Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

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OUTCOME 11: Mental Health

Topic: NATIONAL MENTAL HEALTH PLAN

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Senator: Senator Fierravanti-Wells

Question:

And what about the report on the third mental health plan? What has happened to that? I have not seen that one yet—or I might have missed it. Is there a report out on the third mental health plan?

Answer:

Under the National Mental Health Plan 2003-2008 (the Third Plan), the Australian Government, states and territories, through the Mental Health Standing Committee (MHSC), had joint responsibility for overseeing the evaluation process. A Summative Evaluation of the Third Plan was conducted by two independent consultants: Mr Charles Curie from the United States of America and Dr Graham Thornicroft from the United Kingdom. The report on the Summative Evaluation was approved by the MHSC in 2009 and was publicly released on the www.mentalhealth.gov.au website. The Summative Evaluation report was archived when the www.mentalhealth.gov.au website transitioned to the www.health.gov.au website. The Summative Evaluation report will be posted on the www.health.gov.au website in 2013. A copy is attached.

Summative Evaluation of the National Mental Health Plan 2003-2008

by

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Disclaimer: The following recommendations and views presented in this report reflect the findings and conclusions of the consultants by the consultants and do not necessarily reflect the views in whole or part of Governments or individual stakeholders. A Reference Group established to support the consultants provided factual input to the paper.

Contents

BIOGRAPHICAL INFORMATION

Charles Curie, MA, ACSW

Charles G. Curie is the principal and founder of **THE CURIE GROUP, LLC**, a management and consulting firm specializing in working with leaders of the healthcare field, particularly the mental health (MH) and substance use (SU) arenas, to facilitate the transformation of services and to attain increasingly positive outcomes in the lives of people worldwide. He has authored and co-authored articles on various topics related to the field, including co-occurring disorders and reduction and elimination of seclusion and restraint practices.

Curie's professional experience spans 30 years in the mental health and substance use services fields as a clinician, service provider, business executive, policy-maker, educator and public administrator. He was nominated in 2001 by the President of the United States and confirmed by the U.S. Senate to head the Substance Abuse and Mental Health Services Administration (SAMHSA). As SAMHSA Administrator, Curie led the $3.4 billion agency responsible for improving the accountability, capacity and effectiveness of the Nation's substance abuse prevention, addictions treatment and mental health services, including The President's New Freedom Commission on Mental Health, the Strategic Prevention Framework for substance use prevention, Access to Recovery, National Outcome Measures for mental health and substance use services and work with post-conflict and war-torn countries MH and SU service systems, including Iraq and Afghanistan.

Prior to 2001, Curie was appointed by the Pennsylvania State Governor as Deputy Secretary for Mental Health and Substance Abuse Services and implemented a nationally recognized mental health and drug and alcohol Medicaid managed care program and a policy to reduce and ultimately eliminate the use of seclusion and restraint practices in the state hospital system which won the *2000 Innovations in American Government Award* sponsored by Harvard University's John F. Kennedy School of Government, the Ford Foundation, and the Council on Excellence in Government.

Currently, he serves on the Board of Directors of the Council on Social Work Education (CSWE) and the national Suicide Prevention Action Network (SPAN).

Graham Thornicroft, MB, BS, MA, MSc, PhD, FRCPsych, MFacPHM, FAMedSci

Graham Thornicroft is a Consultant in Community Psychiatry and Director of Research and Development at the South London and Maudsley NHS Foundation Trust, Professor of Community Psychiatry and Head of the Health Service and Population Research Department at the Institute of Psychiatry, King's College in London. Within the London Region, he was Chair of the Adult Mental Health Strategy Committee of London Region, NHS Executive, and has been Project Advisor to Lambeth, Southwark and Lewisham and Croydon Health Authorities.

At the national level, Professor Thornicroft has been Chair of the Royal College of Psychiatrists Working Party on the Roles and Responsibilities of the Consultant Psychiatrist in Facilities and Services for People with Severe Mental Health Problems, and was Chair of the External Reference Group of National Service Framework for Mental Health in England, offering advice to Ministers on setting the policy blueprint for adult mental health services in England for the current decade. He has been the General Adult Psychiatry Advisor to the Chief Medical Officer, and served as a Mental Health Service Advisor to the House of Commons Health Select Committee.

Professor Thornicroft has served as a member of the Medical Research Council Advisory Board, has completed a secondment to the Department of Health as a Medical Advisor in the Mental Health Division. Internationally, he is a founding Executive Committee Member of European Network for Mental Health Service Evaluation (ENMESH).

Thornicoft's areas of research expertise include: stigma and discrimination, mental health needs assessment, the development of outcome scales, and cost-effectiveness evaluations of mental health care He is the author of over 180 papers in peer-reviewed scientific journals and has authored 20 books.

1 Executive summary

As a result of this review, it was evident to the consultants that significant progress in reforming mental health services has been made throughout Australia since the inception of The Mental Health Strategy and The National Mental Health Policy in the early 1990's. As with any process of reform, early achievements and successes increase the expectations of constituents as to how mental health services should be accessed and delivered. In addition, newer and more effective ways of providing evidence-based care and supports are being continually documented. Addressing these expectations and implementing these new developments are the responsibilities of all levels of government, public and private providers, peak bodies and advocacy groups, to move a system forward in a manner that accommodates such changes and realises on-going reform. Thus, progress is generally determined in the context of the times and the current state of knowledge and technologies.

With this in mind, this summative evaluation shows that progress was made in all the key areas and stated outcomes of the National Mental Health Plan 2003-2008, (The current Plan). It was quite apparent that the ***concept of 'recovery'*** has had a major impact on the discussions being held by the Commonwealth, the States and Territories, consumers, carers, advocates and both public and private providers, to frame public policy, to shape services and service delivery and to develop outcome measures. However, there was a level of dissatisfaction expressed on the part of a range of constituents that not enough progress was made in some parts of the current Plan.

The current National Mental Health Plan commenced in 2003. The intent of The Plan was to *consolidate the achievements of the First and Second Plans, address gaps identified in both, and take the National Mental Health Strategy forward with restated and new directions*. It was intended to be *viewed as an ongoing agenda for service and community development that sets the priorities for 2003-2008 and represents a partnership between key stakeholders in mental health. The roles and responsibilities among government entities is complex and accomplishing an outcome may be dependant on those entities working together as well as with service providers, consumers and carers* [6].

The overall objective of this evaluation is to review whether Australia has continued to pursue and make progress implementing the objectives of the Plan, and whether the range of implemented programmes or actions has affected reform of the mental health sector. The summative evaluation considered: (i) an analysis of the strengths and limitations of the 2003-2008 Plan; (ii) whether a further Plan should be developed; and (iii) what a further Plan should contain.

The reviewers gathered information from a number of sources, including documents supplied by the Department of Health and Ageing and provider groups, consultations with representatives from Australian Government and State and Territory jurisdictions, key stakeholders and site visits. This evaluation report is not intended to be an exhaustive review of existing data, programmes or literature, since the information is available through other sources.

Concurrently with The National Mental Health Plan 2003-2008, there are a number of large-scale mental health initiatives that are being implemented, together with a number of inquiries and reports into the state of Australia's mental health system. These initiatives include the *Council of Australian Governments National Action Plan on Mental Health (2006-2011)* (COAG), *National Depression Initiative (beyondblue).* Key Inquiries and reports include the 2005 Senate Select Committee Inquiry into Mental Health Services, which culminated in a comprehensive report "From Crisis to Community" and the Mental Health Council of Australia's *Not for Service Report (2005).*

The initiatives under the COAG Plan, *beyondblue* and other initiatives all seemed to have been informed by the National Mental Health Strategy and the National Mental Health Plans. The consensus is that COAG attempts to build on the positive aspects of the national mental health plans, while addressing key remaining service gaps.

The National Mental Health Plan 2003-2008 is seen by many as having an aspirational quality and as such, was helpful in sustaining a momentum of the reform of mental health services delivery started in the early 1990's and provided an important 'point of reference' as States and Territories developed their plans and programmes. It also gives consumers, carers and advocates a common ground for pressing for changes in mental health policy and planning.

The frustration expressed in the interviews included that the current Plan did not give specific guidance towards actionable and measurable items. Many of those interviewed viewed the Plan as somewhat too broad by trying to 'be all things to all people' and indicated that the Key Directions or Outcomes could not be identified as accomplished, since the actions required were not clearly defined.

