



**national  
mental  
health  
strategy**

# **National Mental Health Plan 2003–2008**

Australian Health Ministers, July 2003





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ISBN: 0 642 82327 8

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Publications Approval Number: 3329/JN7947

This document can be downloaded from the Department of Health & Ageing's Mental Health & Suicide Prevention Branch website at [www.mentalhealth.gov.au](http://www.mentalhealth.gov.au)

Suggested reference:

Australian Health Ministers. National Mental Health Plan 2003–2008. Canberra: Australian Government, 2003.



# foreword

1992 represented an historic turning point for mental health policy and service delivery in Australia. Recognising the need for a unified, dedicated reform agenda, governments in Australia came together to endorse the principles and the plan for reform under a National Mental Health Strategy.

This commitment by the Australian Government and State and Territory governments to a national framework of reform has underpinned significant change in how services are provided to people with a mental illness, their families and communities. Since the first National Mental Health Plan in 1993, the mental health system has strengthened its capacity to respond to the needs of people with mental illness through major shifts in the settings and workforce that provide care. The development of national information and research has spearheaded improved understanding of mental illness, its causes and impact at a personal, social and economic level. Significant efforts have been made to combine mental health services within the general health system and a community-based system of treatment and support.

There has also been considerable development in the emphasis in mental health care, from a focus only on treatment to consideration of prevention, early intervention, rehabilitation and recovery.

The next five years provide an important opportunity to build upon the policy platform that has been put in place so firmly over the past decade. A whole-of-government, cross-sectoral approach will put the policies into practice, improving the mental health of the Australian community, and improving the care of people with mental illness across the lifespan.

In the National Mental Health Plan 2003–2008, four priority themes are addressed through 34 outcomes. These themes emphasise mental health promotion and prevention, increasing responsiveness to consumers and carers across all mental health and related services, strengthening quality, and fostering research and innovation across the sector for sustainable programs and services.

Ultimately, the Strategy seeks to engage all members of the community in a partnership to improve the mental health of the Australian community. The 2003–2008 Plan will see partnerships with other sectors such as housing, education, welfare, justice and employment, to assist with the recovery of those experiencing mental health problems and mental illness.

In seeking to achieve these goals, all Health Ministers have committed to working together through the National Mental Health Plan 2003–2008, building on the foundations of the last decade in improving the mental health of all Australians.



The Hon. Wendy Edmond  
Chair, Australian Health Ministers' Conference 2003  
Minister for Health, Queensland  
August 2003

# introduction

## A vision for mental health

Good mental health is fundamental to the wellbeing 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 high levels of morbidity and mortality, experiencing poorer general health and higher rates of death from a range of causes, including 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.

Given our current state of knowledge, it is not reasonable to expect that everyone will experience good mental health all the time, nor that the population will ever be totally free of mental health problems and mental illness. However, all people in Australia – regardless of their age, gender, socioeconomic status, ethnicity or cultural background – have certain legitimate expectations regarding their mental health.

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 wellbeing, and develops evidence-based interventions that meet the identified needs of population groups and span the spectrum from prevention to recovery and relapse prevention.

People's day-to-day environments, including their homes, schools and workplaces, should promote mental health, and not be detrimental to it.

When a person's mental health is at risk, service systems should be equipped to intervene early. Those who do experience mental health problems and mental illness, along with their families and carers, should have timely access to a range of high-quality and effective inpatient and community services, regardless of where they live. These services should provide continuity of care, adopt a recovery orientation and promote wellness. The mental health workforce should be equipped to deliver services in a manner that is respectful and meets consumers' and carers' needs.

The mental health system should take a lifespan approach to meeting the needs of the population. It should recognise the differing experiences of consumers and carers across the lifespan from childhood to old age. The needs of children with or at risk of mental health problems and children of parents with a mental illness should be afforded the same attention as adult consumers and carers.



## Mental health, mental health problems and mental illness

Mental health is a complex domain where diverse views exist and where terms are used in different ways, which can sometimes lead to misunderstandings. The National Mental Health Plan 2003–2008 uses certain central terms in the following ways.

Mental health is a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential.<sup>1</sup> It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities.<sup>2</sup> Mental health is not simply the absence of mental illness. Its measurement is complex and there is no widely accepted measurement approach to date. The strong historical association between the terms 'mental health' and 'mental illness' has led some to prefer the term 'emotional and social wellbeing', which also accords with holistic concepts of mental health held by Aboriginal peoples and Torres Strait Islanders and some other cultural groups,<sup>3</sup> or alternatively, the term 'mental health and wellbeing'.

Mental health problems and mental illness refer to the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people. The term mental illness is synonymous with mental disorder. The term mental illness is used throughout the Plan, as it is the term preferred by many consumers. Use of the word 'illness' emphasises that people with mental illness have legitimate health care rights and needs, equivalent to those afforded to consumers of health care for physical illnesses.

A mental illness is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-IVR)<sup>4</sup> or the International Classification of Diseases, Tenth Edition (ICD-10).<sup>5</sup> These classification systems apply to a wide range of mental disorders (for the DSM-IV) and mental and physical disorders (for the ICD-10).

Not all the DSM-IV mental disorders are within the ambit of the National Mental Health Plan 2003–2008. In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and have a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their comorbidity with mental illness.

Mental health problems also interfere with a person's cognitive, emotional or social abilities, but to a lesser extent than a mental illness. Mental health problems are more common mental health complaints and include the mental ill health temporarily experienced as a reaction to life stressors. Mental health problems are less severe and of shorter duration than mental illnesses, but may develop into mental illness. The distinction between mental health problems and mental illness is not well defined and is made on the basis of severity and duration of symptoms.

Recognising that mental health and mental illness are on a continuum, the National Mental Health Plan 2003–2008 considers ways to improve mental health, as well as ways to reduce the prevalence and burden of mental health problems and mental illnesses.

The human rights of all people in Australia should be respected. Individuals should not be discriminated against in housing, law, employment or education. Mental health problems and mental illness should not be stigmatised in the media, by the general community or by mental health services themselves.

Politicians, policy-makers, planners, managers and service providers – across a range of sectors – should put mental health high on the agenda, and consumers, families and carers should be able to genuinely participate as equal partners in national, State/Territory and local decision-making that affects their quality of life.

## The National Mental Health Strategy

The National Mental Health Plan 2003–2008 builds on the work of two previous Plans. In 1992, Australian Health Ministers agreed to a National Mental Health Policy,<sup>6</sup> implemented under a five-year National Mental Health Plan.<sup>7</sup> This represented the first attempt to coordinate mental health care reform through national activities. The Plan focused on State/Territory-based public sector, specialist mental health services. It increased the emphasis on community-based care, decreased reliance on stand-alone psychiatric hospitals, and ‘mainstreamed’ acute beds into general hospitals.<sup>8</sup> At the end of 1997, Australian Health Ministers endorsed the further development of the original reform agenda under the Second National Mental Health Plan.<sup>9</sup> The Second Plan was developed within the framework of the existing National Mental Health Policy, and was designed to consolidate ongoing reform activities and expand into additional areas of focus. It built on the First Plan by adding a focus on mental health promotion and mental illness prevention, and attending to the question of how the public mental health sector could best dovetail with other sectors (e.g. private psychiatrists, general practitioners, the general health sector) and

beyond (e.g. emergency services, non-government organisations) to maximise treatment outcomes and opportunities for recovery. Whereas the First Plan focused largely on severe and disabling low-prevalence illnesses, particularly psychoses, the Second Plan expanded the emphasis to include high-prevalence illnesses such as depression and anxiety disorders.

The Policy<sup>6</sup> and the First and Second Plans were outlined in separate documents,<sup>7,9</sup> and were underpinned by the Mental Health Statement of Rights and Responsibilities.<sup>2</sup> Funding from Schedule F1 of the Medicare Agreements supported the First Plan, and Schedule B funds from the Australian Health Care Agreements assisted the implementation of the Second Plan. Together, these are known as the National Mental Health Strategy. The broad aims of the National Mental Health Strategy remain consistent. They 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

## Priority areas under the First and Second National Mental Health Plans

Priority areas under the First National Mental Health Plan were:

- ❖ Consumer rights
- ❖ The relationship between mental health services and the general health sector
- ❖ Linking mental health services with other sectors
- ❖ Service mix
- ❖ Promotion and prevention
- ❖ Primary care services
- ❖ Carers and non-governmental organisations
- ❖ Mental health workforce
- ❖ Legislation
- ❖ Research and evaluation
- ❖ Standards
- ❖ Monitoring and accountability

## Additional priority areas under the Second National Mental Health Plan were:

- ❖ Promotion and prevention
- ❖ The development of partnerships in service reform
- ❖ The quality and effectiveness of service delivery

Evaluations were undertaken at the end of each of the previous Plans. These involved a number of components, including widespread community consultation, commentary by international experts, and data from the National Mental Health Report. Together, these evaluations suggest that substantial reform has been achieved and the shape of mental health services has been irrevocably altered. The mental health system has strengthened its capacity to respond to the needs of people with mental illness by moving towards the provision of mental health care within the mainstream health system and through community care. Furthermore, the nature of the workforce providing mental health care has changed substantially: the role of primary care, which includes general practice, is acknowledged as a critical area complementing the specialist mental health workforce. The mental health agenda has been broadened from a focus on treatment to incorporating the entire spectrum of interventions, including mental health promotion, the prevention of mental health problems and mental illness, early intervention, and rehabilitation and recovery.

The complexity of the reform process has become increasingly evident. To reform, reshape and redefine mental health care in Australia is an ambitious undertaking. The first ten years of reform have seen an impressive start in terms of policy, but there is much still to be achieved in terms of implementation. The impetus for action with regard to consumer rights has moved from concern over open human rights abuses to awareness of problems of neglect. While formal mechanisms for consumer and carer participation have been put in place, these do not comprise the meaningful participation that is required. Community expectations are now higher regarding access to quality mental health care, and have moved beyond the basic hopes held at the time of the adoption of the National Mental Health Policy in 1992. Australians now expect a timely, respectful, individualised and holistic approach to their mental health care, coordinated within the mainstream health system and delivered in accord with cultural and developmental needs. There is much yet to be done in terms of funding, researching, planning, delivering and reporting on mental health care to realise this expectation.

The evaluation of the First National Mental Health Plan recommended the Second Plan. The evaluation of the Second Plan found support for the renewal of the National Mental Health Strategy, in the form of the development of a third National Mental Health Plan.

