

National Mental Health Policy 2008

National Mental Health Strategy

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Foreword

Most Australians will be directly or indirectly touched by the impact of mental illness at some point in their lives. Mental illness is common, with 3% of us experiencing severe or recurrent illness and up to 45% of us experiencing mental illness at some time in our lives. The impact on those affected, for their families and carers, and for the Australian community, can be profound.

This revised National Mental Health Policy represents a renewed commitment by all Health Ministers and Ministers with responsibility for Mental Health to the continual improvement of Australia's mental health system.

The Policy works towards ensuring Australia has a mental health system that detects and intervenes early in illness, promotes recovery, and ensures that all Australians with a mental illness have access to effective and appropriate treatment and community supports to enable them to participate in the community fully. A system that supports efforts to prevent mental ill health, promotes resilience and lessens the stigma so often attached to mental illness.

The Policy embeds a whole of government approach to mental health, first agreed to by the Council of Australian Governments in July 2006, within the National Mental Health Strategy. Through the Strategy, reforms into the future must maintain the effort and build on the successes of the past, but recognise that new challenges require innovation and new ways of working together across systems and sectors to achieve better outcomes. Health Ministers embrace the challenge of leadership in mental health reform and the need for greater collaboration and commitment across governments to realise and sustain change.

All Governments have increased their mental health reform efforts in recent times, with many significantly investing in clinical and community support services and a number creating new Mental Health Ministerial Portfolio positions, reflecting a strengthened commitment to mental health as a national health priority area. This Policy is the next step towards creating a better mental health system. It is the actions and outcomes to flow from this Policy that will ultimately make the difference.

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In commending this Policy to you, Ministers acknowledge the evident commitment, expertise and experience of all those involved in the revision process, in particular the contributions of the Review Committee responsible for the review. We call on all levels of Government, the private, community and non-government sectors to embrace the Policy and to forge an improved service system to improve the lives of all Australians affected by mental illness.

The Hon Katy Gallagher MP
Chair
Australian Health Ministers Conference

March 2009

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1 Introduction

The vision of the *National Mental Health Policy 2008* is for a mental health system that:

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

The *National Mental Health Policy 2008* provides a strategic vision for further whole-of-government mental health reform in Australia.

The aims of the *National Mental Health Policy 2008* are to:

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

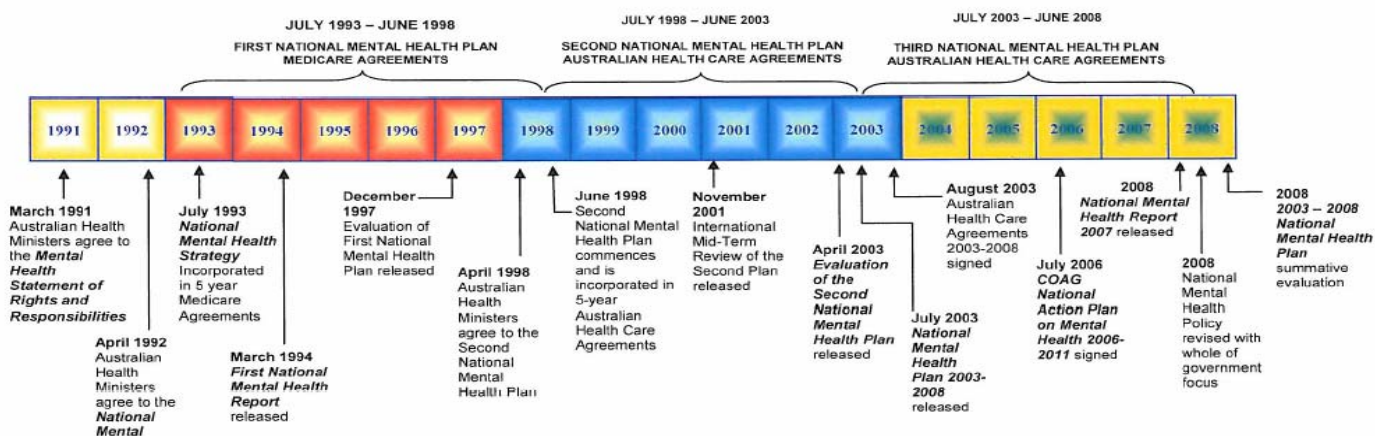
Australia has long been a leader in mental health policy and service development. Successive governments have recognised the need for continued effort, investment and reform, acknowledging the significant disability often associated with mental illness, and the burden it places on individuals and the community. The *National Mental Health Strategy* was agreed in 1992 and comprised:

- the National Mental Health Policy
- the First National Mental Health Plan
- the Mental Health Statement of Rights and Responsibilities
- a funding agreement between the Commonwealth and the states and territories.