The four priority themes of the current Plan provide a broad framework that guides the activities. The evaluation review and responses considered the four themes, which are:

- Promoting mental health and preventing mental health problems and mental illness
- Improving service responsiveness
- Strengthening quality
- Fostering research, innovation and sustainability

Promoting mental health and preventing mental health problems and mental illness

- The widespread consensus is that there has been an increased level of awareness around promoting mental health and specific mental health problems primarily around depression.
- Early intervention is a key component of the COAG Action Plan. As part of the implementation of the COAG Action Plan, specific intervention programmes were developed and implemented.

- The attitudes of the public and providers still had not changed to any great degree when it came to the stigma associated with people with serious mental illnesses, such as schizophrenia and bi-polar disorder.

Improving service responsiveness

- The recently developed guidelines and principles around care coordination have been generally accepted by all jurisdictions, with Reference groups through the COAG Action Plan being established to track progress on care coordination initiatives.
- Several jurisdictions have worked to develop an integrated system of service with a range of entities that typically interact with consumers and carers, including law enforcement, legal services, emergency services and substance use treatment services.
- There are efforts to increase service capacity outside the normal business hours through protocols and memorandums of understanding to address the needs of people with mental illness and mental health problems.
- New methods using technology are being used to serve those in rural areas, including evidence-based telephone, web-based counselling services and expanded and enhanced interactive on-line tools.
- The *Mental Health Services in Rural and Remote Areas* initiative intends to increase funding of mental health services in rural and remote areas based on need rather than a per capita basis to States and Territories.
- Stakeholders and providers expressed the need to continue to work toward a 'seamless' continuum of care for the consumer.
- The recruitment and retention issues in the mental health workforce pose the major challenge to the mental health system of care progressing towards reform.

Strengthening quality

- The 1996 National Standards for Mental Health Services continues to provide a framework for continuous quality improvement and implementation is occurring in the private sector, which will lead to a consistent standard of care and expected care throughout the Australian mental health system.
- There are a number of initiatives, which support strengthening the quality of care through data collection and review for persons with mental health problems and mental illness.
- The Plan informs the development of initiatives targeted toward the indigenous population, but there are several factors continuing to inhibit progress, including the lack of a professional workforce coming from those populations, the remote locations of some groups, and lack of general practitioners to provide care.
- There is support for moving in the direction of all services operating under the 'No Wrong Door' philosophy in order to effectively address the needs of people with co-occurring and mental health and substance use disorders

- The first priority of the *National Safety Priorities in Mental Health* is the development of national demonstration sites to reduce/eliminate the use of seclusion and restraint in in-patient psychiatric units. While there are sites that exhibit significant progress in reducing seclusion and restraint, such an approach does not yet appear to be systemic.
- As more consumers and carers are empowered to speak out and participate in the decision making process, expectations for participation increase. In general, it was the view of many consumers and carers we met that they had less sense of ownership of the current Plan as compared to the previous two Plans.

Fostering research, innovation and sustainability

- There are several examples of innovative initiatives and programmes, which reflect a reformed system of mental health services in Australia.
- The Commonwealth government is investing funds to monitor mental health and the outcomes of care, including the National Health and Medical Research Council (NHMRC).
- The results of the Second National Survey of Mental Health and Wellbeing in 2007 will provide data around the prevalence of mental health problems and utilization of services enabling comparisons with data collected in 1996.
- The COAG plan provides a valuable precedent for the whole of government approach that will be necessary in the implementation of future national mental health plans.
- The results of mental health services studies underway will be used to develop and further sustain existing innovative programmes that support mental health care across the life span.
- Most states and territories gather data on the consumer and carer perceptions as part of the overall assessment of care.
- The private sector also has mechanisms in place to monitor and report on the views of the consumers and carers.
- The research agenda is not clearly defined or prioritised. Without a prioritised research agenda, many research results are not connected in a meaningful way regarding the effectiveness of services and the emergence of evidence based practices.

There is an overwhelming consensus that a current National Mental Health Plan is necessary to maintain and focus momentum for ensuring ongoing reform of mental health care throughout Australia. However, a current Plan should provide clarification on the structure of the National Mental Health Strategy, Policy and Plan in the context of recent developments involving the Council of Australian Governments and the whole of government focus on mental health issues. Consideration should be given to developing a further plan that identifies measurable strategic priorities for action.

The Commonwealth and the States & Territories indicated that it would be helpful if the consultants prioritised the specific recommendations of this report in relation to importance of implementation.

The challenges of limited resources, of States and Territories being at varied stages of progress in implementing Plans 1, 2 and 3, and of attaining alignment of effort among many entities, makes prioritising the specific recommendations of a further National Plan essential to advancing the long-term aims of the National Mental Health Strategy.

The Commonwealth, States & Territories, stakeholders, consumers and carers are to be commended for investing, supporting, defining, pushing and pulling a mental health system forward toward reform. The vision for good mental health is defined in the National Mental Health Plan, 2003 – 2008 as *fundamental to the well-being of individuals, their families, and the whole population. Conversely, mental health problems and mental illness are among the greatest causes of disability, diminished quality of life, and reduced productivity. People affected by mental health problems often have higher rates of morbidity and mortality, experiencing poorer general health and high rates of death by suicide. These conditions are significant in terms of prevalence and disease burden, and have far-reaching impacts for families, carers and others in the community. Mental Health should be understood within a population health framework that takes into account the complex influences on mental health, encourages a holistic approach to improving mental health and well-being, and develops evidence-based interventions that meet the identified needs of population groups and span the spectrum from prevention to recovery and relapse prevention* [6].

The vision reflects the ultimate outcomes, which should be the result of the efforts of all parties of the mental health system to realise reform. The commitment to achieving this reform clearly exists. The goal of this summative evaluation is to help assess the current status of the efforts and give guidance to the pathways forward.

2 Terms of reference

2.1 The terms of reference of the summative evaluation are given as follows.

- The overall objectives of the summative evaluation will be to review whether Australia has continued to pursue and make progress implementing the objectives of the Plan, and whether the range of implemented programmes or actions has affected reform of the mental health sector. In addition, the summative evaluation will comment on whether the processes of reform were the most appropriate for meeting the objectives of the Plan.

2.2 The Plan will be evaluated against four evaluation focus areas and two additional themes that are detailed in Appendix 1. In addition, the consultants will provide:

- specific advice on the suitability of the Plan as a framework for mental health reform in Australia
- recommendations and directions for a possible fourth year mental health plan for the 2008-2013 period.

3 Background and contextual overview

3.1 At the national level the approach to achieving better mental health is framed by:

3.1.1 ***The Mental Health Strategy*** that comprises the:

- National Mental Health Policy;[1]
- National Mental Health Plans;[5;6;7] and
- *Mental Health Statement of Rights and Responsibilities.*

The overarching objectives of the National Mental Health Strategy are to:

- Promote the mental health of the Australian community
- To, where possible, prevent the development of mental disorder
- Reduce the impact of mental disorders on individuals, families and the community
- Assure the rights of people with mental illness.

Recent national mental health reform has been informed by a number of key reports, including: the Senate Select Committee on Mental Health: a national approach to mental health – *From Crisis To Community*[2;3], which in its main findings investigates a number of concerns related to mental health services, and which in its final report sets out 91 recommendations to improve mental health care. The Mental Health Council of Australia's *Not for Service Report (2005)* which reflected the outcomes of a broad national consultation process significantly raised the profile of mental health issues in Australia.

Importantly, the *Australia Health Care Agreements* set out the Australian Government's financial commitment to the provision of public hospital services in each State, and in return, the commitments and obligations of the States and Territories to provide these services. State and Territory Governments are required to at least match the rate of growth in the Australian Government's funding, uphold the Medicare principles, and meet certain deadlines and standards in reporting and performance information[4]. Some jurisdictions have significantly increased investments in mental health since the endorsement of the COAG Action Plan in 2006.

3.1.2 ***The National Mental Health Policy*** was agreed by Australian Health Ministers of the Commonwealth, States and Territories in April 1992, and sets out an overall framework for 'the change in the pattern of mental health care from an institutional to a community orientated approach.' This policy is currently under revision[1].

3.1.3 ***The National Mental Health Plans***, intended as implementation guides for National Policy:

- First Plan: 1993-1998[5]
- Second Plan: 1998-2003[7]
- Third and current Plan: 2003-2008[6;8]

The current Mental Health Plan is supported by a number of other specific plans that underpin certain aspects of mental health including the Multicultural Plan, Safety Plan, Information Plan, Promotion, Prevention and Early Intervention Plan.