## The National Mental Health Plan 2003–2008

The National Mental Health Plan 2003–2008 consolidates the achievements of the First and Second Plans, addresses gaps identified in both, and takes the National Mental Health Strategy forward with restated and new directions. It can be viewed as an ongoing agenda for service and community development that sets priorities for 2003–2008. It represents a partnership between the key stakeholders in mental health.



# scope of the national mental health plan 2003–2008

## Renewing the National Mental Health Strategy: the policy framework

The overarching aims of the National Mental Health Strategy outlined in the previous section have not changed, and guide the National Mental Health Plan (2003–2008). The policy aims are sufficiently broad in scope to allow for the consolidation of existing reform activities and for strengthening the focus in areas of particular significance.

Like its predecessors, the Plan also encompasses the seminal principles contained in the Mental Health Statement of Rights and Responsibilities.<sup>2</sup> This embodies the values of the United Nations Resolution 98B (Resolution on the Protection of Rights of People with Mental Illness) and outlines the philosophical underpinning of the National Mental Health Strategy on civil and human rights.

As noted, the First and Second National Mental Health Plans were, in part, operationalised through Schedule F of the Medicare Agreements (1993–1998) and Schedule B of the Australian Health Care Agreements (1998–2003), respectively. These bilateral funding agreements between the Commonwealth and each State and Territory have provided crucial financial support for the Plans, and have contributed to the successful outcomes of the National Mental Health Strategy to date.

## Striking the optimal balance

The National Mental Health Plan (2003–2008) builds on the priorities of both the First and Second Plans. It consolidates existing reforms, begun under the first two Plans, which have been regarded as consistent with international best practice. At the same time, it strengthens the focus in areas of particular significance. Strong commitment to the national agenda by the Australian and State/Territory governments is necessary to capitalise on earlier achievements and to address identified priorities, so that all Australians can benefit. It recognises that some initiatives will bear fruit within the next five years, while others will lay the groundwork for achievements that may take much longer. The new Plan does not seek to specify projects to be funded within the new reform agenda, but rather to identify priority areas of work within an agreed policy framework. It also does not provide details of all the developments and initiatives that have taken place in the last decade, as these are contained in other documents.<sup>10,11</sup>

# 2



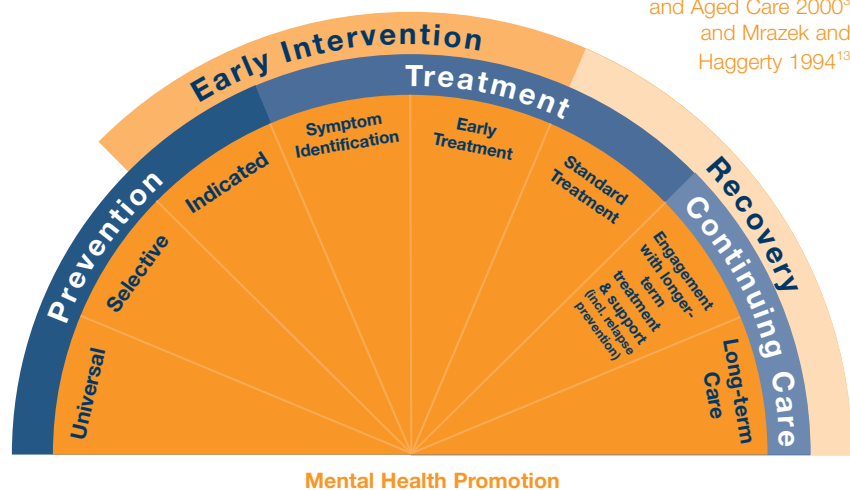
## Adopting a population health framework

The National Mental Health Plan 2003–2008 adopts a population health framework. This framework is based on an understanding that the influences on mental health occur in the events and settings of everyday life. It recognises that health and illness result from the complex interplay of biological, psychological, social, environmental and economic factors at all levels – individual, family, community, national and global. The determinants of mental health status, at the population level, comprise a range of psychosocial and environmental factors, including income, employment, poverty, education and access to community resources, as well as demographic factors. The population health framework recognises the importance of mental health issues across the lifespan, from infancy to old age, and across diverse groups within the population. It recognises the contribution of physical health to mental wellbeing and the effect of mental health on physical health. It also recognises the effect of mental illnesses occurring comorbidly with drug and alcohol problems and other conditions. The corollary of this is that a population mental health approach recognises that effective linkages must be forged with other sectors in order to achieve collaborative planning in a way that builds capacity and takes account of local needs and circumstances.<sup>3,12</sup>

The framework also stresses the importance of monitoring mental health and mental illness within populations – both at single points in time and longitudinally – in order to describe the epidemiology of given mental illnesses and to provide information to match the level and type of interventions to population needs. This recognises the importance of mental health issues across the lifespan and in those with diverse and complex needs.<sup>12</sup> This epidemiological information is crucial to determining the impact of policies and programs on rates of mental health problems and mental illness and their associated disability. In addition, it provides a picture of unmet need for services. It is essential, within a population health approach, that interventions are supported by an appropriate evidence base, and informed by ongoing monitoring and evaluation. In order for this to occur, it is necessary to develop an overarching research and evaluation agenda and to build capacity in research and evaluation at a local level.

Within the population health framework, the Plan recognises that interventions to promote mental health and reduce the impact of mental health problems and mental illness must be developed relevant to the needs of population groups. These interventions must be comprehensive, encompassing the entire spectrum of interventions from prevention to recovery and relapse prevention (see Figure 1). They should be viewed as complementary. Prevention and promotion efforts are necessary complements to, and not substitutes for, core clinical and community support services. Only a balance of interventions across the entire spectrum can meet the diverse needs of population groups and thus impact on incidence, prevalence, morbidity, mortality and other factors associated with mental health problems and mental illness.

**Figure 1.**  
Spectrum of interventions for mental health  
Source: adapted from Commonwealth Department of Health and Aged Care 2000<sup>3</sup> and Mrazek and Haggerty 1994<sup>13</sup>



## Aims

The aims of the National Mental Health Strategy remain an appropriate guide to change.

To reiterate, 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

## Principles

The following principles underpin the reform process and are fundamental to realising the above aims.

### **All people in need of mental health care should have access to timely and effective services, irrespective of where they live**

Australia's universal health care system guarantees access to basic health care (including mental health care) as a fundamental right. Individuals in need of care should not only have timely access to such care, but the services they receive should be of a quality that is at least consistent with other developed countries, if not better. Access to and quality of care should be equitable, and people should not be disadvantaged by, for example, being on a relatively low income, having particularly complex needs or living in a rural area. These principles of access and equity require governments to take responsibility for planning and regulating mental health care, providing services through a mixture of public and private delivery and financing systems.

### **The rights of consumers, and their families and carers, must shape reform**

The rights of consumers and carers in policy, planning and delivery of mental health services should be protected. Consumers, and their families and carers, should be empowered to fully and meaningfully participate at all levels, including in individual treatment plans, service delivery, planning and policy. Sometimes the approach required to address the rights of consumers and carers will be uniform across both groups. At other times, tailored approaches will be required for each group, or for subgroups within them, such as children and adolescents who either are experiencing mental health problems themselves or have a parent with a mental illness.



## **Mental health care should be responsive to the continuing and differing needs of consumers, families and carers, and communities**

Mental health care should be responsive to needs as they vary across the lifespan, recognising that the needs of children and adolescents differ from those of adults, which differ from those of older people. It should be responsive to the needs of consumers as they vary across the course of an illness. It should be culturally appropriate and safe. It should be responsive to the unique needs of specific population groups, including people who live in rural and remote communities, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and people with complex needs.

## **The quality and safety of mental health care must be ensured**

Monitoring of and accountability for the quality and safety of mental health care is essential to ensuring the rights of consumers, families and carers, and the community. Priority should be given to implementing the National Mental Health Standards,<sup>14</sup> and operationalising data collection systems that can inform decisions related to quality and safety. Furthermore, information and information systems need to be available, and outcome measures should be developed that are agreed on in consultation with all those individuals and groups likely to be affected.

## **A recovery orientation should drive service delivery**

Recovery has been defined as 'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and, or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability'<sup>15</sup>. Recovery is both a process and an outcome and is essential for promoting hope, wellbeing, and a valued sense of self-determination for people with mental illness. A recovery orientation emphasises the development of new meaning and purpose for consumers and the ability to pursue personal goals. Mental health service providers should operate within a framework that supports recovery.

## **Investment in the workforce is essential**

The nature of the workforce providing mental health care in Australia has changed substantially over the last decade. The specialist mental health sector, including public and private providers, still has a crucial role to play, but the primary care sector is now acknowledged as a critical element. In terms of professional groups, the workforce is now diverse, and includes psychiatrists, nurses, psychologists, social workers, occupational therapists, other allied health providers, general practitioners and Aboriginal and Torres Strait Islander health workers.

The supply, distribution and composition of the mental health workforce are fundamental to quality services. Not only should the overall size of the workforce match community needs, its distribution must be right. Balancing the composition of the mental health workforce is important. This should aim for an appropriate mix of medical, nursing and allied health professionals, providers from the specialist mental health sector and the primary care sector, public and private sector providers, and inpatient and community workers. These providers should represent an optimal mix of professions and skills, and should foster a team approach to service provision.

Beyond this, consideration must be given to who comprises the workforce and how the workforce is used. This requires new and innovative perspectives on who can best contribute to improving mental health.

The attitudes, knowledge and skills of the mental health workforce are also fundamental to the improvement of mental health services. A mental health workforce that actively works against stigma and discrimination is fundamental. The workforce should be prepared to work within genuine partnership models, particularly with consumers and carers. The workforce also needs to be highly skilled and knowledgeable and be able to work within a shared understanding of best practice and evidence.

Addressing workforce issues is important for the mental health of the workforce itself. It is important to strive for a workforce that is equipped to provide the services demanded of it, is not stretched beyond its capacity, and is valued by consumers, carers and the community.



### **Innovation must be strongly encouraged and supported**

There is much yet to learn about the causes and treatment of mental health problems and mental illness and the delivery of mental health care. High priority should be given to research into the aetiology of mental illness, new treatments (biological, psychological and social), and ways to reduce risks for mental health problems and increase resilience. New models of service delivery and improved interventions that are more responsive to diversity of need should also be developed and evaluated for their effectiveness and cost-effectiveness.

