treatment

What does this measure?

The proportion of admissions to admitted patient specialised mental health services that are involuntary.

Domain

Less avoidable harm.

Links to plan priority areas

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

Improving Aboriginal and Torres Strait Islander mental health and suicide prevention.

Data source

National Hospital Morbidity Database.

Availability

Data are updated annually. Most recent data are from 2014–15.

Who is included?

People using admitted patient specialised mental health services. Data breakdowns are available for age groups, sex, Indigenous status and state and territory.

Data limitations

Patients may be admitted involuntarily and then choose to continue their care on a voluntary basis. Current national data can only identify admissions where a patient has been involuntary for some or all of the admission. The Safety and Quality Partnership Standing Committee (SQPSC) is investigating options to reporting the length of the involuntary portion of the admission.

PI 24: Experience of discrimination in people with mental illness

What does this measure?

The proportion of people with a mental illness who report the experience of discrimination.

Domain

Stigma and discrimination.

Links to plan priority areas

Reducing stigma and discrimination.

Data source

General Social Survey (GSS), Australian Bureau of Statistics.

Availability

The GSS is conducted approximately every 4 years, most recently in 2014.

Who is included?

All Australians. Data breakdowns are available for age groups, sex, Indigenous status and state and territory.

Data limitations

Mental illness is identified through self-report.

Acknowledgements

Mental Health Drug and Alcohol Principal Committee members

Michael Pervan	Tasmania (Chair)
John Allan	Queensland
Karin Lines	New South Wales
Margaret Grigg	Victoria
Richard Bromhead and Mary Wood	Australian Capital Territory
Peggy Brown and Denise Riordan	Northern Territory
Tim Marney	Western Australia
Narelle Butt	Tasmania
Aaron Groves	South Australia
Mark Cormack	Australian Government
JulieAnne Anderson	Secretariat

Fifth Plan Writers Group members

Peggy Brown (to December 2016)	Northern Territory
Aaron Groves	South Australia
Julie Anderson	Consumer
Margaret Springgay AM	Carer
Grant Sara	New South Wales / Mental Health Information Strategy Standing Committee
John Allan AM	Queensland / Safety and Quality Partnerships Standing Committee
Bill Buckingham	Commonwealth Consultant
Harvey Whiteford	Commonwealth Consultant
Marianna Serghi	Commonwealth Consultant
David McGrath	Commonwealth Consultant

Commonwealth Secretariat

Led by Shane Porter and Simon Cleverley

<u>Glossary</u>

For the purposes of the Fifth Plan, the key terms below have the following meanings.

Aboriginal Community Controlled Health Services (ACCHS) A primary health care service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate health service to the community that controls it, through a locally elected Board of Management.

Adverse health outcome An outcome that has the potential to negatively affect a person's state of health.

Australian Commission on Safety and Quality in Health Care (ACSQHC) The agency that leads and coordinates national improvements in safety and quality in health care across Australia.

Burden of disease A measure used to assess and compare the relative impact of different diseases and injuries on populations.

Care navigator A person who works collaboratively with consumers and carers to assist them in finding the most appropriate treatment, care or supports.

Carer A person who cares for or otherwise supports a person living with mental illness. A carer has a close relationship with the person living with mental illness and may be a family member, friend, neighbour or member of a broader community.

Carer Experience of Service (CES) survey Gathers information from carers about their experiences of care, and aims to help mental health services and carers to work together to build better services.

Community supports Non-clinical services in the community that assist people living with mental illness to live meaningful and contributing lives and support them in their recovery. These may include services that relate to daily living skills, self-care and self-management, physical health, social connectedness, housing, education and employment.

Community Managed Organisation (CMO) A not-for-profit, non-government organisation governed by a Board of Management. CMOs range from single-focus, locally based organisations to large national and international organisations working across a range of areas.

Community managed sector The community managed sector is predominantly made up of not-for-profit organisations providing community-based support services that help keep people well in the community. They provide prevention, early intervention and rehabilitation programs and psychosocial services that support recovery from mental illness. Some also provide treatment-related and counselling services.

Comorbidity The presence of one or more diseases or disorders in a person, in addition to a primary disease or disorder.

Consumer A person living with mental illness who uses, has used or may use a mental health service.