3.2 At the State and Territory Level, a range of mental health policy documents guide the detailed planning and implementation of services.

3.3 In 2006 the ***Council of Australian Governments (COAG)*** endorsed a new National Action Plan on Mental Health 2006-2011 (the COAG Action Plan), which 'provides a strategic framework that emphasises co-ordination and collaboration between government, private and non-government providers, in order to deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community.[9]

The four specific outcomes to be achieved from the COAG Action Plan, consistent with the broad objectives of the Mental Health Strategy, are:

- reducing the prevalence and severity of mental illness in Australia;
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;
- increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

Importantly, the implementation of this plan draws upon additional and significant financial commitments from both the Commonwealth and the State and Territories. The COAG Action plan also represents a 'whole of government' approach and involves commitments from the Premiers of the States and Territories and all those Ministries (Commonwealth and States and Territories) that have an impact upon the treatment interventions and services, which are needed to support individuals with mental illnesses in the community [9].

Key elements in this plan include 'greater focus on promotion, prevention and early intervention; improved access to mental health services, including in Indigenous and rural communities; more stable accommodation and support; and meaningful participation in recreational, social, employment and other activities in the community. Improving the care system will involve a focus on better coordinated care and building workforce capacity.[9]

4 Methodology used in the summative evaluation

4.1 Document Review

The consultants reviewed a range of documents sent in advance by the Department of Health and Ageing. Those documents included the following:

- National Mental Health Plan 2003 -2008[6]
- National Mental Health Working Group. Implementation Plan for the National Mental Health Plan 2003-2008 [10]
- National Mental Health Plan 1998-2002[7]
- National Mental Health Plan 1998-2002, Midterm review[11]
- National Mental Health Plan 1998-2002, Evaluation[12]
- Implementation Plan for the National Mental Health Plan 2003-2008, Monitoring Report[8]
- National Mental Health Report 2005[13]
- COAG National Action Plan on Mental Health 2006-2011[9]
- National Mental Health Policy 1992[1]
- National Suicide Prevention Strategy – National Evaluation 2006[14]
- Senate Select Committee Inquiry into Mental Health 'From Crisis to Community Report'[15]
- Senate Select Committee on Mental Health. A National Approach to Mental Health - from Crisis to Community: Final Report[3]
- Mental Health Council of Australia report 'Time for Service'[16]
- Mental Health Council of Australia report 'Smart Service'[17]
- Australian Health Ministers Advisory Council. National Safety Priorities in Mental Health: a National Plan for Reducing Harm. Canberra: Commonwealth of Australia; 2005[18]

A detailed list of all the documents reviewed can be found in Appendix 7.2. This Summative Evaluation therefore needs to be considered within the wider text of the developments prior to the Third National Mental Health Plan, and in relation to other current related policies and initiatives. The information derived from the documents is not outlined separately in this evaluation report; rather it is included in relevant areas throughout the document.

4.2 Targeted Consultations

From August 16th-24th the consultants held a series of targeted consultation meetings in Canberra, Hobart, Melbourne and Sydney. The meetings were held with representatives from Australian Government and State and Territory jurisdictions, key stakeholders. Several sites visits were also undertaken, including visits to mental health services in ACT, New South Wales, Tasmania and Victoria. The purpose of these meetings was to gauge and analyse the views of the stakeholders on the effectiveness and appropriateness of the initiatives taken under the 2003-2008 Plan. A total of over 90 individuals were consulted directly, with their comments received on a non-attributable basis, and a series of further briefing documents were received from stakeholders.

4.3 Findings

This summative evaluation presents the key themes arising from these stakeholders in terms of:

(i) an analysis of the strengths and limitations of the 2003-2008 Plan;
(ii) whether a further Plan should be developed; and
(iii) what a further Plan should contain.

On some of the key evaluation issues addressed, from among the very wide range of stakeholders consulted, there were a few views that could be considered as 'outliers'. Nevertheless, the reviewers found a high level of consensus for the large majority of the questions addressed, and the points included in relation to the evaluation of the current National Mental Health Plan, and proposals for a further National Mental Health Plan include only those considerations that do attract a high level of support from across the range of stakeholders consulted.

5 Evaluation of the National Mental Health Plan 2003-2008

5.1 Analysis of the information obtained during the consultation phase

There was a clear consensus among those interviewed that the current Plan was important in continuing the progress made since the establishment of the National Mental Health Strategy in 1992 and the implementation of the first two National Plans[5;7]. There was widespread agreement that the aims of the National Mental Health Strategy, which were reiterated as a guide to the current Plan[6], were still appropriate and relevant. These aims are:

- To promote the mental health of the Australian community
- To, where possible, prevent the development of mental disorder
- To reduce the impact of mental disorder on individuals, families and the community
- To assure the rights of people with mental disorder

There was also overwhelming support for the principles outlined in the Plan, as they continued to be viewed as 'fundamental to realising the aims'. All the principles outlined in the Plan were mentioned as being essential to on-going reforms in mental health service delivery. Those principles included:

- assuring access to timely and effective services regardless of geography;
- consumer, family and carer participation at all levels of the mental health services system delivery (including policy development, National and State planning and individual treatment/recovery plans);
- ensuring the quality and safety of mental health care;
- a recovery orientation should drive service delivery;
- investment in the workforce is essential;
- innovation must be strongly supported and encouraged;
- sustainability of effective (evidence based) interventions must be ensured;
- resources for mental health must recognise the impact of mental health problems and mental illnesses;
- mental health reforms require a whole-of government approach.

A range of interviewees commented that the ***current National Plan provided an important 'point of reference'*** as States and Territories developed their plans and programmes. It also gives consumers, carers and advocates a common ground for pressing for changes in mental health policy and planning.

The current Plan was viewed by many as having an 'aspirational' quality and as such, was helpful in sustaining a momentum of the reform of mental health services delivery started in the early 1990's[19].

It was quite apparent that the ***concept of 'recovery'*** to frame public policy, to shape services and service delivery and to develop outcome measures is having a major impact on the discussions being held by the Commonwealth, the States and Territories, consumers, carers, advocates and both public and private providers[20]. The current Plan with its emphasis on recovery and consumer/carer participation was seen as essential in moving the recovery approach forward.

The current National Mental Health Plan needs to be evaluated in the context of a number of large-scale developments and programs, including the *Council of Australian Governments National Action Plan on Mental Health (2006-2011)* (COAG)[9], *National Depression Initiative* (*beyondblue*[21-23]). In addition, in 2005, a Senate Mental Health Inquiry was conducted and a further Senate Inquiry into mental health services is currently underway. [3;15]. The consultants noted that the COAG Plan[9], *beyondblue* and other initiatives all seemed to have been informed by the Mental Health Policy, including each of the five year the National Mental Health Plans.

The COAG Plan is a 'whole of government' approach and represents the potential to move forward with a structure, which includes all the programmes and portfolio areas that affect the lives of people with mental illness and children with serious emotional disturbances[9]. The current Plan, as with the previous plans, is primarily a Health Ministers' (Australian Health Ministers Conference) plan. Historically, it has been difficult to foster a 'whole of government' approach. The consensus is that COAG attempts to build on the positive aspects of the national mental health plans while at the same time attempts to address any weaknesses.

The COAG plan is in the early stages of implementation and as the implementation moves forward, its funded services will need to be further integrated into the existing service delivery system. There is a shared view among stakeholders that the continued focus will improve the mental health system and offer better life outcomes for all Australians with mental health problems and mental illness. In an important sense, therefore, the COAG plan provides an invaluable precedent for the type and degree of cross-governmental collaboration (including all relevant ministries) that will be necessary to successfully implement future national mental health plans.

5.2 Comment on progress and effectiveness of Plan against evaluation focus areas

The four priority themes, which provided a broad framework, were embraced by the majority interviewed as appropriate to guiding the activities of the Plan. Those four priority themes are:

- Promoting mental health and preventing mental health problems and mental illness
- Improving service responsiveness

- Strengthening quality
- Fostering research, innovation and sustainability

5.2.1 Promoting mental health and preventing mental health problems and mental illness.

The widespread consensus is that there has been an ***increased level of awareness*** around promoting mental health and specific mental health problems. A significant contributor to this awareness at a national level is the bipartisan initiative, *beyondblue* which is funded by the Commonwealth and State and Territory governments, to address issues associated with depression, anxiety and related substance abuse disorders. *beyondblue* and its partners, including governments, schools, and community organisations is a model in raising awareness and reducing stigma.