### **Sustainability of effective interventions must be ensured**

Approaches that are evidence-based in methodologically sound evaluations should be sustained and replicated in other settings (tailored to local need as appropriate). Conversely, approaches that are not based in evidence should not continue to be supported. This cycle of innovation, research/evaluation and sustainability will contribute to building an evidence base to inform best practice.

### **Resources for mental health must recognise the impacts of mental health problems and mental illness**

Mental health warrants a resource base that reflects the impacts of mental health problems and mental illness on individuals, their families and carers, and the community. Resources are necessary to support the reduction of these impacts, and should be related to defined need. Resources should be directed at services and interventions – across the spectrum from mental health promotion and mental illness prevention to recovery and relapse prevention – for which there is evidence of effective outcomes. Strategies to manage demand and increase service efficiency and effectiveness need to be developed.

## **Mental health reforms must occur in concert with other developments in the broader health sector**

There is a complex interplay between mental and physical health and responsibility for mental health should extend beyond the mental health sector. For example, reforms that relate to improving access to mental health services for Aboriginal and Torres Strait Islander people should be aligned with the Social and Emotional Wellbeing Framework being developed by the Social Health Reference Group, which deals with Aboriginal and Torres Strait Islander-specific services as well as general mental health services and services in other sectors.

## **Mental health reforms require a whole-of-government approach**

Improving the mental health of Australians cannot be achieved within the health sector alone. A whole-of-government approach is required which brings together a range of sectors that impact on the mental health of individuals, such as housing, education, welfare and justice. Together, these sectors have an important role to play in promoting the mental health and wellbeing of the general population, and assisting with the recovery of those experiencing mental health problems and mental illness. Partnerships with these other sectors must be fostered, in order to develop a broader, whole-of-government approach to mental health that promotes positive reforms. As an example, the mental health sector should provide targeted support to other sectors to develop mental health impact statements for given initiatives.

## **Priority themes**

### **The new Plan is guided by four priority themes:**

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



# roles, responsibilities and accountability

## Roles and responsibilities

The National Mental Health Plan (2003–2008) provides a national policy and implementation framework for a coordinated national approach to improving Australia's mental health. It represents a commitment to this framework by all Health Ministers. It recognises that a number of areas within given Australian Government and State/Territory health departments have responsibilities for mental health, and have key roles to play. In addition, it represents an acknowledgement by Health Ministers that they need to work with their counterparts in other portfolios in order to achieve the aims stated in the Plan. The policies of other sectors, such as housing, employment, justice, welfare and education, can have a significant mental health impact. Agencies responsible for promoting human rights, such as the Human Rights and Equal Opportunity Commission and State/Territory anti-discrimination authorities, also have an important role to play. This Plan is seeking to improve Australia's mental health through linkages with these other areas of public policy, including with areas aimed at promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people.

This Plan represents a commitment by the Australian Government to take forward the mental health agenda within the Federal jurisdiction. It also represents a commitment by the Australian and State/Territory governments to apply mental health funding to develop services in a manner consistent with the aims of the renewed National Mental Health Strategy.

In reaffirming a commitment to the National Mental Health Strategy, State and Territory governments undertake to:

- ∴ Work with the private and non-government sectors, and with consumers and carers, to plan for, organise, fund and either deliver or purchase a comprehensive mix of mental health services and/or programs that:
  - reflect the spectrum of care from mental health promotion and mental illness prevention to rehabilitation and recovery;
  - provide access to a range of appropriate inpatient and community services;
  - are culturally appropriate and safe; provide continuity of care across the lifespan, catering for children and adolescents, adults and older people;
  - promote access for all people in Australia; and cater for specific population groups, including people who live in rural and remote communities, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and people with complex needs
- ∴ Manage resources within mental health services and/or programs to reflect national and State/Territory policies and responsiveness to local need and circumstances
- ∴ Strengthen mechanisms to facilitate the genuine participation of consumers, families and carers in decision-making at all levels
- ∴ Ensure linkages at the State/Territory, area/regional and service delivery levels of mental health services and/or programs and other general health and community initiatives
- ∴ Provide comprehensive data on mental health service delivery and reform activities for national reporting
- ∴ Support mental health research and evaluation, with a view to developing a sound evidence base

# 3



In reaffirming a commitment to the National Mental Health Strategy, the Australian Government undertakes to:

- ∴ Finance and administer programs, consistent with Commonwealth and State/Territory funding arrangements (e.g., Medicare Benefits Schedule, Pharmaceutical Benefits Schedule, the Australian Health Care Agreements and income support payments)
- ∴ Ensure people with mental health problems and mental illness and their families and carers are not discriminated against in gaining access to health care, community support, justice, employment and training opportunities, and other programs which are the responsibility of the Australian Government
- ∴ Foster linkages with relevant national reform agendas and partnerships with national stakeholders
- ∴ Strengthen mechanisms to facilitate the genuine participation of consumers, families and carers in decision-making at all levels
- ∴ Foster the development of mental health research and evaluation, with a view to developing a sound evidence base, and disseminate information regarding good practice models of mental health service delivery
- ∴ In consultation with the States and Territories, seek to ensure an adequate supply of high-quality mental health personnel through targeted education and training development

In addition to these specific undertakings within their own jurisdictions, the Commonwealth and States/ Territories will work with each other, and with consumers, their families and carers, and the community to further the mental health agenda in Australia.

Consistent with the First and Second National Mental Health Plans, and to ensure that ongoing priority is accorded to mental health issues, a Working Group will be established which will oversee implementation of the renewed National Mental Health Strategy. The Working Group will include consumer and carer representation, and its remit will be to:

- ∴ Provide a forum to promote the renewed National Mental Health Strategy and monitor the implementation of the Plan
- ∴ Consider and make recommendation on, emerging mental health issues, and report to Health Ministers as appropriate
- ∴ Provide key stakeholder perspectives on priorities and approaches for national projects funded by the Commonwealth under the renewed National Mental Health Strategy
- ∴ Involve national stakeholders and other relevant organisations, agencies and individuals as appropriate
- ∴ Initiate action to evaluate the Plan

## Accountability

Clear and transparent accountability regarding resource use and service quality is essential. This was a major theme emerging from the evaluation of the Second National Mental Health Plan,<sup>16</sup> particularly from consultations conducted by the Mental Health Council of Australia.<sup>17</sup> Appropriate

mechanisms are required to ensure accountability for the expenditure of mental health resources, for the processes of service development, and for the achievement of outcomes. These mechanisms need to straddle sectors at both the Commonwealth and the State/Territory level, as well as at the service delivery level, and should be part of a process of continuous quality improvement.

National monitoring is important, and should occur through continued national reporting, and through independent evaluation of the Plan, described later. At the same time, States and Territories should develop their own monitoring systems, relevant to their responsibilities.

Specific and measurable indicators of achievement in each of the four priority themes identified in the Plan should be agreed on early in its life. Methods should be established whereby national and State/Territory data can be collected to inform progress against these criteria, focusing on the broad outcomes identified.

At a service delivery level, greater transparency is required in order for consumers, carers and the community to be regularly informed about the quality, effectiveness and cost-effectiveness of care. Indicators need to regularly report on critical aspects of services, such as waiting times and consumer and carer experiences of service delivery. Public reporting of a range of indicators should be encouraged as part of the accountability process. Other approaches to increasing accountability at a service delivery level include ongoing implementation of consumer outcome measures that can be used routinely, and the full implementation of the National Mental Health Standards.<sup>14</sup>

# priority themes

As noted earlier, the activities of the National Mental Health Plan (2003–2008) are guided by four priority themes:

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

For each priority theme, outcomes and key directions for achieving these outcomes are identified. These outcomes and key directions represent agreed areas of focus to be addressed by governments. In some cases, the responsibility for the achievement of the outcomes lies with the Australian Government; in others, it lies with State/Territory governments. This reflects the complexity of mental health care delivery in Australia, where the Australian Government is responsible, for example, for funding private psychiatrists and general practitioners, and the State/Territory governments are responsible, for example, for the provision of public sector mental health services. Often the achievement of given outcomes will be dependent on the Australian and State/Territory governments working with each other, as well as with service providers, consumers, their families and carers, communities and other key stakeholders.

In outlining these outcomes and key directions, the Plan recognises that different jurisdictions have already progressed the mental health agenda, but have done so at different paces and in different areas. The Plan represents an effort to build on existing developments, taking account of the points different jurisdictions have reached and recognising that some outcomes and key directions are dependent on the achievement of others. It acknowledges that different jurisdictions should have the flexibility to prioritise the key directions required to achieve given outcomes, on the basis of their own local needs. It also recognises that some jurisdictions may add their own key directions, again in response to local needs. Monitoring and evaluation will target these broad outcomes.

## Promoting mental health and preventing mental health problems and mental illness

The National Mental Health Plan 2003–2008 continues the work begun under the Second National Mental Health Plan (progressed through the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health<sup>3</sup> and the LIFE Framework<sup>18</sup>) in the areas of mental health promotion, and mental illness and suicide prevention.



## Promoting mental health

Mental health promotion aims to protect, support and sustain the emotional and social wellbeing of the population, from the earliest years through adult life to old age. It should address people who are currently well, those at risk of developing a mental health problem, and those experiencing mental health problems or mental illness.

A range of factors influences mental health. Public policies in sectors such as health, housing, welfare, education, employment, justice and corrections, art, sport and recreation, and the media impact on mental health. Supportive social, economic, educational, cultural and physical environments provide a basic framework for developing and maintaining mental health, particularly for children and adolescents whose early experiences shape their later mental health. Communities that recognise and accept diversity also contribute to social and emotional wellbeing. Communities in which people feel involved, included and empowered to influence decisions that affect them are supportive of mental health.

Knowledge about risk and protective factors for mental health, symptoms of mental health problems and mental illness, and sources of help and self-help contribute to emotional resilience. Such knowledge is also essential in order to dispel the stigma of mental illness. The media have a major role to play in community education regarding mental health, but there are opportunities for all sectors to contribute to improving the mental health knowledge and skills of individuals, groups and communities. Settings such as schools, workplaces, primary care and community organisations are particularly suitable for such education.