As can be seen in the following diagram, the overarching vision and intent of the Policy has been operationalised through three National Mental Health Plans, the most recent being the 2003–08 Plan.

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Milestones in the development of the National Mental Health Strategy, 1991-2008



Note: COAG refers to Council of Australian Governments.

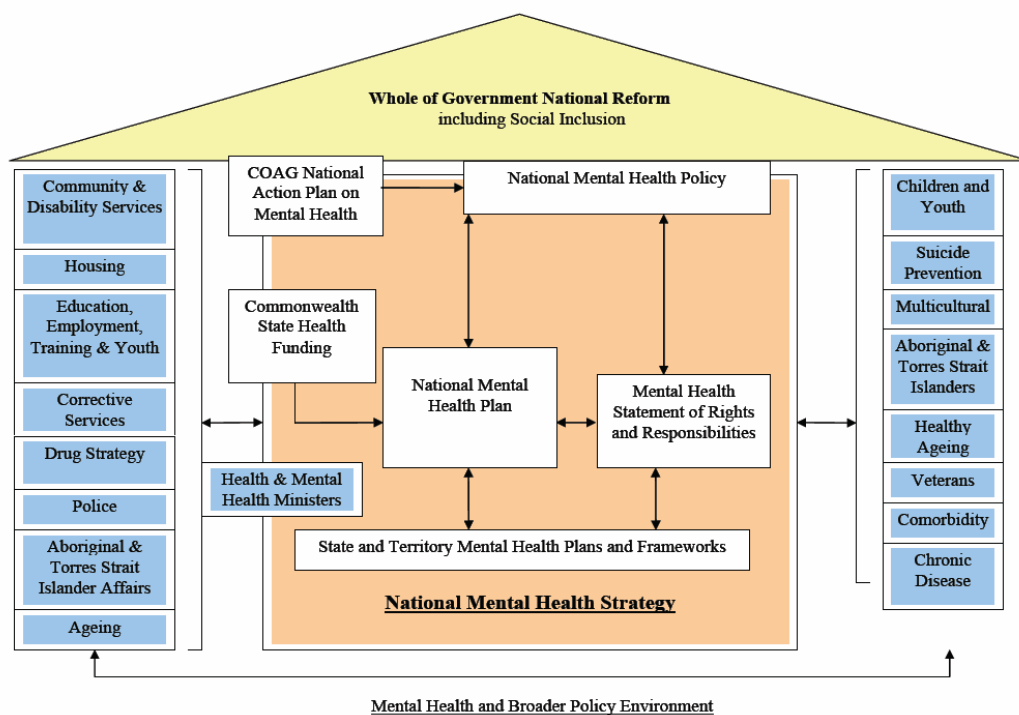
While the first plan emphasised structural changes in where and how mental health services were delivered, subsequent plans have broadened the approach to give a stronger focus on partnerships between different sectors, inclusion of promotion, prevention and early intervention activity, and a greater emphasis on the roles of consumers and carers. Workforce issues have been given greater prominence, as has the importance of research, innovation and sustainability. Previous plans have been linked to funding through the Australian Health Care Agreements. Each of the plans has undergone evaluation. In addition, the Strategy led to nationally endorsed safety priorities, an information development plan and development of *National Standards for Mental Health Services* and *Practice Standards for the Workforce*.

In 2006 the Council of Australian Governments (COAG) responded to the growing recognition of the scale and significance of mental health issues and the importance of areas such as housing, employment, justice, community and disability support to enhance recovery from mental illness. The Council agreed that further effort was required to overcome historical boundaries between jurisdictions, and to better engage government portfolios to bring a whole-of-government focus to mental health reform. The resulting *National Action Plan on Mental Health 2006-2011* brought a whole-of-government approach to mental health and included significant new investment and an emphasis on care coordination and governments working together. A number of jurisdictions have created new ministerial portfolios or departmental responsibilities to support this renewed emphasis on reform in mental health. Individual jurisdictions have developed mental health plans tailored to local issues or challenges, but consistent with the overarching directions of reform set by the national strategy. There has also been increased policy attention to related areas such as homelessness, social inclusion, and employment support.