The initiative, through independent evaluation, has demonstrated that the stigma associated with depression is declining and people are seeking treatment at higher rates. Other initiatives or publications mentioned were, *Alerting the Community Links between Illicit Drugs and Mental Health Illness campaign,* the *Guide to Help Reach People at Risk of Suicide, Autism Spectrum Disorder, Improving Mental Health Wellbeing* in New South Wales, *The Partnership for Healthy Communities* in Queensland, *The Plan for Action 2005-2007 Promoting Mental Health and Wellbeing* in Victoria and ACT *Action Plan for Mental Health Promotion, Prevention and Early Intervention.*

Funded by the Australian Government, the Australian Rotary Health Research Fund (ARHRF) is involved in another important mental health awareness campaign through Rotary clubs and radio and television community service announcements. The campaign has a number of aims, including increasing community understanding of mental illness; reducing stigma directed towards persons with a mental illness and their carers; and encouraging people with a mental health problem or illness to seek help.

MindMatters was highlighted during the interviews as a curriculum taught in secondary schools promoting student mental health, well-being and resiliency. Evaluations conducted during the Plan's implementation generally concluded that *MindMatters* has been positively effective in influencing the attitudes and behaviour of students toward mental health issues. *MindMatters* was recognised by schools as enhancing the effectiveness of anti-bullying programmes and resiliency building approaches.

This programme was cited as an example of one that involves more of a 'whole of government' approach that promotes awareness and helps in the prevention of mental problems.[24] All states and territories have implemented evidence based prevention and early intervention programs, e.g. Western Australia's *YouthReach Service and* New South Wales' *MindMatters.*

There was a consensus among stakeholders that a concerted effort is needed to address societal attitudes toward people with serious mental illnesses. While the above initiatives were viewed as helpful and effective especially in regard to high prevalence disorders, the attitudes of the public and providers still had not changed to any great degree when it came to the stigma associated with people with serious mental illnesses, such as schizophrenia and bi-polar disorder.

Early intervention is a key component of the COAG Action Plan[9]. As part of the implementation of the Action Plan, specific intervention programmes were introduced, including the New Early Intervention Services for Parents, Children and Young People and the Better Access Initiative[25]. The Medicare Benefits Schedule data used by the Department of Health and Ageing to monitor uptake and spread of MBS funded services indicate that in the twelve months since the introduction of the new Medicare items, more than 2.2 million episodes of mental health care have been subsidised by Medicare. In addition, the Australian government published in 2006: *Pathways of Recovery: 4As Framework for preventing further episode of mental illness, Pathways of Recovery: Preventing Further Episodes of Mental Illness (Monograph), Pathways of Recovery: Report of the National Consultation on Preventing Further Episodes of Mental Illness.*

5.2.2 Improving service responsiveness

Approximately $3.9 billion was spent on mental health services across Commonwealth and State and Territory Governments in 2005. Approximately $4 billion was attached to the COAG Action Plan over five years, and around $400 million has been allocated through the current Australian Health Care Agreements for national mental health reform activities. This funding is providing increased access to a more integrated service system nationally. For example, several jurisdictions have worked to develop an integrated system of service with other services that may interact with mental health clients, including law enforcement, legal services, emergency services and substance use services.

The reviewers had the opportunity to meet with several entities that provide services to consumers outside the traditional mental health system in Tasmania. Similar developments are occurring in all other jurisdictions. Jurisdictions are also working to increase service capacity outside the normal business hours through protocols and memorandums of understanding to cater for people with mental illness, including emergency services and those that offer 24-hour access.

A general concern expressed was that although several NGO's were mentioned as operating at a high level, others do not yet have the operating capacity needed to address local needs. Efforts are underway in various parts of Australia to strengthen the provider base of the mental health service delivery system. Governments are beginning to address the NGO service capacity issue, with New South Wales committing an additional $4 million to mental health services and the Australian Government recently announcing $6 million to increase provider capacity nationwide.

The recently developed guidelines and principles for care coordination have been generally accepted by all jurisdictions and reference groups have been established to progress care coordination initiatives in each States and Territory. Stakeholders and providers expressed the need to ***work together to establish a 'seamless' continuum of care*** for the consumer. The reviewers were able to visit a programme in Victoria, where a State provider and an NGO were working together to provide services to consumers in an integrated manner. The providers shared a facility and collaborated at the direct care level. It is understood that a similar program operates in Western Australia.

5.2.3 Strengthening quality

The 1996 National Standards for Mental Health Services continues to provide a framework for continuous quality improvement and is currently under review to ensure that the Standards remain current and relevant. The implementation of the Standards is also occurring in the private sector, which will lead to a consistent standard of care and expected care throughout the system. The current Plan is seen as a reference point for the States and Territories and in their service planning processes. The comments to the interviewers were clear regarding the focus of the National Plans in several quality areas and the Principles in the First and Second Plans have created continuity to the implementation of the current Plan.

There are ***a number of national initiatives, which support strengthening the quality of care*** through data collection and review for persons with mental health problems and mental illness, including National Minimum Data Sets, the National Outcome and Casemix Collection, the Australia Mental Health Outcomes and Classification Network, and the Centralised Data Management Service for the Private Mental Health Alliance[20]. A concern expressed was that there are duplicate efforts in the data being collected and whether the data collected is relevant in measuring appropriate outcomes. The consultants suggest that the data collected and analysed needs to be able to inform decision-making, such as the connection between practice, treatment, intervention and research.

Regarding the specific needs of various populations groups, initiatives supporting the objectives of the current Plan have been implemented, including the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Well Being 2004-2009*[26]. The consensus among those interviewed is that the current Plan informs the development of initiatives targeted at special populations, but there are several factors continuing to inhibit progress. Among the factors cited is the lack of a professional workforce coming from those populations, the remote locations of some groups, and lack of general practitioners to provide care.

There is a general impression that the development of accreditation standards is progressing, but the issues around the workforce are adversely affecting the quality of service and service delivery.

The system of mental health care throughout Australia was described as facing a serious challenge because of the ***ongoing workforce development issues*** facing Australia and other nations. These issues include a consistent impression among stakeholders that more mental health professionals are leaving the field (due to retirements and other factors) than entering the field. Consumers, carers and government officials all described a concern around the appropriate training of direct care staff in the principles of recovery and in evidence-based practices. In addition, there is a perception that professional schools and academia are not keeping pace with the new knowledge around interventions that facilitate recovery.

Stakeholders generally agree that little progress has been made in ***systemically addressing the needs of people with co-occurring disorders***. Mental health and substance abuse services are still typically delivered in a separate 'siloed' manner. There was strong support for moving in the direction of all services operating under the 'No Wrong Door' philosophy. There is also an effort on the part of the State and Territories to better integrate mental health and drug and alcohol services to address the needs of individuals with co-occurring disorders.

It was also evident that the ***reduction and elimination of seclusion and restraint*** measures are addressed in inpatient and residential settings as a part of the Third Plan. The Australian Government has committed approximately $2.7 million towards addressing the first priority of the *National Safety Priorities in Mental Health*: the development of national demonstration sites to reduce/eliminate the use of seclusion and restraint in in-patient psychiatric units. While there are sites that exhibit progress in reducing seclusion and restraint, such an approach does not yet appear to be systemic. For example, seclusion rooms are still being built in new facilities.

The current National Mental Health Plan gives consumers, carers and advocates a 'point of reference' for establishing the 'common ground' in pressing for continued reform. It was clear from comments made by consumer and carer representatives that consumer participation at all levels of the mental health system (Commonwealth policy, State & Territorial policy, programme development and individual treatment/recovery plans) has increased over the course of implementation of the three National Plans. Consumers and carers are involved in peak bodies and a number of initiatives, including the revision of the *National Mental Health Policy*[1].

Consumers, carers and the broader range of stakeholders also stated that consumers and carers felt disengaged in the development of the current National Plan. It was evident that efforts were made, especially through the structure of the Mental Health Council of Australia, to gain a consumer and carer perspective. The Council was established and funded by the Commonwealth government, in part, to facilitate a unified message to the Commonwealth government from all mental health stakeholders.

It was thought stakeholders having 'one voice' would facilitate more efficient and effective communication to government officials. The Consumer & Carer Forum was established by the then Mental Health Working Group to develop a new pathway of consumer and carer communication and influence and was found to be helpful in facilitating further direct consumer care and communication.