Much of the activity in mental health promotion needs to occur beyond the system of direct mental health service provision, in other sectors that impact on the daily lives of individuals and communities. However, those who work in mental health have an important role to play in engaging these other sectors and alerting them to their capacity to impact positively upon mental health. Mental health services need to embrace mental health promotion in their own settings, by adopting a recovery orientation for consumers. Furthermore, mental health services should consider their wider role in terms of promoting mental health. Attitudes of the mental health workforce can perpetuate the stigma of mental illness. Improved attitudes towards consumers, their families and carers, along with continuous professional development that emphasises the priority of consumer rights and participation, are urgently needed.

**Outcome 1: Increase in the extent to which mental health promotion is incorporated into policy and planning, at Commonwealth, State/Territory and local levels**

**Key direction 1.1:** Seek commitment from relevant Australian, State and Territory government departments to incorporate mental health promotion into their policies and activities, where relevant

**Outcome 2: Increase in the extent to which mental health and social and emotional wellbeing is promoted within communities**

**Key direction 2.1:** Work with communities to increase their capacity to support active participation by all members and to foster environments that promote mental health.

**Outcome 3: Increased levels of mental health literacy in the general community and in particular settings, and decreased levels of stigma experienced by people with mental health problems and mental illness**

**Key direction 3.1:** Build on initiatives aimed at raising community awareness about mental health, mental health problems and mental illness

**Key direction 3.2:** Develop new and innovative programs and continue to support existing programs aimed at increasing mental health literacy and resilience, delivered in specific settings

**Key direction 3.3:** Further promotion of accurate portrayal of mental health problems and mental illness in the media

**Key direction 3.4:** Support anti-discrimination initiatives aimed at identifying and combating the impact of racism on the wellbeing of Aboriginal and Torres Strait Islander populations, and people from culturally and linguistically diverse backgrounds

**Outcome 4: Increased extent to which mental health services adopt a recovery orientation**

**Key direction 4.1:** In collaboration with consumers and their families and carers, encourage mental health services to work in ways that promote mental health

**Key direction 4.2:** Increase the capacity of consumers to take charge of their own care, through self-help resources, culturally appropriate training packages, networks and advocacy agencies

**Key direction 4.3:** Increase the capacity of mental health services to more appropriately support consumer and carer participation, for example by identifying roles where consumer and carer employment within mental health services is important to a recovery orientation

**Key direction 4.4:** Work with the employment and training sectors, and with businesses, to support and enhance the employment of consumers and carers

## Preventing mental health problems, mental illness and suicide

Endeavouring to prevent mental health problems, mental illness and suicide involves understanding the factors that heighten the risk of these occurring and the factors that are protective against them, identifying the groups and individuals who can potentially benefit from interventions, and developing, disseminating and implementing effective interventions across the lifespan.

Risk factors increase the likelihood that a mental health problem will develop and exacerbate the impact of existing problems. Risk factors can reside within the individual or within the family, social network, community or institutions that surround the individual. Protective factors give people resilience in the face of adversity. They moderate the impact of stress and transient symptoms on emotional and social wellbeing. Like risk factors, protective factors derive from all domains of life.

An understanding of risk and protective factors enables preventive interventions to be targeted. Preventive interventions can be targeted universally at the general population, selectively at population subgroups or individuals whose risk of developing mental health problems or mental illness is significantly higher than average, or as indicated by the needs of high-risk individuals, such as those with early signs and symptoms of mental health problems and mental illness.

Most of the risk and protective factors for mental health problems, mental illness and suicide lie outside the ambit of mental health services, in sectors that impact on the daily lives of individuals and communities. Changes to risk and protective factors generally require long-term sustained efforts across multiple sectors of the community and government; these changes cannot be achieved by the mental health sector alone. Instead, the mental health sector must forge partnerships with other sectors in order to develop successful interventions that favourably shift risk and protective factors.

Having said this, there is much that the mental health sector can achieve within its own ambit. Mental health services need to be aware of the risk and protective factors within their own sphere of influence, particularly for groups such as Aboriginal and Torres Strait Islander people. Mental and general health services must recognise the interdependency of physical and mental health, and be aware of the potential impact of physical conditions on mental health and vice versa. General practitioners may be particularly well placed in this regard, given their role in providing for consumers' interwoven mental and physical health care needs. Mental health services must also be aware of the increased risk to the mental health of the children, families and carers of consumers, and have some responsibility for interventions that reduce risk and increase protective factors for these people.

## Outcome 5: Increased capacity of communities to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk

**Key direction 5.1:** Continue the initiatives put in place through the National Mental Health Promotion, Prevention and Early Intervention Action Plan<sup>3</sup>

**Key direction 5.2:** Consolidate the evidence base from Australia and overseas on risk and protective factors, conduct high-quality research to address gaps in knowledge, conduct methodologically appropriate evaluations of universal, selective and indicated interventions across the lifespan and for different population groups, and widely disseminate the findings of this work in a nationally coordinated manner

**Key direction 5.3:** Implement evidence-based universal, selective and indicated interventions in collaboration with other sectors

**Key direction 5.4:** Support and encourage specialist mental health services, primary care services and general health services to respond to risk and protective factors and to early signs and symptoms in their own settings

## **Outcome 6: Reduction in suicidal behaviours, reduction in risk factors for suicidal behaviours, and enhancement of protective factors for suicidal behaviours**

**Key direction 6.1:** Recognise and enhance the synergy between national and State/Territory-based strategies aimed at reducing suicide and enhancing mental health

**Key direction 6.2:** Promote activities aimed at reducing risk factors and enhancing protective factors for suicidal behaviours for the general community and for groups at heightened risk, such as Aboriginal and Torres Strait Islander people

## **Improving service responsiveness**

Since the advent of the National Mental Health Strategy, the complexion of mental health service delivery has changed considerably. The system is no longer based on large stand-alone psychiatric institutions, and now mainly provides care within the mainstream health system and primarily through community-based services, in both the public and private sectors. Although this represents a major achievement in policy and planning terms, the evaluation of the Second National Mental Health Plan,<sup>11</sup> and, in particular, the consultations undertaken by the Mental Health Council of Australia,<sup>17</sup> reported the need to improve services to be more responsive to consumers, their families and carers across all age groups. Restricted access, poor continuity and lack of support for carers were specifically highlighted. This Plan continues to address the ongoing challenge of improving service responsiveness, focusing

specifically on issues of access, continuity of care and support for carers.

### **Access to care**

Consumers and their families and carers should be able to access services appropriate to their needs, both within and beyond the specialist mental health sector. Services should be responsive to those with mental health needs in all population groups and across the lifespan. Equitable access depends upon an appropriate level, mix and distribution of services. This poses challenges, especially given the demographic and geographical variations between jurisdictions.

Access issues can arise across the continuum of care, but there are certain points where access is particularly problematic. Public sector access to acute care (e.g., acute inpatient units and crisis assessment teams) is an area of concern, as is access to early intervention services, access to extended, community-based residential care, and access to recovery, rehabilitation and relapse prevention programs. Consumers have expressed a desire for access to a wider range of inpatient replacement services in the private sector. Access to general practitioners – who are often the first point of access for people with mental health problems and perform an important role in providing ongoing physical and mental health monitoring and care – is also problematic, due to reductions in bulk-billing, a maldistribution of the general practitioner workforce, and support for general practitioners to provide mental health care.

Non-government organisations have performed a key role in providing support services for those with mental health problems and mental illness, in advocating for services to be more responsive, and in educating and supporting carers. While the demand on non-government mental health organisations has increased significantly over the past decade, their funding base remains limited.

Beyond mental health services, consumers experience persistent inequities regarding access to some of the support services that are essential to recovery and which impact on their capacity to manage in the community. These services include accommodation, disability, income support, education and training, and employment services.

Certain groups in the community encounter specific access challenges due to cultural, linguistic and geographical barriers, and service gaps. These groups include Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people using forensic services, and people living in rural and remote areas. In addition, those with complex needs are not optimally served. People with comorbid conditions, particularly comorbid substance use disorders, but also intellectual disability and physical illness and disability, often have complex needs that require a coordinated response from multiple service sectors.

**Outcome 7: National agreement on the broad levels and mix of services necessary to align current and future supply of and demand for mental health care across the lifespan**

**Key direction 7.1:** Develop State/Territory-level empirical modelling of factors affecting supply and demand, which may include population surveys, service mapping exercises, and consultation with consumers, families, carers and providers

**Key direction 7.2:** Develop and implement plans to align supply with population need, taking into account available resources and the impact of diversity on models of care

**Key direction 7.3:** Consult with representatives from across the mental health sector, including, for example, public and private specialist mental health providers and primary care providers, to understand their workforce needs

**Outcome 8: Improved access to acute care**

**Key direction 8.1:** Develop a wider spectrum of acute care options in both the public and private sectors, to ensure timely response to people presenting for assessment, and prompt response to people assessed as being in need of acute care

**Key direction 8.2:** Increase the capacity of inpatient units, crisis assessment teams and emergency departments to provide assessments, triage/referral and acute care, through ongoing staff support and the promotion of evidence-based practice

**Key direction 8.3:** Improve linkages between acute inpatient units, crisis assessment teams and emergency departments, and between these services and other relevant providers, which may include general practitioners, private psychiatrists, private hospitals, ambulance services and the police

**Key direction 8.4:** Continue to support deinstitutionalisation activities, as necessary and appropriate

**Outcome 9: Improved access to early intervention services**

**Key direction 9.1:** Develop and implement evidence-based early intervention strategies for diverse population groups and a broad range of clinical conditions

**Key direction 9.2:** Provide incentives for providers in the public, private and non-government sectors to practise early intervention

**Key direction 9.3:** Develop and implement training programs for consumers, families and carers in understanding signs of illness, onset and relapse and timely access to services

**Outcome 10: Improved access to a range of community-based care alternatives**

**Key direction 10.1:** Extend community-based options for the delivery of care, which may include pre-admission and post-discharge support, and residential and community support, where appropriate

**Outcome 11: Improved access to general practitioners and other primary care providers**

**Key direction 11.1:** Ongoing support for existing programs in which general practitioners and other primary care clinicians (including, for example, community nurses, psychologists, social workers, occupational therapists, and other allied health providers) provide mental health care to the community

**Key direction 11.2:** Foster the development of primary care programs in which general practitioners and mental health professionals provide shared mental health care

**Key direction 11.3:** Strengthen linkages between general practitioners and providers within the specialist mental health sector (both public and private), in order to improve clinical support from and access to private psychiatrists, and shared care protocols

**Key direction 11.4:** Continue to develop strategies that enhance the role of general practitioners and other primary care providers in delivering mental health care, particularly in rural and remote areas