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As illustrated in the figure below, there is a complex interplay between areas of government endeavour in the provision of mental health services, and other services that impact on the lives of those with mental illness and contribute to their stability and recovery. This figure does not include detail regarding areas of additional work that has occurred over the life of the National Mental Health Strategy, and which continues to inform policy and service development. These areas include work on;

- National Mental Health Service Standards
- National Practice Standards
- Promotion, Prevention and Early Intervention
- Forensic Mental Health Principles.



It is in this context that the *National Mental Health Policy 2008* has been developed. It recognises the need for ongoing national reform. It recognises the importance of maintaining the momentum created by the COAG process to support a vision of a seamless and connected care system which is consumer focussed and recovery oriented and where people are supported to engage with the community and participate to their full potential. It recognises that attention to promotion, prevention, and early intervention across the life span will benefit the whole community. It recognises the need for collaboration across a range of services provided or funded by different government and private sectors, non-government agencies, individuals and organisations in the community to improve the mental health of Australians. Most importantly, it recognises that to achieve the desired outcomes there must be ongoing development and support of

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a skilled workforce delivering quality services that are based on the best evidence and are continually monitored and evaluated.

The *National Mental Health Policy 2008* acknowledges our Indigenous heritage and the unique contribution of Indigenous people's culture and heritage to our society.

Furthermore, it recognises Indigenous people's distinctive rights to status and culture, self-determination and the land. It acknowledges that this recognition and identity is fundamental to the well-being of Indigenous Australians. It recognises that mutual respect, respect and responsibility are required to close the gap on indigenous disadvantage and to improve mental health and well-being.

The strategic framework provided by the *National Mental Health Policy 2008* is deliberately aspirational. It should be viewed as a broad agenda to guide coordinated efforts in mental health reform over the next decade. The Policy will be operationalised and implemented through the development of national plans and those developed by individual jurisdictions.

1.1 Aims

The aims of the *National Mental Health Policy 2008* are to:

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

These aims provide a context for the plans developed at a state and national level. They recognise a continuum between mental health, mental health problems and mental illness. Some people may experience episodes of mental illness that require clinical treatment and community services. Others may face emotional or mental health problems which affect their ability to fulfil their social roles and require specific services to help them overcome these problems. People at risk of developing mental health problems or mental illness can benefit from preventive or early intervention activities. Community

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awareness from mental health promotion efforts can reduce stigma and discrimination and increase opportunities for prevention and early intervention.

1.2 Scope

The *National Mental Health Policy 2008* provides a strategic framework to support improved mental health outcomes for people at risk of or experiencing mental health problems or mental illness. It recognises that certain groups in the community, including homeless and disadvantaged people, those exposed to traumatic events, and those with serious or chronic health problems are at heightened risk of mental health problems and mental illness. Aboriginal and Torres Strait Islander peoples face unique issues in terms of social and emotional well-being, and experience higher rates of mental health problems and mental illness than other Australians.

The *National Mental Health Policy 2008* also recognises that certain life stages such as adolescence and old age may be associated with increased risk. It does not seek to replace existing policies, plans and frameworks that target particular groups. Policy directions for individual groups have not been identified. However, specific groups are mentioned by example. The *National Mental Health Policy 2008* recognises that the approach for any group should be based on the best available evidence for that group and tailored to their particular needs.

1.3 A renewed approach to mental health

There have been many gains during the life of the National Mental Health Strategy. These have been seen in better access to a wider range of services, improved quality in service delivery and more robust and accountable legislation. However, it is now widely recognised that an approach which incorporates a number of different areas of clinical and community support across sectors of government is necessary to reduce the prevalence of mental health problems and mental illness, maximise the mental health of all Australians and deliver health equality across all groups.