Contributing life The National Mental Health Commission outlines that a contributing life is one where people living with mental illness can expect the same rights, opportunities and health as the wider community. It is a life enriched with close connections to family and friends, supported by good health, wellbeing and health care. It means having a safe, stable and secure home and having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering.

Diagnostic overshadowing Misattribution of a person's physical health symptoms to their mental illness, resulting in inadequate diagnosis and treatment.

Discrimination (mental illness) Unfair treatment of a person or group of people on the basis of a particular characteristic. Discrimination happens when people act on stigmatising views about people living with mental illness.

Early intervention The early identification of risk factors and provision of timely treatment, care or support for people experiencing early signs and symptoms of mental illness. It aims to prevent the incidence, severity and impact of mental illness.

Gayaa Dhuwi (Proud Spirit) Declaration A declaration on Aboriginal and Torres Strait Islander leadership across all parts of the Australian mental health system to achieve the highest attainable standard of mental health and suicide prevention outcomes for Aboriginal and Torres Strait Islander peoples.

Governments Commonwealth, state and territory governments.

Lived experience (mental illness) People with lived experience are people who identify either as someone who is living with (or has lived with) mental illness or someone who is caring for or otherwise supporting (or has cared for or otherwise supported) a person who is living with (or has lived with) mental illness. People with lived experience are sometimes referred to as consumers and carers.

Lived experience (suicide) People who think about suicide, people who have attempted suicide, people who care for someone with suicidal behaviour, people who are bereaved by suicide, and people who are impacted by suicide in some other way, such as a workplace incident.

Living in the Community Questionnaire (LCQ) Gathers information from consumers about aspects of social inclusion and recovery by exploring aspects of their life in the community such as social activities, participation in employment or study, living situation and physical health care.

Local Hospital Networks (LHNs) Entities established by state and territory governments to manage single or small groups of public hospital services, including managing budgets and being directly responsible for performance. Most, but not all, LHNs are responsible for managing public hospital services in a defined geographical area. At the discretion of states and territories, LHNs may also manage other health services such as community-based health services. LHNs may have different names in some jurisdictions. For example, they are referred to as Local Health Districts in New South Wales, Health and Hospital Services in Queensland, Local Health Services in South Australia, and the Tasmanian Health Service in Tasmania.

Mental disorder See mental illness.

Mental health The World Health Organization defines mental health as a state of wellbeing in which every person realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to their community.

Mental health service system Comprises all services that have a primary function of providing treatment, care or support to people living with mental illness and/or their carers.

Mental health problem Diminished cognitive, emotional or social abilities but not to the extent that the diagnostic criteria for a mental illness are met.

Mental illness A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders, and schizophrenia.

National Disability Insurance Scheme (NDIS) Provides eligible participants with permanent and significant disability with the reasonable and necessary supports they need to enjoy an ordinary life. The NDIS also connects people with disability and their carers, including people who are not NDIS participants and their carers, to supports in their community.

National Mental Health Service Planning Framework (NMHSPF) A framework to guide evidence-based decision-making about the mix and level of mental health services and workforce needed to meet local circumstances.

National Mental Health Strategy A framework to guide mental health reform. It includes the National Mental Health Policy, the Mental Health Statement of Rights and Responsibilities and four successive National Mental Health Plans.

National Safety and Quality Health Service (NSQHS) Standards Standards that 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 expected standards of safety and quality are met.

National Standards for Mental Health Services (NSMHS) Standards that assist in the development and implementation of appropriate practices and guide continuous quality improvement across the broad range of mental health services.

Non-fatal burden A measure of healthy years lost due to ill health. Non-fatal burden is assessed when calculating the total burden of disease experienced by a population.

Indicator A quantitative measure that is used to assess the extent to which a given objective has been achieved.

Peer worker Workers who have a lived experience of mental illness and who provide valuable contributions by sharing their experience of mental illness and recovery with others. Peer workers are employed across a range of service settings and perform a variety of roles, including providing individual support, delivering education programs, providing support for housing and employment, coaching and running groups and activities.

Person-centred Treatment, care and support that places the person at the centre of their own care and considers the needs of the person's carers.

Prevention (mental illness) Action taken to prevent the development of mental illness, including action to promote mental health and wellbeing and action to reduce the risk factors for mental illness.

Prevention (suicide) Action taken to reduce the incidence of suicide.