**Outcome 12: Improved access to private psychiatrists**

**Key direction 12.1:** Promote strategies that improve access to private psychiatrists, which may include improving referral pathways, increasing the timeliness of assessments and increasing the availability of out-of-hours services

**Key direction 12.2:** Expand shared care models between general practitioners, private psychiatrists and public sector providers

**Key direction 12.3:** Increase the participation of private psychiatrists in consultation-liaison services

**Key direction 12.4:** Improve access to private psychiatrists for people in rural and remote areas (e.g., through e-health)

**Outcome 13: Increased access to recovery and rehabilitation programs**

**Key direction 13.1:** Foster evidence-based recovery and rehabilitation programs within and outside clinical frameworks, and across the public, private and non-government sectors, which may include psychosocial, recreational and vocational programs

**Key direction 13.2:** Improve referral options for general practitioners and private psychiatrists in terms of recovery and rehabilitation programs offered in the public, private and non-government sectors

**Outcome 14: Increased access to appropriate, long-term supported accommodation**

**Key direction 14.1:** Develop and consolidate links with departments of housing

**Key direction 14.2:** Strengthen the capacity to meet the needs of marginalised groups, such as homeless people with mental health problems and mental illness

**Outcome 15: Increased support and recognition of the role of non-government organisations**

**Key direction 15.1:** Develop evidence-based models of service delivery to clarify the role and function of non-government organisations regarding support and advocacy, as well as psychosocial rehabilitation

**Key direction 15.2:** Continue development of the non-government sector to increase the capacity of non-government organisations to support consumers, families and carers

**Outcome 16: Improved access to services for Aboriginal and Torres Strait Islander people**

**Key direction 16.1:** Include Aboriginal and Torres Strait Islander people in mental health policy-making and planning

**Key direction 16.2:** Deliver mental health care through partnerships between mental health services and Aboriginal and Torres Strait Islander-specific health services, with Aboriginal and Torres Strait Islander people taking a lead role through the Social and Emotional Wellbeing Framework Agreement Partnership Forums

**Key direction 16.3:** Facilitate access for Aboriginal and Torres Strait Islander people to mental health services, which may include recognising the importance of early intervention in the primary care setting, increasing outreach services, and improving access to psychiatrists

**Key direction 16.4:** Improve the cultural appropriateness and safety of mental health service options for Aboriginal and Torres Strait Islander people, through enhancing knowledge of risk factors for Aboriginal and Torres Strait Islander people, improving cultural awareness for the mental health workforce, addressing workforce issues for Aboriginal and Torres Strait Islander health and mental health workers, and supporting community initiatives

**Key direction 16.5:** Improve linkages between mainstream mental health services and general practitioners, and Aboriginal and Torres Strait Islander health services and drug and alcohol services



**Key direction 16.6:** Support the implementation of the Social and Emotional Wellbeing Framework, once agreed upon

**Key direction 16.7:** Drawing on the Social and Emotional Wellbeing Framework and this Plan, support the development and implementation of State and Territory Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Plans

**Outcome 17: Improved access for other population groups of all age groups with diverse and complex needs**

**Key direction 17.1:** Develop State/Territory Plans to address issues of access for groups who are disadvantaged by geography, demographic factors, cultural and linguistic diversity, or clinical conditions

**Key direction 17.2:** Provide a broader range of options for mental health care for these groups, by improving linkages between mainstream mental health services and population-specific services, which might include forensic services, transcultural services, youth services, aged care services, or homeless services

**Key direction 17.3:** Provide better linkages between the mental health and general health sectors in order to improve access to mental health services for people with physical health conditions and to improve access to physical health services for people with mental illness

**Outcome 18: Equitable access to housing, employment services, disability services, social services, education and justice**

**Key direction 18.1:** Foster linkages with other key sectors via joint policy and planning initiatives, at Commonwealth, State/Territory and local service delivery levels

**Key direction 18.2:** Clarify roles and responsibilities of different sectors

**Key direction 18.3:** Cooperate across sectors to increase the provision of effective and innovative services to people with mental health problems and mental illness

## Continuity of care

Continuity of care remains a key challenge. It involves continuity across the course of illness, recognising that consumers will have different needs at different points in time. Continuity of care also encompasses the notion of coordination of services across the lifespan, and in the transitions between child and adolescent services and adult services, and between adult services and aged care services.

Continuity of care involves an integrated specialist mental health system with appropriate inpatient-community and public-private linkages. It also involves linkages between the specialist mental health sector and primary health care, between the mental health sector and the wider health system, and strong relationships with systems outside the health sector that provide

support for people with mental health problems and mental illness. More than this, it requires appropriate and timely information transfer, with careful consideration of privacy principles. Continuity of care is not necessarily synonymous with continuous care, and may sometimes be episodic, involving good exit planning and contingency arrangements.

As with access, continuity of care will only be realised with agreement about the appropriate level, mix and distribution of services. Continuity of care requires maintenance of mainstreaming efforts in recognition of the interaction between mental and physical health, the development of care pathways that enable consumers, families and carers to move easily between services, and a recognition that consumers vary in terms of the complexity of their needs, and that their needs may change over time.



### **Outcome 19: Enhanced care pathways across the spectrum of care**

**Key direction 19.1:** Document and implement nationally agreed, evidence-based care pathways (developed on the basis of empirical studies and consultation with consumers, families, carers and mental health professionals) that reflect the complexity of needs among different consumer groups and in different settings and take into account the different mix of services and service providers in different States and Territories

**Key direction 19.2:** Develop service eligibility criteria that are based on consumer needs, rather than service structure

**Key direction 19.3:** Explore the development of standard assessment processes and shared assessment and outcome tools for use within and across service sectors

**Key direction 19.4:** Improve linkages between the specialist mental health sector and the primary care sector, and between the public mental health sector and the private mental health sector

**Key direction 19.5:** Increase recognition of the impacts of physical health on mental health and vice versa, and improve the capacity of the mental health sector and the general health sector to deal with this complex interrelationship

### **Outcome 20: Improved access to services across the lifespan**

**Key direction 20.1:** Ensure the development of child and adolescent mental health services as a key component of the mental health services framework

**Key direction 20.2:** Ensure older people's mental health services are developed as a key component of the mental health services framework

**Key direction 20.3:** Foster improved alignment of mental health policy with child, youth, family and older people policies at Commonwealth and State/Territory levels

**Key direction 20.4:** Ensure that child and adolescent mental health services and mental health services for older people are better linked with the broader mental health and primary care sectors

**Key direction 20.5:** Increase the options for the provision of evidence-based mental health care across the lifespan, recognising the benefits not only of child, adolescent and aged care specific approaches, but also of system-wide approaches

### **Outcome 21: Reduced service system gaps and increased integration between private and public mental health services**

**Key direction 21.1:** Continue to consolidate and extend the gains made under the First and Second National Mental Health Plans, building on initiatives such as the Mental Health Integration Projects

### **Outcome 22: Improved coordination between the mental health sector and other areas of health, such as child and adolescent services, general adult services, aged care services, drug and alcohol services and Aboriginal and Torres Strait Islander health services**

**Key direction 22.1:** Enhance cooperation between the mental health sector and other sectors in terms of service provision, with better articulation of roles and responsibilities

**Key direction 22.2:** Improve continuity of care between Aboriginal and Torres Strait Islander health services and mental health services through planning and partnership mechanisms at the local level

### **Support for families and carers**

With the move to more community-focused treatment for people with mental illness, the enhanced role of carers must be recognised and supported. The needs of families and carers, particularly where children are carers, should be acknowledged and services put in place to support their efforts and ensure that their own wellbeing is maintained. Initiatives to include families and carers in treatment planning are essential. Mental health services should become more responsive to the needs of carers and increase support options, particularly in providing better access to

### Outcome 23: Improved support for families and carers

**Key direction 23.1:** Develop guidelines for carer plans which, in conjunction with individual consumer care plans, emphasise regular review of the needs of carers

**Key direction 23.2:** Improve the range of support services available for carers, which may include respite services and services for children of parents with a mental illness

**Key direction 23.3:** Improve the extent to which information is shared with carers so they are able to participate in care planning

## Strengthening quality

Definitions of quality tend to be imprecise, but in general terms the notion of quality emphasises appropriate, evidence-based care that leads to measurable improvement and good results. This Plan aims to better reflect the full range of objectives of the National Mental Health Strategy and progresses the quality agenda using structures implemented through the First and Second Plans to achieve and measure high-quality outcomes. In particular, this Plan continues to support the implementation of the National Standards for Mental Health Services.<sup>14</sup>

## Consumer rights and legislation

The rights of people with mental health problems and mental illness should be guaranteed and protected across the life span and at all times throughout the course of illness and recovery in accordance with the Mental Health Statement of Rights

and Responsibilities<sup>2</sup> and national and international conventions. Mental health services should be delivered in the least restrictive environment, with an emphasis on privacy, dignity and respect. Consumers should have access to information on their rights, to advocacy services and to effective and appropriate mechanisms for complaint and redress.

### Outcome 24: Continue to ensure all States and Territories have legislation and service provision that protects the rights of consumers and the community

**Key direction 24.1:** Continue review of mental health and related legislation

**Key direction 24.2:** Ensure the capability exists to permit interstate transfer of individuals detained under mental health legislation

**Key direction 24.3:** Review the adequacy of existing complaints systems

## Consumer and carer participation

Consumer and carer participation and partnership at all levels in policy, planning and treatment is a hallmark of a quality mental health system. Consumers and carers report that there have been increased opportunities for participation in policy and planning, particularly at a national level. However, participation at other policy and planning levels, and participation in service planning and delivery across the spectrum of care from promotion and prevention to recovery, has not yet been achieved. Further work is required to ensure that meaningful participation by all consumers, and their carers and families, is realised.