In this context the Policy brings together a range of sectors that impact on the mental health of individuals and their families and communities, including, health, aged and community care, housing, education, employment, welfare, justice and Indigenous affairs. Together, these sectors have an important role to play in promoting the mental health and well-being of the general population, and contribute to prevention and early intervention, and the recovery of those experiencing mental health problems and mental illness.

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Across many areas of government, effort is being directed to achieve greater social inclusion for all of the community – but especially for those groups most at risk of social exclusion, such as those who experience homelessness, Aboriginal and Torres Strait Islander peoples and disadvantaged children. The goal of social inclusion recognises that good mental health is fundamental to the well-being of individuals, families and communities. Conversely, mental health problems and mental illness can cause high levels of disability and reduced quality of life for those who experience them, impact on their families and friends, and can have significant societal and economic consequences. In a 12 month period, one in five Australians will experience a mental health problem or mental illness. Reducing this will not only have benefits for individuals, but will benefit the whole community through increased well-being and productivity.

Mental health problems and mental illness are influenced by a complex interplay of biological, psychological, social, environmental and economic factors. This is true for all Australians, but may have particular significance in the case of Aboriginal and Torres Strait Islander peoples who view social and emotional well-being holistically.

A population health framework should underpin mental health policy and practice. Such a framework recognises the complex range of determinants and consequences of mental health and illness. In addition, it acknowledges the importance of mental health issues throughout the lifespan, and across diverse population groups. It also recognises the two-way relationship between physical health and mental health, acknowledging that each has an impact on the other. It recognises that many mental illnesses are comorbid with drug and alcohol problems and other conditions. A population health framework also stresses the importance of a strong evidence base, including epidemiological data on mental health problems and mental illnesses and evaluative data on access to and outcomes of interventions.

Central to the population health framework is a range of high quality, effective interventions that target those at different levels of risk or with different levels of need. The interventions should be comprehensive, ranging from prevention and early intervention through treatment to continuing care and prevention of relapse. There is a major focus on recovery which emphasises the development of new meaning and purpose, and the ability to pursue personal goals within the community. Mental health promotion should target the whole population and promote mental health and well-being among people with mental illness, their carers and families.

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Some interventions are clearly the responsibility of the specialist mental health sector, or other parts of the health sector. For example, a mix of community-based and inpatient clinical treatment services designed to provide crisis, acute, non-acute and ongoing care should be provided by public and private sector mental health services, psychiatrists, general practitioners, mental health nurses, psychologists and other allied health professionals. Other interventions might be provided by the mental health sector or by other sectors outside health, depending on their specific approach. For example, some elements of care might be provided through ongoing contact with and support from a community mental health team, but other, equally important elements of support might be provided through a housing or employment service. Integration and coordination between these areas will enable services to be 'wrap around' the person accessing services.

Services should be responsive to the differing needs of people with mental health problems and mental illness and must be equipped to promote optimal individual and family outcomes and to assist recovery. In the mental health sector, this translates into providing appropriately-tailored, culturally-respectful, evidence-based service delivery. Services need to provide coordinated care and to respond flexibly to individual needs. These interventions should address biological, psychological and social factors and aim to intervene early to prevent or reduce individuals' symptoms, improve their functioning and increase quality of life. It is important that people with mental health problems and mental illness have a significant say in their individual treatment, and, more broadly, in how the mental health service system is organised and run. Services must be accountable, able to demonstrate how they are achieving a desired level of quality and access, and open to review.

Beyond the mental health sector, this may involve ensuring that a person with mental illness has access to non-government services, peer support or secure long-term housing options, or can participate fully in a vocational training program. Alternatively, it may involve ensuring that a person with mental illness is no more likely than any other member of the community to be arrested or jailed. Working together in a coordinated manner will maximise the mental health of all Australians.

This Policy reaffirms the importance of good mental health, not just the absence or reduction in mental illness, for our whole community. It sets a vision for the continuing reform of mental health service delivery across all sectors. Those experiencing, or at risk of experiencing, mental health problems or illness will receive services that meet their clinical and support needs. They will be actively involved in their own care and recovery, in a system that promotes participation and collaboration across multiple sectors, levels of government and government agencies.

Policy directions

2.1 The rights and responsibilities of people with mental health problems and mental illness

The rights and responsibilities of people with mental health problems and mental illness will be acknowledged and respected. Services must be provided in accordance with agreed national and international obligations.