Primary Health Networks (PHNs) Entities contracted by the Commonwealth to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.

Primary care Generally the first point of contact for people living with mental health problems or mental illness and their carers. Primary care providers include general practitioners, nurses, allied health professionals, pharmacists and Aboriginal and Torres Strait Islander health workers.

Productivity The efficiency with which inputs (such as labour) are converted into outputs (such as goods and services). Growth in productivity can lead to improvements in living standards.

Promotion (mental illness) Action taken to promote mental health and wellbeing.

Psychosocial disability The disability experience of people with impairments and participation restrictions related to mental illness. These impairments and restrictions can include reduced ability to function, think clearly, experience full physical health and manage the social and emotional aspects of their lives.

Recovery The National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers outlines that there is no single description or definition of recovery, because recovery is different for everyone. It notes that central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing, free of stigma and discrimination. Some characteristics of recovery commonly cited are that it is a unique and personal journey; a normal human process; an ongoing experience and not the same as an end point or cure; a journey rarely taken alone; and nonlinear, with it being frequently interspersed with both achievement and setbacks. It defines personal recovery as being able to create and live a meaningful and contributing life in a community of choice, with or without the presence of mental illness.

Regional level The level between the macro level of governments and micro level of service delivery. The regional level is where practical, targeted and locally appropriate action can be taken and strong community collaborations and partnerships can be formed. A region is not necessarily confined to the boundaries of a specific Primary Health Network or Local Hospital Network.

Secondary care Care provided by medical specialists. Secondary care providers can include psychiatrists and psychologists.

Self-stigma (mental illness) Stigmatising views that people living with mental illness hold about themselves. Self-stigma occurs when people living with mental illness accept the negative opinions or judgments held by others about people living with mental illness.

Severe mental illness Characterised by a severe level of clinical symptoms and often some degree of disruption to social, personal, family and occupational functioning. Severe mental illness is often described as comprising three subcategories:

- Severe and episodic mental illness—refers to people who have discrete episodes of illness interspersed with periods of minimal symptoms and disability or even remission. This group comprises about two-thirds of all adults who have a severe mental illness.

- Severe and persistent mental illness—refers to people with a severe mental illness where symptoms and/or associated disability continue at moderate to high levels without remission over long periods (years rather than months). This group represents about one-third of all adults who have a severe mental illness.

- Severe and persistent illness with complex multi-agency needs—refers to people with severe and persistent illness whose symptoms are the most severe and who are the most disabled. The most intensive clinical care (assertive clinical treatment in the community often supplemented by hospitalisation), along with regular non-clinical support from multiple agencies, is required to assist the person in managing their day-to-day roles in life (for example, personal and housing support). This group is relatively small (approx. 0.4 per cent of adult population, or 60 000 people) and is the group targeted for Tier 3 packages under the NDIS.

Severe and complex mental illness Refers to mental illness that is not directly aligned to any one of the above subcategories of severe mental illness. Rather, it is broader and may include episodic or chronic (persistent) conditions that are not confined to specific diagnostic categories. While incorporating severely disabled people (that is, people with persistent illness with complex multi-agency needs), it also includes people who have complexities that are not disability related— for example, people who have a severe mental illness comorbid with a chronic physical illness; people who may have no functional impairment arising from their mental illness but whose illness is adversely impacted on by complex social factors; people with multiple recurrent acute episodes that require frequent hospital care; people who present a high suicide risk; or people who have a need for coordinated assistance across a range of health and disability support agencies.

Social and emotional wellbeing Refers to the Aboriginal and Torres Strait Islander view of health. This view is holistic and includes mental health and other factors such as the social, spiritual and cultural wellbeing of people and the broader community.

Social inclusion The opportunity for people to participate in society through employment and access to services; connect with family, friends, personal interests and the local community; deal with personal crises; and have their voices heard.

Social stigma (mental illness) Individual and collective stigmatising attitudes and beliefs about people living with mental illness. Social stigma reinforces self-stigma and structural stigma.

Specialised mental health services Include services provided by psychiatric hospitals, psychiatric units or wards in hospitals, community mental health care services and residential mental health services.

Stepped care An evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to a person's needs. Within a stepped care approach, a person is supported to transition up to higher-intensity services or transition down to lower-intensity services as their needs change.