### Outcome 25: Increased levels of full and meaningful consumer, family and carer participation in policy and in service planning, delivery and evaluation at all levels with evidence of improvement in quality

**Key direction 25.1:** Review and improve current structures for ensuring meaningful consumer, family and carer participation in policy and services planning, development and evaluation at national, State/Territory and local levels, including participation by consumer and carer workers

**Key direction 25.2:** Include Aboriginal and Torres Strait community, consumer and carer representatives on appropriate committees through the Aboriginal and Torres Strait Islander Framework Agreement Partnership Forums

**Key direction 25.3:** Review and improve structures (e.g., advocacy support mechanisms) for ensuring consumer, family and carer participation in individual care and recovery plans

**Key direction 25.4:** Identify improved service quality and consumer outcomes afforded by enhancing consumer, family and carer participation at all levels

**Key direction 25.5:** Encourage the demonstration of meaningful consumer, family and carer participation at all levels

**Key direction 25.6:** Provide support and training for consumers, carers and their families to strengthen their capacity to participate at all levels, particularly in quality assurance processes

## Safety

Safety is a key component of quality and involves minimising the likelihood of potential harm from mental health care.<sup>19</sup>

### Outcome 26: Increased safety of consumers, carers and families, staff and the community and a reduction in adverse incidents

**Key direction 26.1:** Develop and implement safety protocols that make the activities and environment of mental health services safer for consumers, carers, families, staff and the community

**Key direction 26.2:** Educate consumers, carers, families and the mental health workforce in the safe and quality use of medicines

**Key direction 26.3:** Undertake developmental work to determine how quality assurance in mental health can be broadened to link with and incorporate wider health quality and safety policies and agendas

## Standards and monitoring

High-quality mental health services will be facilitated through continual review of performance, assessment and accreditation. The mental health quality agenda needs to be broadened from its current emphasis on service inputs and structure to service impacts and outcomes. This can be achieved through the development of a culture of measurement and the establishment of consumer- and clinician-rated

measurement systems, national benchmarking of mental health services, and agreement on, and establishment of, appropriate levels and mix of services.

### Outcome 27: Increased service quality and numbers of services that meet specified quality criteria in both the public and private specialist mental health sectors

**Key direction 27.1:** Develop a nationally agreed set of performance indicators that focus on mental health care outputs and outcomes and provide information to managers at all levels of the mental health care system, as well as contributing to an understanding of population needs

**Key direction 27.2:** Establish continuous quality improvement cycles and public reporting based on the Mental Health Service Standards and the National Practice Standards for the Mental Health Workforce, including comprehensive implementation and ongoing accreditation and review

**Key direction 27.3:** Benchmark like services against performance indicators

**Key direction 27.4:** Review national standards to ensure their relevance for key groups with particular needs

### Outcome 28: Comprehensive implementation and further development of routine consumer outcome measures in mental health

**Key direction 28.1:** Continue to support and develop outcome measurement systems, including full implementation of routine outcome measurement systems, in the mental health sector and for use by other mental health providers and related service sectors

**Key direction 28.2:** Establish a national strategy in collaboration between the Commonwealth, States and Territories for database development, data analysis (which may include normative comparisons and benchmarking exercises), dissemination and training

**Key direction 28.3:** Support the implementation of routine outcome measurement

**Key direction 28.4:** Support improvements in the effectiveness and quality of mental health services, through the development of complementary outcome measures and instruments for specialist sectors and particular groups, such as Aboriginal and Torres Strait Islander people and culturally and linguistically diverse communities

### Outcome 29: Monitoring of the performance of mental health services regarding emotional and social wellbeing issues, through the collection and sharing of information and data

**Key direction 29.1:** Identify, monitor and disseminate information about effective models of service and partnerships that improve service responsiveness to Aboriginal and Torres Strait Islander people

**Key direction 29.2:** Improve the usage of Aboriginal and Torres Strait Islander identifiers in health data collections

## Funding

The development of strategies that create incentives for high-quality care is crucial.

### Outcome 30: Reform of public sector funding models to better reflect need

**Key direction 30.1:** Continue the development of mental health casemix classifications through the Australian Mental Health Outcomes and Classification Network

**Key direction 30.2:** Develop funding formulae based on population needs, weighted for Aboriginal and Torres Strait Islander populations, rural and remote locations and other relevant variables

**Key direction 30.3:** Develop funding formulae taking into account provision of programs which will lessen the adverse impacts of mental health problems and mental illness

### Outcome 31: Improved ability of the private sector to meet need through funding models and related reform

**Key direction 31.1:** Explore ways in which the private health sector can deliver a wider range of services

**Key direction 31.2:** Explore the potential for private health funds to offer a wider range of service products

**Key direction 31.3:** Explore models of funding that support involvement of allied health professionals in private mental health service provision

**Key direction 31.4:** Review impediments and other barriers to innovative service delivery that is appropriate and effective

## Workforce

Workforce attitudes, skills, training and education are fundamental to quality mental health care. This Plan focuses on strengthening and supporting the ability of the mental health workforce to provide quality care and to build partnerships with consumers, carers and their families at all stages of service delivery and care. Consideration is also given to the supply, organisation, deployment and retention of the mental health workforce, and their resulting impact on quality.

### Outcome 32: Improved attitudes, values, knowledge and skills of the mental health workforce

**Key direction 32.1:** Implement the National Practice Standards for the Mental Health Workforce to: promote best practice; guide and support clinical supervision mentoring; structure continuing education and curricula development; assist in recruitment and staff retention; and complement other competency standards

**Key direction 32.2:** Strengthen the role of consumers and carers working in the mental health system through increased training and support

**Key direction 32.3:** In consultation with consumers and carers, professional discipline groups and service providers, promote the development and delivery of undergraduate, postgraduate and ongoing training in mental health for the specialist mental health workforce (public and private), general practitioners and other primary care providers, and non-government sector workers in order to improve knowledge and skills in assessments, triage/referral, acute care; early intervention, building effective clinical and service linkages, meeting the needs of specific population groups, and providing care across the lifespan

**Key direction 32.4:** Train mental health workers and primary health care professionals in recognition of the interrelatedness of physical and mental illness

**Key direction 32.5:** Increase the cultural competency of the mental health workforce



### Outcome 33: Improved supply and distribution of the mental health workforce

**Key direction 33.1:** Develop initiatives to retain clinicians in the specialist public health workforce

**Key direction 33.2:** Enhance the role of general practitioners and allied health professionals in providing mental health care, particularly in rural and remote areas

**Key direction 33.3:** Provide incentives for private psychiatrists, general practitioners and allied health professionals to work with public sector mental health services and vice versa

**Key direction 33.4:** Promote the involvement of professional bodies and education and training institutions in the planning of workforce supply

**Key direction 33.5:** Increase the proportion of Aboriginal and Torres Strait Islander mental health workers within the mental health workforce, and provide appropriate support and career structures

**Key direction 33.6:** Strengthen initiatives to enhance the recruitment, retention, status, skills and numbers of the mental health nursing workforce

### Outcome 34: Improved workforce environment

**Key direction 34.1:** Improve occupational health and safety for the mental health workforce

**Key direction 34.2:** Improve the communication infrastructure of the mental health workforce

**Key direction 34.3:** Improve support for general practitioners and other primary mental health providers, especially in rural and remote areas

### Fostering research, innovation and sustainability

Much has been achieved throughout the First and Second National Mental Health Plans in reforming the Australian mental health system. A range of innovative initiatives, including clinical trials, pilot projects, research and development programs have informed this process, providing a strong foundation for innovation in the National Mental Health Plan (2003–2008).

This Plan is committed to the future development of a strategic mental health research agenda to underpin mental health policy and practice. This will optimise the research investment that has been made throughout the life of the National Mental Health Strategy and take a strong, forward-looking approach to research development and sustainability. The National Mental Health Plan 2003–2008 embraces the challenge to promote research into mental health and mental illness across the lifespan, develop and trial new treatments and models of care and technology, and evaluate the effectiveness, long-term sustainability and applicability of this work in the mental health system.

### Setting the research agenda

The burden of disease attributable to mental illness is growing in Australia, as in all countries, and the demand for services and the complexity of illnesses is increasing. The extent to which much of the burden is unable to be averted is becoming clearer. The research achievements made to date have been significant, but there is a pressing need to meet this growing demand through increased research knowledge and understanding of the aetiology of mental health problems and mental illness and better treatments and cures.

No country has the capacity to address all its research and development needs. Prioritisation of new and existing research initiatives will be crucial to ensuring optimum investment of the research dollar. During the period of the Second National Mental Health Plan the Australian Government commissioned an analysis of the mental health research priorities of a wide range of mental health stakeholders.<sup>20</sup> The findings of this work will inform the prioritisation process.

Partnerships are necessary in order to promote research that strategically informs policy-makers, planners, decision-makers who allocate funding and services, managers and service providers. A national framework for coordinated, innovative research and development will be established. The framework will be strongly informed by consumer and carer perspectives, and underpinned by the objectives of the National Mental Health Plan 2003–2008. It will incorporate and consolidate existing research initiatives to ensure their outcomes are achieved. The research will be holistic, and recovery- and outcome-

orientated, and will identify clinical and service level interventions that have the greatest potential to increase population mental health and reduce suffering across the lifespan.

The development of a strong research culture and critical research mass within the mental health sector is crucial. So too are research partnerships between sectors, institutions and disciplines.

Enhanced research capacity will be encouraged and supported through linkages and funding partnerships with other sectors, and between investigators, policy-makers and funders in the public and private sectors.

## Fostering innovation

### Promoting mental health and preventing mental health problems and mental illness

Furthering our knowledge of the promotion of mental health and the prevention of mental illness is an important element of the research agenda. There has been limited research into the determinants of mental health and wellbeing across the lifespan. Research into causal pathways and risk and protective factors for mental health will be encouraged. The implementation of effective and efficacious strategies to promote mental health and prevent mental health problems will be fostered. Early intervention initiatives that can be generalised to and sustained within health and mainstream mental health services will also be prioritised.

### Improving service responsiveness

As knowledge of the aetiology of illness becomes more sophisticated, it will be crucial to rigorously explore 'what works for whom and in what settings' and to translate this into mainstream mental health practice. Research will continue to develop more innovative and cost-effective treatments and service models for people with mental health problems and mental illness, including under-researched groups. Suicide will be an area of ongoing focus, as will the development of psychosocial rehabilitation systems and models that facilitate recovery.

The period of the First and Second National Mental Health Plans has seen changes in the complexity of and demand for services, and the structure and mix of mental health services. Research can help provide ways that consumer, family and carer needs are more successfully met within this evolving environment. Initiatives that develop new and improved models of service delivery will be supported. These might include comprehensive continuums of care within and outside the mental health sector, the development and implementation of effective intersectoral care models, and innovative approaches to the establishment of pathways to care. Research initiatives will also focus on the development of care packages required by different groups with mental health problems and on mental illness as a basis for future service mix and level and assessment of optimal levels of care. The use of new technologies, including e-health and telephone innovations in care, will be explored.<sup>21</sup>

## Strengthening quality

Continued research to develop consumer- and carer-administered mental health measures is important. Research should include the development and implementation of quality and outcome measures, including consumer- and carer-rated outcome measures, instruments to measure access and pathways to care, indicators of functionality, distress and meaningful consumer and carer participation. There will also be a focus on the development of outcome measurement systems relevant to Aboriginal and Torres Strait Islander people and to specialty areas, particularly child and adolescent services.