All Australians, including those with mental health problems and mental illness, have a right to participate meaningfully in individual and community life without discrimination, stigma or exclusion. All Australians should be able to access contemporary and relevant literature, information and advocacy services to ensure that they understand and are free to exercise these rights and responsibilities without prejudice.

People with mental health problems and mental illness should be able to access a necessary range of mental and general health services, disability services, and services offering vocational rehabilitation, housing and supported accommodation, and respite care. They should be able to expect that workers with whom they come into contact will uphold their rights and deliver fair and proper standards of care and service provision. In turn, they have a responsibility to work together with these services towards their recovery and to respect the rights, well-being and safety of other people working in or using these services.

People with mental health problems and mental illness have rights and responsibilities to be informed about and involved in decisions about their own individual treatment. They also have the right to contribute to the formulation of mental health legislation and policy, and to the design, implementation and evaluation of mental health services at national, state/territory and local levels to ensure that services comprehensively meet their needs, including from a cultural perspective. Mental health legislation should include recognition of these rights and the conditions that apply when decision-making is delegated. Mental health legislation should be underpinned by consistent principles that support, wherever possible, people moving between jurisdictions.

People with mental health problems and mental illness are vulnerable to human rights' violations in the community and in a variety of services due to stigma, discrimination and the absence of legal protection. Media reporting and public education should seek to lessen rather than add to stigma. Peoples' rights to meaningful community participation

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and to consent to or refuse treatment should be protected and dignity, privacy and respect safeguarded. Individual rights should be balanced against the rights of carers, families and the wider community.

Every attempt should be made to provide services in a way that is culturally safe. The special rights of Indigenous Australians must be respected and there should be no tolerance of discrimination or racism in service environments.

2.2 *Mental health promotion*

<p>Mental health promotion activities will support destigmatisation and assist Australians to become emotionally resilient, cope with negative experiences and participate in their communities.</p>

Mental health promotion aims to maximise the ability of children, youth, adults and older people to realise their potential, cope with normal stresses of life, and participate meaningfully in their communities. It also seeks to increase awareness and understanding of mental health problems and mental illness, reduce stigma and discrimination, and encourage help-seeking behaviour where this is needed.

At an individual level, mental health promotion focuses on increasing emotional resilience and reducing vulnerability to mental health problems through the development of personal skills and self esteem which lead to an increased capacity to cope with life transitions and stresses. At a community level, it seeks to build healthy environments (e.g. schools, workplaces), and to foster inclusive and supportive social networks. At a structural level it is concerned with ensuring that public policies address mental health and well-being by, for example, promoting equity and inclusion and reducing discrimination through responsible media commentary.

Successful mental health promotion ideally combines an approach that involves many different government agencies and community organisations to deliver coordinated programs at the individual, community and system levels. Much of the effort in mental health promotion needs to occur beyond the healthcare system, in sectors that impact on the daily lives of individuals and communities to support the development of resilience and maintenance of mental well being. These include housing, education, employment, welfare and justice. In the health sector, mental health promotion should be incorporated into the activities of general health promotion units. Mental health services should also adopt a recovery-oriented approach and deliver services in a respectful and non-judgemental manner.

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Mainstream mental health promotion activities have received considerable attention in recent times, with, for example, destigmatisation campaigns being targeted at whole communities. These efforts are important and should be consolidated, expanded and complemented by promotional activities that target specific population groups.

2.3 Preventing mental health problems and mental illness, and reducing suicide risk

The proportion of Australians with mental health problems, mental illness and at risk of suicide will be reduced.

There are multiple risk factors for mental health problems and mental illness. Some risk factors may act as immediate precursors to mental health problems and mental illness. These include bereavement, relationship breakdown, removal from family and social supports, being in a carer role, unemployment and other major life events. Others are longer term and include biological predisposition and adverse childhood events, including deprivation and abuse. Some risk factors are linked to the individual, such as drug and alcohol use and physical health problems; others occur at a community level and include social exclusion, discrimination and bullying. Certain life stages render individuals particularly vulnerable (e.g. childhood, adolescence and old age). Some population groups, such as Aboriginal and Torres Strait Islander peoples, and people who are homeless, unemployed, newly-arrived or refugees, are recognised as being at heightened risk and should therefore receive particular attention.