However, as more consumers and carers are empowered to speak out and participate in the decision making process, expectations for participation increase. In general, it was the view of several consumers and carers that they had less sense of ownership of the current Plan as compared to the previous two Plans. All levels of government need to ***develop more and varied structures of gaining consumer and carer 'voices'***, as those perspectives continue to evolve.

5.2.4 Fostering research, innovation and sustainability

According to those interviewed, the Commonwealth is viewed as having clear responsibility for setting the national mental health agenda and for developing and advancing research and evaluation for mental health services. There are several areas where the Commonwealth government is investing funds to monitor mental health and the outcomes of care[20], including the National Health and Medical Research Council (NHMRC). The results of the Second National Survey of Mental Health and Wellbeing in 2007 will provide data around the prevalence of mental health problems and utilisation of services. All jurisdictions collect and provide input to national data collections to monitor performance across services and governments.

On a national level, there are twenty-three organisations participating in forums involved in benchmarking mental health services and enable comparisons with data collected previously in 1996. The results of these studies can be used to develop and further sustain existing innovative programmes that support mental health care across the life span[17]. Most states and territories gather data on the consumer and carer perceptions as part of the overall assessment of care. The private sector also has mechanisms in place to monitor and report on the views of the consumers and carers.

While there will be new data available from a variety of activities presently underway, a comment often heard in the interviews was that ***the research agenda is not clearly defined or prioritised***. One example is that various academic and research institutes carry out funded research projects and each having its own mission and agenda. Without a prioritised research agenda, many research results are not connected in a meaningful way to give a comprehensive picture of services effectiveness and the emergence of evidence based practices. What this means in practice is a mechanism to direct resources to applied mental health research in order to achieve treatment and service improvements over, for example, a five year time-frame.

There was a need expressed for a more ***'user friendly' way to access information*** for mental health research findings, programme evaluation results and documented evidence based practices. Several stakeholders indicated that easy access (web based) to such information would be helpful in disseminating information to the front lines of service and enabling consumers and carers to pursue information for self care and recovery plan development (see Section 6.7). Consideration should be given to how this need might be addressed through various collaborations, technological approaches and other potential models for knowledge dissemination.

5.3 Effect of implemented programmes on reform of the mental health sector

There are several examples of innovative initiatives and interventions, which reflect movement toward a reformed system of mental health services. Those initiatives/programmes include, but are not limited to:

- Australia Central Territory's Belconnen Adult Community Mental Health Teams' model of programmes fully integrated into community activities, e.g. arts and crafts and exercise classes
- 'Step up/step down' treatment programmes
- *Better Access* Initiative
- Mental Health Services State-wide Hotline in Tasmania
- New South Wales Housing and Accommodation Support Initiative
- Integrated co-occurring treatment programmes
- Integrated public/private service delivery
- Technology based services
- The COAG's PHAMS initiative
- Western Australia's Emergency Department mental health liaison nurses and on-duty registrars
- Primary Mental Health and Early Interventions Teams in Victoria
- Seclusion and restraint elimination/reduction interventions
- The *Access to Allied Psychological Services* component of *Better Outcomes in Mental Health Care Programmes*, which designs services based on local needs[20]
- Continued focus on early intervention for psychosis
- Queensland's Housing and Support Program
- Better General Health for People with Mental Illness Project in ACT
- Integrated Primary and Community Care Services in New South Wales
- Supported measures leading to a continuing fall in suicide rates[18]
- Focus upon the gap between total prevalence and treated prevalence
- Support for further deinstitutionalisation and mainstreaming of in-patient care

The frustration expressed in the interviews was that the current Plan did not give specific guidance towards actionable items. Measurable targets with timeframes were not established and there were not models of care identified for priority implementation. These factors contributed to an inconsistency in applying the Plan in a systemic way. The Plan was criticised for being too aspirational and much like a policy document, rather than an action-oriented plan. Many of those interviewed viewed ***The Plan as exceedingly broad by trying to 'be all things to all people'***.

5.4 Mental health workforce

There was a strong and widely held view that the challenges in relation to mental health workforce pose a major obstacle to a reformed mental health system of care. We understand that:

- recruiting and retaining staff to rural and remote areas remains a challenge;
- insufficient information is currently available about the current distribution of State, NGO, private hospital, and private practice mental health resources, and that areas of greatest need should be identified;[13]

- best practice should be identified in terms of recruiting, training, rewarding, retaining staff;
- it is important to consult with staff in determining what elements of a remuneration package are most important to staff;
- There is often insufficient clarity about some staff roles, for example case managers, within a given service setting.
- Mental health workforce challenges are further compounded by an ageing mental health workforce, in particular mental health nurses.

These issues are addressed in the recommendations set out in Section 6.2.

5.5 Underserved groups

While most of our consultations concerned the provision of mental health services to the whole Australian population, there is widespread concern that particular groups are currently seriously underserved. Groups identified include children and adolescents, culturally and linguistically diverse populations, Indigenous people, people with mental illness who are incarcerated; and people with comorbid substance abuse and mental health disorders.

5.5.1 Indigenous mental health

One of the challenges cited is ***the delivery of services to indigenous people living in rural and remote areas***. Recognising that a there are a broad range of challenges for Indigenous people in accessing culturally appropriate services in urban and metropolitan areas, there are particular challenges in delivering appropriate mental health services for Indigenous people in rural and remote areas. The *Mental Health Services in Rural and Remote Areas* initiative intends to increase funding of mental health services in rural and remote areas based on need rather than a per capita basis to States and Territories.

In addition, new methods utilising technology are being used and considered to provide care, including evidence-based telephone, web-based counselling services and expanded and enhanced interactive on-line tools. The evaluators were not able to conduct any on-site evaluations in remote areas where indigenous people reside, nor to undertake a review of the relevant health indicators, in order to determine if progress is made in developing access to, and uptake of, care to the indigenous populations.

Australia is not alone in needing to address this ongoing challenge of providing access to care to indigenous and remote populations. Other nations, such as Canada and the United States face similar challenges in geography and workforce capacity to meet the mental health needs of indigenous people. Ongoing efforts need to continue to provide for the needs of these high-risk populations, and to evaluate the impact of on-going mental health treatment approaches.

The Aboriginal and Torres Strait Islander Health Performance Framework 2005[26] provides the basis for quantitative measurement of the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health. It shows that 'Aboriginal and Torres Strait Islander peoples experience higher rates of both social and emotional well-being problems and some mental disorders than other Australians.'

The Australian Health Ministers' Advisory Council, 2006, *Aboriginal and Torres Strait Islander Health Performance Framework Report*[26] indicates that Aboriginal and Torres Strait Islander peoples have higher levels of acute morbidity and mortality from mental illness, assault, self-harm and suicide than other Australians. The report states, for example, that 'Some specific mental health conditions were more frequent for Aboriginal and Torres Strait Islander peoples, particularly alcohol abuse (2.6 times higher), drug abuse (2.2 times higher), and schizophrenia (1.6 times higher) Aboriginal and Torres Strait Islander peoples were hospitalised for mental and behavioural disorders at twice the rate of other Australians. Mortality rates were also twice as high.' We therefore make proposals in relation to indigenous mental health in Section 6.6.1.

5.5.2 Mental health of prisoners

We have learned that about 10% of prisoners have a psychotic disorder, up to 70% of prisoners have substance abuse disorders and that approximately 50% of prisoners have co-occurring substance use and mental health disorders. Our consultations also informed us that there are considerable variations in the quantity and quality of mental health care provided to prisoners. We conclude that more needs to be done in relation to prisoners with mental illness, and our recommendations are set out in Section 6.6.2.

5.5.3 ***Co-occurring ('dual diagnosis') disorders i.e. psychotic disorders with concurrent substance misuse/dependency***

We heard a widespread consensus that people with such multiple disorders are relatively poorly served by mental health and by substance use services. There is strong support for developing new models of care e.g. those based on the 'No Wrong Door' approach that signposts consumers to the right service site wherever they enter care. To achieve this there is a requirement to provide care based upon best international evidence of effective practice, and also to introduce innovative models and to evaluate their success. We therefore recommend that such initiatives are included in a Fourth National Mental Health Plan, as set out in Section 6.6.3.

6 Directions & recommendations for a possible further National Mental Health Plan

6.1 Need for a further National Mental Health Plan

In terms of the overall direction, there is an ***overwhelming consensus*** that a further National Mental Health Plan is necessary to maintain and focus momentum for better mental health care throughout Australia.