Stigma A negative opinion or judgment that excludes, rejects, shames or devalues a person or group of people on the basis of a particular characteristic. Stigma may include self-stigma, social stigma and structural stigma. Stigma against people living with mental illness involves perceptions or representations of them as violent, unpredictable, dangerous, prone to criminality, incompetent, undeserving or weak in character.

Structural stigma (mental illness) The policies and practices of social institutions that restrict opportunities for people living with mental illness. Structural stigma reinforces self-stigma and social stigma.

Suicidal behaviours A range of behaviours that include thinking about suicide (ideation), planning a suicide, attempting suicide and taking one's own life.

Trauma informed care and practice An organisational and practice approach to delivering health and human services directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological and emotional safety for consumers, their families and carers, and service providers.

Your Experience of Service (YES) survey Gathers information from consumers about their experiences of care and aims to help mental health services and consumers to work together to build better services.

References

i   Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing, Australia, 2007. Summary of Results, Cat no 4326.0, Canberra: ABS 2016.

ii   Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing, Australia, 2007. Summary of Results, Cat no 4326.0, Canberra: ABS 2016.

iii   Western Australian Mental Health Commission (2015), Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth, Western Australian Mental Health Commission.

      The Royal Australian and New Zealand College of Psychiatrists. The economic cost of serious mental illness and comorbidities in Australia and New Zealand. RANZCP. 2016.

iv   Lawrence D, Hancock KJ, Kisely S (2013), The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. BMJ 2013;346:f2539.

v   Australian Institute of Health and Welfare. Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3.BOD 4. Canberra, AIHW.

vi   Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Burden of Disease Study series no. 6. Cat. no. BOD 7. Canberra: AIHW.

vii   OECD (2015), Mental Health and Work: Australia, Mental Health and Work. Paris, OECD Publishing.

viii Maple M, Kwan M, Borrowdale K, Riley J, Murray S, Sanford R. The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia. Sydney, Suicide Prevention Australia.

ix   Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016

x   Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016

xi   Australian Institute of Health and Welfare 2010. A snapshot of men's health in regional and remote

1   National Mental Health Commission. Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Sydney: NHMC, 2014.

2   Rosenstreich G. LGBTI people mental health and suicide. Revised 2nd edn. Sydney: National LGBTI Health Alliance, 2013.

3   Australian Bureau of Statistics, Causes of Death, Australia, 2015, Cat no 3303.0. Canberra:ABS,2016

4   Australian Bureau of Statistics, The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples, 2012, Cat no 4704.0, Canberra:ABS, 2016

5   Australian Bureau of Statistics, Australian Aboriginal and Torres Strait Islander Health Survey, 2013, Cat no 4727.0.55.001. Canberra: ABS, 2016

6   Australian Bureau of Statistics, National Aboriginal and Torres Strait Islander Social Survey, 2016, Cat no 4714.0, Canberra:ABS, 2016

7   The National Eating Disorders Collaboration. Eating disorders: The way forward: An Australian national framework. Sydney: NEDC, 2010.

8   The National Eating Disorders Collaboration. An integrated response to complexity—national eating disorders framework 2012. Sydney: NEDC, 2012.

9   Australian Institute of Health and Welfare, National Health Workforce Planning and Research Collaboration 2011: Mental Health Non-Government Organisation Workforce Project Final Report. Adelaide: Health Workforce Australia, 2016,

10   Australian Institute of Health and Welfare. Healthy communities: Hospitalisations for mental health conditions and self-harm in 2013–14. Canberra: AIHW, 2016. Available from: http://www. myhealthycommunities.gov.au/Content/publications/downloads/AIHW_HC_Report_Mental_ Health_September_2016.pdf?t=1474920674856

11   A. C. McFarlane, S. E. Hodson, M. Van Hooff & C. Davies (2011). Mental health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report, Department of Defence: Canberra.

12   Fisher J, Cabral de Mello M, Patel V, Rahman A, Tran T, Holton S, Holmes W. Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: A systematic review. Bull World Health Organ 2012; 90:139–49.

13   Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR (2015) The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra

14   National Ageing Research Institute. Depression in older age: A scoping study. Final Report. Melbourne: beyondblue, 2009.

15   Australian Bureau of Statistics, Causes of Death, Australia, 2015, Cat no 3303.0. Canberra:ABS,2016

16   Department of Developmental Disability Neuropsychiatry. Accessible mental health services for people with an intellectual disability: A guide for providers. Sydney: University of New South Wales, Department of Developmental Disability Neuropsychiatry, 2014.