Human resources are critical to effective mental health programs. Research which focuses on workforce supply, organisation and environment is critical. Research into the training needs of different groups within the mental health workforce, and the long-term impact and effectiveness of these strategies, is also important.

Innovative approaches to quality improvement based on the National Mental Health Service Standards and the National Practice Standards for the Mental Health Workforce will be progressed throughout the period of the National Mental Health Plan (2003–2008). Developmental work will also be undertaken to determine how quality assurance in mental health can incorporate the wider quality and safety agenda in health and beyond. Disability associated with mental health problems and mental illness has implications not only for the individual and their family but also for society as a whole. There are costs associated with not treating mental health problems and mental illness, and effective treatments that reduce or eliminate disability have considerable economic return. In an environment of limited resources and increasing demand, it is important to justify resource usage in terms of consumer outcomes and returns on investment. Mental health research must answer economic as well as clinical questions.

Research in this area is in its infancy in Australia and will be promoted through the period of the National Mental Health Plan (2003–2008). Areas of focus will include quantifying the economic benefits of reducing the burden of care and the benefits of disability reduction within and outside the workforce. Potential areas for further research that will support economic analyses include epidemiological longitudinal and large population studies that focus on the prevalence and burden of disease, and casemix projects that identify consumer attributes that predict resource use in different settings.

## Ensuring sustainability

Australia has embraced the reform agenda with enthusiasm and important pilots and trials have been undertaken in a number of areas. There is concern, however, that pilot projects and developmental research initiatives do not attract ongoing, sustainable funding despite demonstrated effectiveness. This Plan emphasises the need to optimise the investment in pilot projects by ensuring that innovation found to be effective and appropriate is effectively disseminated and adequately resourced to enable ongoing implementation and translation into mainstream, evidence-based best practice.



# evaluation

The First and Second National Mental Health Plans both emphasised the importance of measurement and accountability. Both Plans were evaluated, with each evaluation containing a number of components that assessed their appropriateness and effectiveness. In both cases, these components included a mix of quantitative data, taken primarily from the information in the relevant National Mental Health Report, and qualitative data derived from consultations with key informants and commentary from international experts.

This Plan stresses the need to continue public reporting of nationally aggregated data, and maintains a commitment to independent evaluation. Steps should be put in place at the outset of this Plan to ensure that its evaluation is an integral part of its implementation. Evaluation efforts should begin when the Plan commences. Early on, it will be important to translate the broad outcomes of the Plan into a series of nationally consistent indicators, against which success, or lack of success, can be measured. Developing these indicators will allow a determination of what data need to be collected. Evaluation efforts should be broad in scope, and collect baseline information against which to assess the impacts and outcomes of reforms across all

sectors. It will be important to determine which indicators can be measured with information that is currently collected, and which ones will require additional information to be sought. Redevelopment of reporting frameworks will need to reflect changed and agreed service directions. Qualitative information will continue to be vital in the evaluation. The views of consumers, families and carers must be solicited, as must the views of the broader community. Ideally, key informant interviews would occur at different stages of the Plan, and not just at its conclusion.

Just as the overall evaluation of the Plan is crucial, so too is the evaluation of specific initiatives undertaken within it. In particular, pilot projects that are conducted with funding under the Plan should be subjected to rigorous scrutiny, so that it is possible to determine what works, what does not work, and what should be replicated or further developed.

# 5



# conclusion

The National Mental Health Plan 2003–2008 provides a framework for consolidating the achievements of and building on the First and Second National Mental Health Plans. It emphasises the centrality of consumers, families and carers in reform. This Plan focuses on achieving gains through a population health framework, and sets important priorities for the next five years of the National Mental Health Strategy.

In taking forward this Plan, it should be the aim of all stakeholders to improve the mental health and wellbeing of the Australian community, and to improve the treatment, care and quality of life of people with mental health problems and mental illness across the lifespan. The next five years provide an important opportunity to build on the gains made over the past decade.



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# glossary of terms and definitions

**Acute care:** Acute care services provide specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that the treatment effort is focused on symptom reduction with a reasonable expectation of substantial improvement. In general, acute psychiatric services provide relatively short-term treatment. Acute services may be:

- :: Focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing psychiatric disorder for whom there has been an acute exacerbation of symptoms
- :: Targeted at the general population, or specialist in nature, targeted at specific clinical populations. The latter group includes psychogeriatric, child and adolescent, and forensic psychiatry services

**Advocacy:** Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support to enable them to represent themselves.

**Benchmarking:** Benchmarking is concerned with the systematic process of searching for and implementing a standard of best practice within an individual service or similar groups of services. Benchmarking activities focus on service excellence, customer/client needs, and concerns about changing organisational culture. (Bullivant, JRN. Benchmarking for continuous improvement in the public sector. UK: Longman, 1994.)

**Care pathways:** Formally articulated mapping of services provided within and across sectors and with agreed streamlined entry/exit procedures that support continuity of care by ensuring that consumers of services are able to negotiate the system in a seamless and timely manner.

**Carer:** A person whose life is affected by virtue of a family or close relationship and caring role with a consumer.

**Case management:** The mechanism of ensuring access to and coordination of the range of services necessary to meet the identified needs of a person within and outside the integrated mental health service. People with mental illness requiring case management are usually living in the community and have long-term needs necessitating access to health and other relevant community services.

**Casemix:** A classification system that combines episodes of care into clinically meaningful groups, such that episodes within a given group require the same level of resources.

**Clinical indicator:** A measure of clinical management and outcomes of care; a method of monitoring care and services which attempts to identify problem areas and evaluate trends, in order to direct attention to issues requiring further review.



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**Colocated service:** Psychiatric inpatient services established physically and organisationally as part of a general hospital. There are two variations on this theme:

- ∴ The psychiatric unit is built and managed as a unit within a general hospital, or
- ∴ The psychiatric service operates in a separate building but is located on, or immediately adjoining, the general hospital campus. Beds within the psychiatric service are classified as 'colocated' providing all of the following criteria apply: (a) a single organisational or management structure covers the general hospital and the psychiatric facility; (b) a single employer covers the staff of the general hospital and the psychiatric service; (c) the location of the general hospital and the psychiatric service can be regarded as part of a single, overall hospital campus; and (d) the patients of the psychiatric service are regarded as patients of the single integrated health service

**Community capacity building:**

Developing investment in mental health on multiple levels in government and non-government sectors, and utilising the knowledge and expertise of consumers, carers and others in the general population.

**Complex conditions:** Conditions in which a person experiences mental illness as well as other multiple and complex social, emotional and/or physical health problems. Complex conditions include mental illness with problematic substance abuse, histories of abuse, intellectual disability, and challenging, at risk, suicidal and criminal behaviours. People with complex conditions often have needs that require a co-ordinated response from multiple service sectors.

**Consultation-liaison services:**

Formal support and clinical guidance provided by specialist mental health care to other providers, including general practitioners.

**Consumer:** A person who is currently utilising, or has previously utilised, a mental health service.

**Continuity of care:** Linkage of components of individualised treatment and care across health service agencies according to individual needs.

**Cost-effectiveness:** The most effective use of limited resources. Cost-effectiveness analysis summarises the health benefits and resources used by a health program. (Over, M. Economics for Health Sector Analysis – Concepts and Cases. Washington, D.C: The World Bank, 1992.)

**Crisis assessment teams:** Mental health teams which provide 24-hour mobile support and intervention for people who are being considered for psychiatric hospital admission. Crisis assessment teams also provide treatment and support for people whose acute mental illness can be managed in the community. (Adapted from Auditor General. Mental Health Services for People in Crisis. Victoria, 2002.)

**Disease burden:** The impact of a mental illness on the psychological, social and economic wellbeing of consumers, carers and their families caused by premature mortality, and disability.

**Early intervention:** Timely interventions which target people displaying the early signs and symptoms of a mental health problem or a mental disorder. Early intervention also encompasses the early identification of patients suffering from a first episode of disorder.

**Epidemiology:** The study of the distribution and determinants of mental health and illness as applied to a whole community.

**Extended, community-based residential care:**

Medium- to long-term inpatient and residential treatment and rehabilitation for individuals who have unremitting and severe symptoms of mental illness.

**Forensic services:** Services provided to:

- ⌘ Offenders or alleged offenders referred by police, courts, legal practitioners or independent statutory bodies for psychiatric assessment and/or treatment
- ⌘ Alleged offenders detained, or on conditional release, as being unfit to plead or not guilty by reason of mental impairment
- ⌘ Offenders or alleged offenders with mental illness ordered by courts or independent statutory bodies to be detained as an inpatient in a secure forensic facility
- ⌘ Prisoners with mental illness requiring secure inpatient hospital treatment
- ⌘ Selected high-risk offenders with a mental illness referred by releasing authorities
- ⌘ Prisoners with mental illness requiring specialist mental health assessment and/or treatment in prison
- ⌘ People with mental illness in mainstream mental health services who are a significant danger to their carers or the community and who require the involvement of a specialist forensic mental health service (the diagnostic groups of people who determine this group will be determined by the jurisdiction)

**Framework Agreements:**

Framework Agreements commit the parties to a joint process of regional planning to meet Aboriginal and Torres Strait Islander health needs within that jurisdiction, and to guide future resource allocation.

**Integrated mental health services:**

A network of specialised mental health service components within the general health system, coordinated across inpatient and community settings, to ensure continuity of care for consumers. The components can encompass assessment, crisis intervention, acute care, extended care, treatment, rehabilitation, specialised residential and housing support services, and domiciliary care services. The network can be coordinated through area/regional management and uses a case management system across service components.

**Integration:** The process whereby inpatient and community components of a mental health service become coordinated as a single, specialist network and include mechanisms which link intake, assessment, crisis intervention, and acute, extended and ongoing treatment using a case management approach to ensure continuity of care.

**Intersectoral linkages:**

Collaboration between mental health policies/programs/services and other relevant policies/programs/services at Australian, State/Territory and local government levels, as well as in the private and non-government sectors, designed to ensure the overall needs of people with mental illness are addressed effectively.