At the same time, many take the view that at the outset of a further Plan that there should be a ***clarification in the structure of the national mental health Strategy, Policy and Plan*** that realigns the policy context for the Strategy with developments through the COAG process. Further, the Plan should clearly be an Implementation Plan, with a clear focus on a small number of key actions necessary to be completed nationwide during 2008-2013.

Many groups also told us that a further Plan should not be rushed in its development, and in particular should have a strong and representative ***participation from consumer and carer stakeholder groups*** throughout the whole process. It will be important not only to utilise the Mental Health Council of Australia, but engage broadly with a wide rage of key stakeholders.

In addition, it may be useful to produce abbreviated versions of the revised Policy and further Plan to ensure it is clearly understandable to all the different ***key audiences*** and stakeholder groups.

6.2 Workforce

The challenges across the entire mental health workforce pose the greatest current challenge to the sustainability of a viable mental health system of care. A clear forward looking plan is required in the near future, which specifies the numbers of staff needed, with their defined skills and competences, up to 10 years ahead and across all sectors providing services for people with mental illness. Indeed many have told us that the provision of a sufficient ***workforce is a fundamental precondition*** for the successful implementation of a further Plan.

There is a need to ***map the current distribution*** of State, NGO, private hospital, and private practice mental health resources to identify areas of greatest need. Further, it is necessary to ***identify best practice*** to recruit/train/reward/retain staff and review evidence of what elements are most important to current and potential staff as part of a remuneration package. Among the most pressing issues in relation to the mental health professions are the following:

- For ***psychiatrists***, there is a need to understand public versus private sector pay and service package differentials, and their effects on the distribution of psychiatrists in relation to geographical and diagnostic/disability needs.

- For ***psychologists***, there has been a recent expansion of provision in private practice and some clinical teams report a loss of psychological therapists from State sector. These trends need to be measured precisely over time, along with developing methods to recruit sufficient psychological practitioners to work within the State system.

- Regarding ***mental health nurses and allied professions,*** specialist courses should be provided, ideally with sufficient financial incentives for students to undertake and complete such courses. Consideration also needs to be given to broader education and retention strategies to replace and increase the number of mental health nurses, as the average age of mental health nurses in several States and Territories is 45-50 years.

For the future provision of skills and competences across the mental health professions, we are persuaded that the following issues need to be addressed in short term:

- Clarification of key roles in relation to other case manager and direct care staff;
- Identification of effective methods for staff recruitment and retention in rural and remote areas;
- Greater provision of funded clinical placements for staff-in-training, especially in community settings, and in clinical sites in rural and remote areas, along with proper recognition and reimbursement of tuition and supervision costs;
- Plan to be developed with key partners on strengthening the workforce providing mental health care to indigenous groups, and then funded and performance managed.

The scale, urgency and trends in the issues mean that we agree with those who have told us that Australia is now experiencing a ***serious healthcare staffing challenge not unlike many other countries***. The response needed that is commensurate with these challenges should not be underestimated and we therefore recommend that in relation to any further recommended National Mental Health Plans, that a coherent ***strategy for the mental health workforce*** be developed as a priority.

6.3 Mental health awareness and anti-stigma interventions

The wider context of the achievement of the National Mental Health Plans since 1993 is the society within which care and treatment takes place, and how far mental health is seen as integral to a healthy society. There is strong evidence that many people with mental illness still experience stigma and discrimination, that in some cases is described as worse than the primary condition.

We have been very impressed by the success of Australian Commonwealth Government initiatives such as *beyondblue* and Stigma Watch (SANE), and by the promise shown by headspace, which have promoted the social inclusion of people with mental illness, as discussed in Section 5.2.1. At the same time, these efforts might in the future build upon their work so far to address differentiated population

sub-groups, for example in relation to age or ethnicity, and also extend reach of these campaigns to other diagnostic groups.

There should also be continued evaluation to assess impact of mental health awareness interventions. Work on developing a special focus on attitudes of mental health staff that promote recovery and on training staff on needs of consumers in key service organisations such as Centrelink should also be promoted with additional support 'experts by experience' for speakers bureaux and mental health awareness projects.

Other initiatives that would facilitate better awareness and anti-stigma interventions could include extending resource kits for employers that build on work to date by *beyondblue* and by developing current media tracking work to monitor how far mass media responsibly report mental health matters.

6.4 Employment

Noting that employment is not within the responsibility of Health Ministers, the provision of proper work and employment opportunities for people with mental illness emerged very clearly from the consultations as a high priority across the mental health sector. In particular, we suggest that there is an extension of consumer consultant, and peer support worker schemes which are also carefully evaluated to share learning, and that arrangements are made to implement to the required scale, successful models providing greater opportunities for people with mental illness to participate in the paid labour market.

A further whole of government approach should contain a renewed focus on workforce entry and retention, including the full application of the *Disability Discrimination Act* to people with mental illness.

6.5 Housing

The shortage of capacity and necessary range of accommodation for people with mental illness was described across all States and Territories. There are no widely agreed models of the range of necessary accommodation, including clinically supported housing for people with disabilities related to mental illness. As up to 40% of homeless people have severe mental illness, there is a need to implement plans already existing on short and longer term provision of accommodation, along with assertive treatment and care.

The actions that are necessary, emerging from our consultations include the provision of regularly updated and detailed information on the level and nature of need for supported housing. In addition, dissemination of information and evidence of best practice models on accommodation, including clear models of short term provision for homeless people with mental illness, with agreed pathways for move-on/ longer term provision and action plans with agreed targets, responsibilities, budgets, timescales and review points is recommended.

Information exchange on successful partnerships between clinical services and NGOs for the provision of supported housing, a Memoranda of Understanding between

Health and Housing Ministries on shared priorities for housing provision, and action plans which have been successfully performance managed would also be of benefit.

The consultants note that putting into practice a coherent housing plan will need to have the full participation of relevant department of government both at Commonwealth and at State and Territory levels.

6.6 Underserved groups

As noted in 5.5, there is widespread concern that particular groups are currently seriously underserved.

6.6.1 Indigenous mental health

The views received by the external consultants fully support this analysis of The Australian Health Ministers' Advisory Council, 2006, *Aboriginal and Torres Strait Islander Health Performance Framework Report*[26] (see Section 5.5.1) when it stated that the 'policy response to social and emotional well-being problems needs to be multi-dimensional, and focus not only on mental health services. It needs to involve a wide range of stakeholders including Aboriginal and Torres Strait Islander communities, the health sector, housing, education, employment and economic development, family services, crime prevention and justice.'

To support these developments it may also be useful to conduct a *review of international best practice in improving indigenous mental health* be conducted, and used to guide the formulation of a renewed and practical, consensually agreed action programme for better indigenous mental health [27].

6.6.2 Mental health of prisoners

We have learned that about 10% of prisoners have a psychotic disorder, up to 70% of prisoners have substance abuse disorders, and that approximately 50% of prisoners have co-occurring substance use/ mental health disorders. Our consultations also informed us that there are considerable variations in the quantity and quality of mental health care provided to prisoners.

We therefore recommend that a further National Mental Health Plan addresses the following issues:

- more widespread dissemination of practice innovations such as mental health courts, court assessment and diversion schemes, prison in-reach services, and post-release care co-ordination.
- active steps are taken to reorient criminal justice staff to the model of therapeutic jurisprudence.
- to inform system planning, information should be gathered nationally on the levels, nature and trends in mental illness among people in prisons.

6.6.3 Co-occurring ('dual diagnosis') disorders i.e. psychotic disorders with concurrent substance misuse/dependency

We heard a widespread consensus that people with such multiple disorders are relatively poorly served by mental health and by substance use services. There is strong support for developing new models of care e.g. those based on the 'No Wrong Door' approach that signposts consumers to the right service site wherever they enter care. To achieve this there is a requirement to provide care based upon best international evidence of effective practice, and also to introduce innovative models and to evaluate their success.

6.7 Information and evidence for better mental health

Many of those we consulted expressed a need for more clearly identified targets to be set and regularly measured at the national level, to guide and assess the performance of mental health services[13;28;29]. Such arrangements should include performance targets set in relation to reducing and eliminating seclusion and restraint incidents are seen as examples of good practice.

Regular monitoring and public reporting for both public and private hospitals and implementation of evidence-based approaches to the reduction and ultimate elimination of seclusion and restraint as part of quality improvement plans and moving towards a recovery orientation should also be considered. These targets may well also apply to private sector mental health services in Australia, which accounted for 20.8% of all mental health expenditure in 2002-3, excluding PBS, and provided about 28% of available and occupied psychiatric bed days.