17   New South Wales Mental Health Commission. Living well: A strategic plan for mental health in NSW. Sydney: NSW Mental Health Commission, 2014.

18   Department of Developmental Disability Neuropsychiatry. Accessible mental health services for people with an intellectual disability: A guide for providers. Sydney: University of New South Wales, Department of Developmental Disability Neuropsychiatry, 2014.

19   Kitchener BA, Jorm AF, Kelly CM, Pappas R, Frize M. Intellectual disability mental health first aid manual. 2nd edn. Melbourne: Mental Health First Aid Australia, 2010.

20   [20] National Aboriginal and Torres Strait Islander Leadership in Mental Health. Gayaa Dhuwi (Proud Spirit) Declaration. NATSILMH, 2015. Available from: http://natsilmh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf

21   National Mental Health Commission. Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Sydney: NHMC, 2014.

22   National Mental Health Commission. Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Sydney: NHMC, 2014.

23   Western Australian Mental Health Commission (2015). Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth, Western Australian Mental Health Commission.

24   Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016.

25   Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016.

26   Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016.

27   Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016.

28   Australian Institute of Health and Welfare: Harrison JE & Henley G 2014. Suicide and hospitalised self-harm in Australia: trends and analysis. Injury research and statistics series no. 93. Cat. no. INJCAT 169. Canberra: AIHW.

29   Department of Health and Ageing. Living is for everyone: A framework for the prevention of suicide in Australia. Canberra: Commonwealth of Australia, 2007.

30   Victorian Government. Victorian suicide prevention framework 2016–25. Victoria: Department of Health and Human Services, 2016.

31   Department of Health and Ageing. Living is for everyone: A framework for the prevention of suicide in Australia. Canberra: Commonwealth of Australia, 2007.

32   KPMG Health Economics. The economic cost of suicide in Australia. KPMG, 2013.

33   Hunter E, Milroy H. Aboriginal and Torres Strait Islander suicide in context. Arch Suicide Res 2006;10(2):141–57.

34   Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016.

35   National Mental Health Commission. Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Sydney: NHMC, 2014.

36   National Mental Health Commission. Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Sydney: NHMC, 2014.

37   Council of Australian Governments. Principles to determine the responsibilities of the National Disability Insurance Scheme and other service systems. COAG, 2015. Available from: https://www.coag.gov.au/sites/default/files/communique/NDIS-Principles-to-Determine-Responsibilities-NDIS-and-Other-Service.pdf

38   Australian Bureau of Statistics. Australian Health Survey, 2011–12. Cat no 4364.0.55.001. Canberra: ABS, 2016.

39   Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander social survey, 2014–15. Cat no 4714.0. Canberra: ABS, 2016.

40   Australian Institutes of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Canberra: AIHW, 2015.

41   Australian Bureau of Statistics. Suicides, Australia, 2010. Cat no 3309.0. Canberra: ABS, 2012.

42   Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander health organisations, online services report 2012–2013. Cat no IHW 139. Canberra: AIHW, 2014.

43   Australian Institute of Health and Welfare. The health of Australia's prisoners 2012. Cat no PHE 170. Canberra: AIHW, 2013.

44   Department of Health and Ageing. National Aboriginal and Torres Strait Islander health plan 2013–2023. Canberra: Commonwealth of Australia, 2013.

45   Royal Australian and New Zealand College of Psychiatrists. Keeping body and mind together: Improving the physical health and life expectancy of people with severe mental illness. RANZCP, 2015.

46   Thornicroft G. Premature death among people with mental illness. BMJ 2013;346:345–53.

47   Lawrence D, Hancock KJ, Kisely S. The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. The BMJ. 2013; 346:f2539

48   Royal Australian and New Zealand College of Psychiatrists. Keeping body and mind together: Improving the physical health and life expectancy of people with severe mental illness. RANZCP, 2015.

49   National Mental Health Commission. National consensus statement on physical health and mental illness. Canberra: Commonwealth of Australia, 2016.

50   The Mental and Physical Health Platform. Mental and physical health charter. [FULL CITATION TBC]

51   De Hert M, Correll CU, Bobes J, Cetkovich-Bakmas M, Cohen D, Asai I, Leucht S. Physical illness in patients with severe mental disorders: I: Prevalence, impact of medications and disparities in health care. World Psychiatry, 2011;10(1):52–63.