**Mainstream health services:**

Services provided by health professionals in a wide range of agencies, including general hospitals, general practice and community health centres. Mental health services will be delivered and managed as an integral part of mainstream health services so they can be accessed in the same way as other services.

**Mental health:** A state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential.<sup>21</sup> It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with

their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities.<sup>2</sup> Mental health is not simply the absence of mental illness. Its measurement is complex and there is no widely accepted measurement approach to date. The strong historical association between the terms 'mental health' and 'mental illness' has led some to prefer the term 'emotional and social wellbeing', which also accords with holistic concepts of mental health held by Aboriginal peoples and Torres Strait Islanders and some other cultural groups,<sup>10</sup> or alternatively, the term 'mental health and wellbeing'.

**Mental health literacy:** The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors for and causes of mental health problems and mental illness; knowledge of self-treatment and of professional help available; and attitudes that promote recognition and appropriate help-seeking. (Jorm, A. et al. "Mental Health Literacy: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment". Medical Journal of Australia. 1997:166,182.)

**Mental health problems:** A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health.

**Mental health sector:** Includes the specialist mental health sector (both public and private) and elements of the primary care sector providing mental health care.

**Mental illness:** A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is



generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-IV)<sup>1</sup> or the International Classification of Diseases, Tenth Edition (ICD-10).<sup>4</sup> These classification systems apply to a wide range of mental disorders (for the DSM-IV) and mental and physical disorders (for the ICD-10). Not all the DSM-IV mental disorders are within the ambit of the National Mental Health Plan 2003–2008. In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system and there is a separate, but linked, national strategy. Similarly, dementia is treated primarily in aged care settings. Both are considered important in terms of their comorbidity with mental illness.

**Morbidity:** The incidence of disease within a population.

**Mortality:** Death attributable to mental illness.

**Multidisciplinary clinical team:** The identifiable group of mental health personnel comprising a mix of professionals responsible for the treatment and care of people with mental illness.

**Non-government organisations:**

Private, not-for-profit, community-managed organisations that provide community support services for people affected by mental illness. Non-government organisations may promote self-help and provide support and advocacy services for consumers and carers or have a psychosocial rehabilitation role.

**Outcome:** A measurable change in the health of an individual, or group of people or population, which is attributable to interventions or services.

**Outreach services:** Community-based mobile support, rehabilitation and treatment services, primarily provided on a visiting basis.

**Performance indicators:** Measures of change in the health status of populations and in service delivery and clinical practice, collected in order to monitor and improve clinical, social, vocational and economic outcomes.

**Population health approach:** An understanding that the influences on mental health are complex and occur in the events and settings of everyday life. A population health approach

encourages a holistic approach to improving mental health and wellbeing and develops evidence-based interventions that meet the identified needs of population groups and span the spectrum from prevention to recovery and relapse prevention across the lifespan.

**Private sector mental health**

**services:** Specialised health services that are specifically designed for people with a mental health problem or mental disorder seeking treatment in the private sector. In Australia, private sector mental health services include the range of mental health care and services provided by psychiatrists in private practice, and those inpatient and day-only services provided by private hospitals, for which private health insurance funds pay benefits. Private sector services may also include services provided in general hospital settings and services provided by general practitioners and by other allied health professionals.

**Primary care sector:** The primary care sector includes general practitioners, and many other primary care providers such as emergency departments and community health centres, as well as others who are integrally involved in the detection, diagnosis and treatment of mental illness, and/or have much to offer in terms of promoting mental health.

**Productivity:** The amount of output per unit of inputs used to produce it. It may be measured by the number of hours engaged in work or other activities carried out by an individual which contributes to some good/product or service being produced.

**Psychogeriatric services:** These services principally target people aged 65 years and over, or younger people with age-related psychogeriatric disorders. Classification of services in this category requires recognition by the regional or central funding authority of the special focus of the inpatient, community and ambulatory services on aged persons. This category does not include general psychiatry services that may treat older people as part of their usual service delivery.

**Psychosocial rehabilitation:** Services with a primary focus on interventions to reduce functional impairments that limit the independence of people whose independence and physical/psychological functioning has been negatively impacted upon as a result of a mental illness. Psychosocial rehabilitation focuses on disability and the promotion of personal recovery, giving people the

opportunity to work, live and enjoy a social life in the community. It is also characterised by an expectation of substantial improvement over the short to mid-term. This term is sometimes used interchangeably with the term 'rehabilitation'.

**Quality of life:** This term embraces a spectrum of uses and meanings. Within this document 'quality of life' is a multidimensional concept that includes subjectively and objectively ascertained levels of physical, social and emotional functioning. (Adapted from Katschnig H, Freeman H, Sartorius N. Quality of Life in Mental Disorders. England: John Wiley & Sons, 1998.)

**Recovery:** A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose as the person grows beyond the effects of psychiatric disability. (Adapted from Anthony, W.A. Recovery from mental illness: the guiding vision of the mental health service system in the 1990's, *Psychiatric Rehabilitation Journal*, 16(4):159.)

**Referral pathways:** Referral systems and protocols that ensure linkages between services to support continuity of care and ensure that consumers of services are able to negotiate the system in a seamless and timely manner.

**Rehabilitation:** Intervention to reduce functional impairments that limit the independence of consumers. Rehabilitation services are focused on disability and the promotion of personal recovery. Consumers who access rehabilitation services usually have a relatively stable pattern of clinical symptoms and there is an emphasis on relapse prevention. This term is sometimes used interchangeably with the term 'psychosocial rehabilitation'.

**Relapse prevention:** Reducing recurrence of illness and strengthening functioning capacity.

**Service mix:** The combination of services used to meet the spectrum of needs of a consumer.

**Shared care:** Care provided collaboratively by general practitioners and specialist mental health care providers or by public sector mental health services and private psychiatrists.

**Social and emotional wellbeing:** A holistic Aboriginal definition of health includes: mental health; suicide and self-harm; emotional, psychological and spiritual wellbeing; and issues impacting specifically on wellbeing in Aboriginal and Torres Strait Islander communities, such as stolen generation issues or grief, loss and trauma.



**Specialist mental health sector:**

Comprises both public and private mental health services and providers, including some specialist non-government organisations. The primary function of these services is to provide treatment, rehabilitation or community support targeted towards people affected by mental illness. Such activities are delivered by providers, services or facilities that are readily identifiable as both specialised and serving a mental health function.

**Standards:** Clinical practice standards are defined and agreed clinical procedures and practices for the optimal treatment and care of people with mental illness. Service standards define what is required for a quality mental health service.

**Transcultural services:**

Transcultural services promote access to mental health services for people from culturally and linguistically diverse populations. Transcultural services work with consumers, carers, health professionals and the community to promote positive attitudes to mental health and to ensure that the needs of people from culturally and linguistically diverse populations (including access, equity and cultural safety and appropriateness) are addressed at policy, planning and service delivery levels.

**Vocational rehabilitation:**

Services with a primary focus on interventions to assist people who have experienced or continue to experience a mental illness to enter or re-enter the workforce and to sustain employment. Vocational rehabilitation focuses on prevocational preparation, vocational skills training, placement, support and advocacy. People who use these services usually have a relatively stable pattern of clinical symptoms.

# references

- 1:: World Health Organization. Strengthening Mental Health Promotion, WHO Fact Sheet No. 220. Geneva: World Health Organization, 1999.
- 2:: Australian Health Ministers. Mental Health Statement of Rights and Responsibilities. Canberra: Australian Government Publishing Service, 1992.
- 3:: Commonwealth Department of Health and Aged Care. National Action Plan for Promotion, Prevention and Early Intervention for Mental Health. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, 2000.
- 4:: American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition Text Revision (DSM-IV-TR). Washington, D.C.: American Psychiatric Association, 2000.
- 5:: World Health Organization. The International Statistical Classification of Diseases and Health Related Problems, Tenth Revision (ICD-10). Geneva: World Health Organization, 1992.
- 6:: Australian Health Ministers. National Mental Health Policy. Canberra: Australian Government Publishing Service, 1992.
- 7:: Australian Health Ministers. National Mental Health Plan. Canberra: Australian Government Publishing Service, 1992.
- 8:: Whiteford H, Buckingham B, Manderscheid R. Australia's National Mental Health Strategy. *British Journal of Psychiatry* 2002,180 210-215.
- 9:: Australian Health Ministers. Second National Mental Health Plan. Canberra: Mental Health Branch, Commonwealth Department of Health and Family Services, 1998.
- 10:: Commonwealth Department of Health and Ageing. National Mental Health Report. Canberra: Commonwealth of Australia, 2002.
- 11:: Steering Committee for the National Mental Health Plan 2003–2008. Evaluation of the Second National Mental Health Plan. Canberra: Commonwealth Department of Health and Ageing, 2003.
- 12:: Raphael B. A Population Health Model for the Provision of Mental Health Care. Canberra: National Mental Health Strategy, 2000.
- 13:: Mrazek PJ, Haggerty RJ. Reducing the Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington, D.C.: National Academy Press, 1994.
- 14:: AHMAC National Mental Health Working Group. National Standards for Mental Health Services. Canberra: Commonwealth Department of Health and Family Services, 1997.
- 15:: Anthony WA. Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychiatric Rehabilitation Journal* 2000, 16(4): 159.
- 16:: National Mental Health Strategy Evaluation Steering Committee for the Australian Health Ministers' Advisory Council. Evaluation of the National Mental Health Strategy: Final Report. Canberra: Commonwealth Department of Health and Family Services, 1997.
- 17:: Groom G, Hickie I, Davenport T. Out of Hospital, Out of Mind! Canberra: Mental Health Council of Australia, 2003.
- 18:: Commonwealth Department of Health and Aged Care. Living Is For Everyone: A Framework for the Prevention of Suicide and Self-harm in Australia. Canberra: Commonwealth Department of Health and Aged Care, 2000.
- 19:: National Health Performance Committee. National Health Performance Framework Report. Brisbane: Queensland Health, 2001.
- 20:: Jorm A, Griffiths K, Christensen H, Medway J. Research Priorities in Mental Health. Canberra: Centre for Mental Health Research, The Australian National University, 2001.
- 21:: Christensen H, Griffiths K, Evans K. e-Mental Health in Australia: Implications of the Internet and Related Technologies for Policy. Canberra: Centre for Mental Health Research, The Australian National University, 2002.



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