The performance arrangements should also include the completion of the current revision of national standards for care providers and agreed incentives and sanctions for service providers who do/do not meet agreed standards.

A more closely specified ***performance management framework*** should include a small number of measurable national requirements framed within a national data strategy[30], consistent with the COAG Action Plan, and which focus upon the most important agreed priorities (whether framed as Key Performance Indicators, targets or benchmarks[30]). Such a system of performance measures would have the following hallmarks:

- Apply to all jurisdictions, ensuring that adequate funding is provided for the regular, complete, accurate and timely reporting, collation and publication of these data.
- Be published and compared in annual reports to track progress to the agreed targets (for example to regularly make information publicly available on a regular basis about seclusion and restraint events and rates by identified service providers).
- Over time, focus more upon system outcomes or individual consumer (life) outcomes (including consumer experience, employment, education, housing community connectedness and satisfaction, and suicide rates) rather than inputs or processes.[20]

- Be harmonised across comparator providers (e.g. public and private hospitals; State and NGO providers of care co-ordinators).
- Demonstrate simplification and better integration of current centrally collated data including the Report on Government Services, aligned with identified system and service targets.
- Track equity of service provision e.g. between urban and rural areas.
- Offer continued active support at Commonwealth and State and Territory levels to extend individual outcome assessments, and to provide these electronic data in formats useful to clinicians and to planners.[20]
- Demonstrate encouragement for a learning culture based on health service research and programme evaluation.
- New programmes would routinely include measurable targets and regular assessment of progress to targets e.g. implementation of supported employment programmes.

We also recommend there be active consideration to establishing a ***mechanism to co-ordinate and share national mental health resources, which*** includes the following important functions:

- A lexicon of key terms to reduce ambiguity and misunderstanding e.g. via consensus statements:
    - Care co-ordination (clinical or community)
    - Recovery and social inclusion
    - Early intervention
    - Occasions of service
- A very small number of central, unifying concepts for the revised National Policy e.g. social inclusion, recovery, or civic participation.
- A repository of guidelines and protocols on treatments and on recommended staffing levels in different treatment and care settings (e.g. toolkit approach).
- Evidence on effective implementation of best practice guidelines.
- Technical assistance e.g. Evidence-Based Practice for Dual Diagnosis Consumers, or positive, recovery-orientated approaches for staff.
- Information on international best practice in key areas e.g. in advancing indigenous mental health, and telemedicine.
- Information on sources of funds to support applied research and programme evaluation that will be judged by relevant criteria and not by criteria developed for basic/laboratory research.
- Co-ordinated leadership training, for individual mental health clinical and managerial staff, and for NGO staff to enhance capacity.
- A clearing house for operation information on local alliances to maximise co-ordination within districts/areas between provider organisations, teams and practitioners.

- Central resources to reflect, for example at governmental level, the shared responsibility between Commonwealth and at State/Territory levels, and across portfolios, including Health and Aging, Veterans Affairs, Employment Education and Workplace Relations, Families, Housing, Community Services and Indigenous Affairs, Human Services, and Attorney Generals.
- To all sectors the results of relevant applied research and programme evaluation that can inform planning and practice.
- The dissemination of information on best practice in staff recruitment and retention in rural and remote areas, e.g. in reimbursement packages, telemedicine techniques, rotational schemes, urban-rural mixed portfolio posts, and reward structure for continuity in post and for long service, joint clinical-academic positions.
- Distribution of best practice information on provision of mental health care to offenders, including services in prison.
- Implementation guidelines e.g. on best practice in reducing seclusion and restraint, or on respite care.
- Access to a national research register to inform all sector of research in progress, and reduce duplication of effort.
- Co-ordinated materials and information about training courses to assist the reorientation of criminal justice staff to a model of therapeutic jurisprudence
- Information and operational materials to support consumer-led methods including:
    - Self-advocacy
    - Advanced agreements
    - Decision aid tools
    - Consumer consultants
    - Chronic disease managements models

6.8 Consumer and carer participation

Regarding ***consumer and carer participation***, while we heard that some progress has been made during the current National Mental Health Plan[31], the successful further maturation of these forms of involvement can be further consolidated by ensuring clear and transparent reimbursement structures for consumer and carer participation and appropriate budget allocations and by extended employment opportunities including consumer consultants, peer support workers and advocates. Furthermore, there needs to be an overall system focus on recovery and social inclusion.

As the consumer and carer movements mature, more diverse voices and perceptions emerge, more pathways for communication needs to be developed. There is a concern that if the Commonwealth or State and Territory Governments rely on primarily one mechanism to gain a consumer perspective, plans will not have the 'buy-in' of a wide range of impacted individuals and groups.

A recognition of the expectation of participation at every stage of policy and practice planning and implementation and ensuring that there is an extended focus on the

Consumer Experience of Care surveys on a regular basis to track trends and to identify key areas for action.

6.9 A co-ordinated, whole of government approach

Our consultations revealed a broad consensus that a ***whole of government*** approach is required to deliver the cross-sector changes that we outline in this summative evaluation. In addition to health specific ministerial responsibilities, implementation of these recommendations will necessarily include the need for a clear and coordinated partnership across Governments, and their portfolios that have responsibility for aspects of services and support for people with mental illness, including areas such as housing, employment, education, social security, indigenous affairs, corrections and justice.

Without such careful inter-linkages between portfolios, it is conceivable that unanticipated ***adverse consequences*** of current arrangements may affect people with mental illness. For example, work related arrangements can lead to loss of welfare benefits for consumers 'non-compliant' with the generic work/disability capacity assessment test, or welfare related payment arrangements to carers and family members that may not sufficiently appreciate the remitting/relapsing nature of some forms of mental illness, and so lead to loss of disability related income.

A further National Mental Health Plan should recognise the importance of ministerial partnerships and shared responsibilities, together with clear lead, funding and reporting arrangements that cannot be delivered by a single portfolio area alone. This would build upon the whole of government opportunities provided by the success of the COAG Action Plan.[9;32] . We envision that putting such a 'whole of government' approach into practice will be a progressive and evolutionary process that may require commitments across Ministries.

The Australian mental health system is complex, with different levels of government and multiple sectors involved at the different planning and provider levels. Co-ordination mechanisms are therefore vital at each level. For example, potential for improved coordination should include evaluation of pilot programmes to compare models of care integration such as for dual diagnosis consumers, with results shared via the clearing house arrangements as proposed in Section 6.7.

Furthermore, early clarification on whether specified COAG funds are time limited or continuing funding streams will assist ongoing service planning.

6.10 Prioritisation of recommendations for a further Plan

That any future National Mental Health Plan include prioritised areas for action.

A criticism expressed by a range of stakeholders regarding the Third National Plan is its lack of specific direction on implementation of prioritised actions in order to realise the goals of the plan. The Commonwealth and States and Territories indicated that it would be helpful if the consultants prioritised the specific recommendations of this report in relation to importance of implementation.

The challenges of limited resources, of jurisdictions and service systems being at varied stages of progress, and of attaining alignment of effort among many entities [i.e. the Commonwealth, States and Territories, providers (public and private), advocacy groups, peak bodies, academia, professional guilds and legislative bodies, etc] make prioritising the specific recommendations of a further National Plan essential to advancing the aims of the National Mental Health Strategy.

Criteria for prioritising the actions of a further Plan should start with the question, "Does the action..."

1. address areas in the system that currently inhibit systemic change?
2. leverage resources and efforts that will promote the aims of the National Strategy in a systemic manner?
3. need to be implemented in order for other actions to be implemented or implemented more effectively?
4. build on activity from previous plans and is essential in order to assure sustained progress?
5. reflect evidence based practice or encourage the broader use of evidence-based practices, which will accelerate the opportunity for recovery and resilience building in the lives of consumers across the lifespan?

It should be noted that while the above criteria was utilised in determining how the recommendations were prioritised for planning considerations, all of the recommendations are important in order for Australia to realise its vision for mental health services and to continue progress in implementing the Strategy. In addition, a prioritisation process does not mean sequential implementation of recommendations.

Many of these recommendations need to be implemented concurrently in order for effective systemic change to be attained. Higher ranked priority actions should be considered when determining allocation of resources and developing implementation time lines.

Each recommendation of this summative evaluation is listed below in one of three priority groups. Group one includes those actions, which are considered most essential to move the National Strategy forward and are prerequisites to systemic change. The recommendations in groups two and three are still important and should be included as priorities of the fourth plan in order to realise the aims of the National Strategy.