Mental health problems and mental illness, in turn, are risk factors for suicide. Other clinical indicators, such as a previous history of self-harm, are also recognised as being associated with a heightened risk of suicide. The risk factors for suicide are complex, and the interactions between them are poorly understood. An array of social factors such as poverty and recent stressful life events may also elevate the risk of suicide, particularly when combined with underlying vulnerabilities. Certain population groups are recognised as being at particularly high risk, including young males, Aboriginal and Torres Strait Islander peoples, people living in rural areas and prisoners.

There are multiple protective factors that moderate the effect of risk factors and minimise the likelihood that individuals will experience mental health problems, mental illness or engage in suicidal behaviour. Like risk factors, protective factors can be short term or long term, rest with the individual or their community, and vary across the lifespan. They

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can include factors like robust self esteem, emotional resilience and strong social networks.

Prevention involves understanding and minimising factors which heighten risk and enhancing factors which improve resistance to mental health problems, mental illness and suicide. Universal prevention efforts target whole communities, with the aim of promoting resilience in individuals or positively impacting on some aspect of the social environment. Selective interventions target people who are not yet displaying mental health problems or mental illness or engaging in suicidal behaviours, but who exhibit risk factors that predispose them to do so in the future.

To change risk and protective factors at individual and community levels requires coordinated, sustained efforts across multiple sectors. For example, the education sector might join with the mental health sector to deliver resilience programs in primary and secondary schools.

2.4 Early intervention

People with an emerging mental health problem or mental illness will be identified and treated as early as possible in the initial phase and any subsequent episode, to minimise the severity and duration of the condition and to reduce its broader impacts.

Early intervention can reduce the impact of mental health problems and mental illness through interventions for:

- identified at-risk populations
- people experiencing a mental health problem or mental illness for the first time
- people who are experiencing early indications of a relapse or recurrence of illness.

Mental health problems and mental illness often first appear in adolescence or early adulthood, and can seriously disrupt school, work and family relationships. This can have immediate and potentially long-term negative personal and social outcomes, such as substance abuse and behavioural problems. Complex mental health problems can also appear in childhood and infancy and can impact on early development and long-term mental health and well-being. Older Australians can also experience specific problems associated with late onset of mental illness. Within all age groups, some people may experience a single episode whereas others will have recurrences throughout their lives.

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Each episode may have economic and social repercussions, jeopardising education, job and housing security and disrupting relationships.

Successful early identification and intervention requires clear access pathways and a coordinated approach which is suited to individual life stages and situations and takes into account the impact of environmental and social factors on mental health and well-being. Early intervention involves a range of health and other sectors, carers, advocates and families, and requires appropriate services accessible by well-supported referral pathways.

Aboriginal and Torres Strait Islander communities are often characterised by high numbers of children and adolescents, fewer adults and still fewer elders. Innovative, culturally respectful approaches to early intervention are required in these communities.

In the mental health sector, specially-targeted early intervention programs can address underlying difficulties for children and young people with emerging mental health problems. They can also reduce negative impacts for those who are at risk of developing mental illness or who are recovering from a first episode of illness. In addition, they can avert crises for people at risk of relapse by mobilising support when warning signs appear. Where relapse does occur, early intervention programs can minimise the impact of the episode by offering a rapid treatment response.

Workers in sectors outside mental health also have an important role in early intervention because they are often well-placed to observe changes in an individual's behaviour or demeanour and intervene in these settings. For example, a maternal and child health worker may identify behavioural problems in an infant presenting for a routine check; a teacher may notice that a student has become withdrawn; an employer may see that a worker is not coping with his or her usual tasks; or a volunteer serving meals in a homeless persons' shelter may become aware of the changes in a person who comes to the shelter. Families, carers and workers in relevant sectors must be given appropriate support and be equipped with the core knowledge, competencies and resources necessary to detect and respond appropriately to early signs of mental illness.

2.5 Access to the right care at the right time

People with mental health problems and mental illness will have timely access to high quality, coordinated care appropriate to their condition and circumstances, provided by the most appropriate services.