52   Morgan VA, Waterreus A, Jablensky A, Mackinnon A et al. People living with psychotic illness in 2010: The second Australian national survey of psychosis. Aust NZ J Psychiatry 2012;46(8):735–52.

53   Vos T, Barker B, Stanley L, Lopez AD. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane: School of Population Health, The University of Queensland, 2007.

54   Royal Australian and New Zealand College of Psychiatrists. Keeping body and mind together: Improving the physical health and life expectancy of people with severe mental illness. RANZCP, 2016.

55   Naylor C, Das P, Ross S, Honeyman M, Thompson J, Gilburt H. Bringing together physical and mental health: A new frontier for integrated care. London: The Kings Fund, 2016.

56   Australian Bureau of Statistics National Health Survey: Mental Health and co-existing physical health conditions, Australia, 2014 – 15, Cat no 4329.0.00.004. Canberra: ABS, 2016

57   National Health Survey: Mental Health and co-existing physical health conditions, Australian 2014-2015. Cat 4329.0.00.004 170. Canberra: AIHW, 2015

58   Livingston JD. Mental illness-related structural stigma: The downward spiral of systemic exclusion. Calgary: Mental Health Commission of Canada, 2013.

59   beyondblue. Information paper: Stigma and discrimination associated with depression and anxiety. Victoria: beyondblue, 2015.

60   Livingston JD. Mental illness-related structural stigma: The downward spiral of systemic exclusion. Calgary: Mental Health Commission of Canada, 2013.

61   SANE Australia. A life without stigma: A SANE report. Victoria: SANE Australia, 2013.

62   Livingston JD. Mental illness-related structural stigma: The downward spiral of systemic exclusion. Calgary: Mental Health Commission of Canada, 2013.

63   SANE Australia. A life without stigma: A SANE report. Victoria: SANE Australia, 2013.

64   Senate Select Committee on Mental Health. A national approach to mental health—from crisis to community: First Report. Canberra: Department of the Senate, 2006.

65   Rickwood D. Pathways of recovery: Preventing further episodes of mental illness (monograph). Canberra: Department of Health and Ageing, 2006.

66   SANE Australia. A life without stigma: A SANE report. Victoria: SANE Australia, 2013.

67   beyondblue. Information paper: Stigma and discrimination associated with depression and anxiety. Victoria: beyondblue, 2015.

68   Better Health Channel. Stigma, discrimination and mental illness. Victorian Government, 2015. Available from: https://www.betterhealth.vic.gov.au/health/servicesandsupport/stigma-discrimination-and-mental-illness

69   National Mental Health Commission. Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Sydney: NHMC, 2014.

70   beyondblue. Information paper: Stigma and discrimination associated with depression and anxiety. Victoria: beyondblue, 2015.

71   National Mental Health Commission. Contributing lives, thriving communities: Report of the national review of mental health programmes and services. Sydney: NHMC, 2014.

72   SANE Australia. A life without stigma: A SANE report. Victoria: SANE Australia, 2013.

73   Mental Health Council of Australia. Consumer and carer experiences of stigma from mental health and other health professionals. Canberra: MHCA, 2011.

74   Jones S, Howard L, Thornicroft G. Diagnostic overshadowing: Worse physical health care for people with mental illness. Acta Psychiatr Scand 2008;118:169–71.

75   beyondblue. Information paper: Stigma and discrimination associated with depression and anxiety. Victoria: beyondblue, 2015.

76   Mental Health Council of Australia. Consumer and carer experiences of stigma from mental health and other health professionals. Canberra: MHCA, 2011.

77   Hadlaczky G, Hokby S, Mkrtchian A, Carli V, Wasserman D, Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: a meta-analysis. Int Rev Psychiatry 2014;26(4):467–75.

78   Gronholm PC, Henderson C, Deb T, Thornicroft G. Interventions to reduce discrimination and stigma: The state of the art. Soc Psychiatry Psychiatr Epidemiol 2017;52:249–58.

79   Australian Commission on Safety and Quality in Healthcare. Australian Commission on Safety and Quality in Healthcare strategic plan 2014–2019. Canberra: ACSQHC, 2014.

national
mental
health
strategy