Group One Priority Recommendations:

- 6.2 Workforce

That a Mental Health Workforce Strategy which includes current distribution and future requirements be developed.

- 6.5 Housing

That a Housing, Accommodation and Support strategy which includes current best practice and innovative models be developed.

- 6.7 Information and evidence for better mental health
  - performance management framework

That the performance of mental health services be monitored through an agreed framework of outcomes, and resources developed to allow comparison and consistency between jurisdictions and over time.

- 6.8 Consumer and carer participation

That the participation of consumers and carers be further enhanced through clear re-imbursement structures and expanded employment opportunities.

- 6.9 A coordinated whole of government approach

That the importance of a co-ordinated whole of government approach be included in future National Mental Health Plan and Policy development.

Group Two Priority Recommendations:

- 6.3 Mental health awareness and anti-stigma interventions

That the social inclusion of people with a mental illness be promoted through continued effort and evaluation of mental health awareness interventions.

- 6.4 Employment

That there be further exploration of employment opportunities for people with a mental illness including consumer consultants and peer support workers.

- 6.6.1 Indigenous mental health

That an Indigenous Mental Health action programme be formulated.

- 6.6.3 Co-occurring ('dual diagnosis') disorders

That models of care for those with concurrent mental illness and substance abuse be developed.

Group Three Priority Recommendations:

- 6.6.2 Mental health of prisoners

That the mental health needs of prisoners be recognised in the National Mental Health Plan, informed by nationally collated material.

- 6.7 Information and evidence for better mental health
  - mechanism to co-ordinate and share national mental health resources

That the performance of mental health services be monitored through an agreed framework of outcomes, and resources developed to allow comparison and consistency between jurisdictions and over time.

It is important to emphasise that the consultants view all of the recommendations as priorities based upon the review of documents, consideration of the National Mental Health Strategy, constituent interviews and the current thinking internationally on transforming mental health services delivery to a recovery orientation. For example, the recommendations regarding underserved populations (Section 6.6) are all considered important and to be of an urgent nature.

However, addressing the needs of individuals with co-occurring mental illness and substance use disorders will have a systemic impact on all populations receiving mental health services. Listing indigenous mental health in Group Two and mental health of prisoners in Group Three does not diminish the need to focus attention and resources on those two populations in order for the National Mental Health Strategy to realise its aims. In addition, strengthening services to people with co-occurring mental illness would appropriately include a focus on the indigenous populations and individuals in the prison system.

7 Conclusion

This report is a summative evaluation of Australia's National Mental Health Plan 2003 – 2008. The primary objectives of this review are to determine whether Australia and all the responsible entities have made progress implementing the objectives of the Plan, whether the process of reform began in the early 1990's has continued, recommend if a further Plan should be developed and prioritise recommendations that should be included in a further Plan.

This summative evaluation utilised the four priority themes of the Plan as a basis for the review. Those four themes are:

- Promoting mental health and preventing mental health problems and mental illness
- Improving service responsiveness
- Strengthening quality
- Fostering research, innovation and sustainability

The reviewers gathered information from a number of sources including:

- Documents supplied by the Commonwealth, States and Territories, providers, stakeholder groups and peak bodies.
- Consultations conducted throughout Australia with over 90 stakeholders.
- On-site visits to programmes located in Tasmania, Victoria, ACT and New South Wales.

This summative evaluation is not intended to be an exhaustive review of existing programmes, data or literature, as that information is available from a range of other sources. The review was conducted in the context of the implementation of a number of large-scale initiatives and inquiries including the COAG National Plan on Mental Health (2006 – 2011), headspace and *beyondblue*. Each has had an important impact on the continued reform of mental health service delivery.

It was concluded by the reviewers that significant progress has been made since the inception of the mental health reform process of the early 1990's. The concept of "recovery" is having a profound impact on the discussions around the policy development, financing and delivery of mental health services at the federal, state & territorial and local levels. Progress was noted in all four of the priority themes of the current Plan.

The current Plan provided an aspirational quality that was helpful in sustaining a momentum of reform. However, there was a consensus that the current Plan lacked a

prioritisation of activity and specificity around expected outcomes and agreed timeframes. Consumers and carers also felt less ownership of the current Plan than they had of the previous two Plans.

There was widespread support among the stakeholders interviewed that a further National Mental Health Plan is necessary to assure an acceleration of the reform process. This report includes eleven prioritised recommendations to be considered in the development of a further Plan. While the recommendations are provided in a prioritised format, the consultants feel strongly that each recommendation is important and essential to fulfilling the vision for good mental health as articulated in the current Plan.

The ongoing vision for mental health reform should also be a direct source for developing outcome measures that are needed to gauge the progress of systemic reform. Most recommendations can be implemented concurrently. The prioritisation was based upon five criteria including the systemic impact the recommendation would have and whether a recommendation would need to be implemented in order for other recommendations to be effectively put into place.

The consultants would like to thank all the stakeholders who participated in this review for their candour and insights. Again, the Commonwealth, States & Territories, consumers, carers, peak bodies, private providers and advocates should be commended for continuing to press forward for mental health reform. Working to ensure that individuals with mental health problems and mental illnesses have the opportunity for a life and full participation in society is of paramount importance.

7 Appendices

Appendix 1 Evaluation Framework for National Mental Health Plan 2003-2008

Evaluation focus area	Outcome questions: Has the Plan…
Promoting mental health and preventing mental health problems and mental illness	• Promoted mental health and improved mental health knowledge among the Australian population? • Reduced the stigma of mental disorder? • Improved early intervention for first episodes and relapses of mental disorder?
Improving service responsiveness	• Improved continuity of care, particularly across the lifespan? • Improved access to a side range of health, welfare and disability services? • Improved attitudes of service providers towards people with mental disorders? • Continued structural reform of mental health services?
Strengthening quality	• Improved service quality through monitoring and implementation of service standards? • Improved collection and analysis of mental health information? • Improved responsiveness to the specific needs of various population groups, particularly underserved groups? • Improved consumer and carer rights and participation?
Fostering research, innovation and sustainability	• Continued to prioritise mental health within the health research agenda? • Improved the sustainability of the mental health system?

Additional Themes

Service effectiveness	• Improved the quality of services to bring about a desired effect? • Improved services from a customer perspective? • Improved the effectiveness of services with limited overlap and duplication
Future plans	• Should a revised Plan be developed for the 2008-2013 period?

Appendix 2. Documents included by DOHA in the International Expert Review

- Third National Mental Health Plan 2003-2008.
- Second National Mental Health Plan 1998-2002.
- Second National Mental Health Plan 1998-2002, Midterm review.
- Second National Mental Health Plan 1998-2002, Evaluation.
- Implementation Plan for the National Mental Health Plan 2003-2008, Monitoring Report.
- National Mental Health Report 2005.
- COAG National Action Plan on Mental Health 2006-2011.
- National Mental Health Policy 1992.
- National Mental Health Statement of Rights and Responsibilities 1991.
- National Suicide Prevention Strategy – National Evaluation 2006.
- Senate Select Committee Inquiry into Mental Health "From Crisis to Community Report'.
- Palmer Inquiry- "Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau Report" (2005).
- Mental Health Council of Australia report "Time for Service".
- Mental Health Council of Australia report "Smart Service".
- Australian Institute of Health and Welfare Report "Mental Health Services in Australia 2004-2005".

Appendix 3. Consultation Itinerary

August 16

Canberra
Department of Health and Ageing Senior Executives
Mental Health, Drug Strategy and OATSIH Branch Heads
Australian Government Departments
- Families, Community Services and Indigenous Affairs
- Employment and Workforce Relations
- Centrelink
- Veterans Affairs

Australian National Council on Drugs

August 17

Canberra
Mental Health Council of Australia
Melbourne
Private Mental Health Alliance

August 20

Tasmania
TAS Health - Site visits

August 21

Melbourne
Professor Paul Mullin, Victoria Inst. of Forensic Mental Health
DHS Victoria - Site visits
Stakeholder Meeting -
- SANE Australia
- Schizophrenia Fellowship
- Australian Mental Health Consumer Network
- Association for Families and Friends of the Mentally Ill
- National Mental Health Consumer and Carer Forum

August 22

Melbourne
Mental Health State and Territory Standing Committee
beyondblue
Reference Group

August 23

Canberra
ACT Health - Site visits
Mental Health Professionals Association

August 24

Sydney
NSW Health
Professor Gavin Andrews

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