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For people with mental health problems and mental illness to have access to the right care at the right time, a range of inter-connected clinical and community service options should be available. These services should be responsive to the needs of people with mental health problems and mental illness when they arise, and they should promote positive outcomes and facilitate sustained recovery. These services will include primary care, acute care and community support services and may be provided by public and/or private sector services. There should be an adequate and appropriate workforce to provide the range of services required.

The primary care sector is a linchpin in mental health care delivery. For many people with mental health problems and mental illness, their first point of contact will be with a general practitioner. During the past decade, considerable attention has been paid as to how to equip general practitioners with better skills and knowledge to detect, diagnose and manage mental health problems. General practitioners and other primary care workers have been supported by the development of collaborative, multi-disciplinary models of care, new referral options and opportunities for secondary consultation. There will be further refinement to ensure appropriate targeting and use of evidence-based best-practice treatment approaches. Increased access to mental health nurses will complement these developments.

Beyond primary care, consideration must be given to the best way to configure the specialist mental health sector to guarantee that it is responsive to the needs of people with mental illness. Public sector expenditure on mental health services should be accounted for and reported on publicly and be structured to work in a more coordinated way, across Commonwealth, state and territory and private services and sectors. At the area/regional level, the full range of mental health services should be provided by integrated programs, ensuring a balanced and responsive mix of community and inpatient services. The important role played by private providers of inpatient and community mental health services is recognised. Community treatment should be the treatment of choice wherever appropriate, but inpatient care must be available when required. Core community services should include, but not be limited to, crisis assessment and emergency intervention, acute treatment and continuing care, as well as community-based residential support. Core inpatient services should include both acute and non-acute components. Non-acute bed-based services should be community based wherever possible and promote maximum independence and autonomy consistent with safety and physical well-being.

The integration of community and inpatient public sector mental health services has been a focus of the National Mental Health Strategy since its inception in 1992, and much

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progress has been made in this regard. However, integration now needs to go further and cross clinical and non-clinical, primary and tertiary sectors in order to maintain and strengthen the appropriate mix of services.

Specialist mental health services, both public and private should be part of the mainstream health system, supported by strong linkages between physical and mental health units and common accreditation expectations. Private sector services, including private hospital services, are a crucial part of the network of mental health services. Private psychiatrists, psychologists and other allied mental health providers are integral to Australia's mental health system. Access to private providers has been enhanced through reform of the Medicare Benefits Schedule. Public and private providers should be accessible to all geographic areas. Coordination of care between state or territory and Commonwealth health systems are also important. The benefits of linking mental health services into the wider health system include:

- reducing stigma associated with mental health problems and mental illness
- improving the quality of mental health services
- increasing the potential for early detection and intervention
- enhancing equity of access to other health services for people with mental health problems and mental illness
- providing mental health services that are close to and respectful of people's family, community and cultural networks.

Mental health services in the criminal justice system, including police, the courts and the correctional system, are an essential component of the broader mental health service system. Prisoners have high rates of mental health problems and mental illness, and often their presentations are complex and characterised by multiple comorbidities. They may be particularly vulnerable early in their sentences and on release, and their symptoms may be exacerbated by stressors such as isolation, containment in a controlled environment, removal from their families and exposure to violence. Appropriate services should be available to identify and respond to the mental health needs of people who come into contact with the criminal justice system. For some, this will involve diversionary programs; for others it will involve services provided during and after their incarceration. These services may include clinical treatment to ameliorate symptoms of mental illness and support programs designed to prepare and support the individual in their return to the community.

Across all sectors further work is required to enhance access to and the quality of care. Better linkage and coordination is needed between clinical services within the health

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sector to ensure that the person is not 'lost' at critical transition points. These points include, in particular:

- discharge from hospital
- the period following presentation to hospital emergency departments
- on referral from public mental health services to general practitioners
- on referral between public and private mental health specialists.

People may fall through gaps if these transitions are not properly managed.

Many people with mental health problems and mental illness have needs for care that extend beyond clinical treatment. Particularly for those with complex needs or severe mental illness, access to clinical care needs to be complemented by access to a range of supported accommodation options, stable housing, and community support services focussed on employment, income support, education and social and family support. When one or more of these is not met, the person's recovery and their capacity to live in the community are jeopardised. These services should be readily accessible and should not discriminate on the basis of mental health status. They should also be of high quality, and should be coordinated in partnership with clinical care.

Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse populations with mental health problems and mental illness require particular consideration in terms of clinical and community services. Services should be both culturally safe and respectful and in this context Aboriginal and Torres Strait Islander specific services, including community-controlled services, are of particular importance.

The role of the non-government mental health sector has expanded significantly over the past decade. The sector has become an important and integral part of the network of services for people with mental health problems and mental illness. The non-government sector provides crucial support to individuals, as well as to carers and families. Non-government sector services include psychiatric disability support services, advocacy services, peer support services, consumer-operated services, and programs addressing areas such as living skills, vocational training, accommodation support and respite care. In some instances, the non-government sector also provides clinical services.

In order to respond effectively to the varying requirements of people with mental health problems and mental illness, there is a need to develop ways of fostering partnerships and improving linkages between services provided within and across the primary care sector, the public and private specialist mental health sectors, the non-government mental health sector, and other sectors outside health. Innovative approaches to improving continuity of care should be explored. A more integrated approach across

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sectors, with partnerships between housing, employment, education, youth affairs, police, community and disability services, corrective services, and alcohol and drug services will be particularly important. Existing approaches have been expanded under the COAG *National Action Plan on Mental Health 2006–2011*, to ensure that clinical providers and community workers collaborate to meet the treatment and support needs of people with complex mental health problems. Such improved linkages are designed to encourage different elements of the system to work together so that individuals with mental health problems and mental illness can access care in a seamless fashion, irrespective of who is providing or funding that care.

2.6 Participation and inclusion

People with mental health problems and mental illness have the same rights as other Australians to full social, political and economic participation in their communities.

Improved mental health outcomes will increase our human capital through greater productivity and active participation in social and community roles. Community participation (e.g. employment) can have a significant positive mental health impact, such that people with mental health problems and mental illness should be supported to engage in all aspects of society.

There are clear benefits to be gained from an approach that involves government and community partnerships that include but extend beyond mental health. In addition to the examples of housing, employment and criminal justice, other sectors have an important role to play. These sectors include, but are not limited to, education and training, family and community services, immigration and citizenship, Indigenous affairs, defence and veterans' affairs, child and youth affairs, ageing, police, human rights and anti-discrimination, and disability. Such an approach requires strategic, coordinated efforts across sectors.

It is the responsibility of all sectors to promote positive reforms that facilitate participation and inclusion. For example, the provision of appropriate housing and support for individuals with mental health problems and mental illness is widely recognised as enhancing effectiveness of treatment and maintenance of positive outcomes, and decreasing community resistance to deinstitutionalisation. People with mental health problems and mental illness are over-represented among homeless populations, and among those seeking rental assistance and accommodation support. They often experience discrimination in housing, and their housing preferences typically do not

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match the options most commonly made available to them. Multi-faceted coordinated accommodation programs that encompass a range of public and private housing options may redress this imbalance.

Employers should ensure equitable participation in work for people with mental health problems and mental illness who are currently disproportionately represented among unemployed groups, and consequently among those on low incomes. Unemployment and low socio-economic status are identified risk factors for mental illness, and mental health problems can sometimes lead to unemployment and/or a downturn in social mobility. Other social factors, such as discrimination and stigma, may further contribute to disadvantage. A coordinated range of strategies to promote social inclusion is required to correct the current situation.

The criminal justice sector also has a role in ensuring that people with mental health problems and mental illness can participate in and contribute to the community. At present, people with mental health problems and mental illness are over-represented in the criminal justice system, and some, such as Aboriginal and Torres Strait Islander people, experience double disadvantage. People with a mental illness who are arrested for minor offences are four times more likely to be jailed for these offences than their counterparts with no mental illness. Offenders with a mental illness have a higher likelihood of being remanded in custody than non-mentally ill offenders, and spend longer in custody awaiting sentencing. Prisoners have higher rates of mental health problems and mental illness than the general population, and those with mental illness who spend time in jail face additional stigma when they return to the community.

Suitable programs are necessary to divert people with mental health problems and mental illness from criminal courts and from custody when appropriate. Care and support are also required pre and post release to support reintegration into the community in a manner that allows them to fulfil satisfying roles and social inclusion. For those who have experienced prolonged incarceration, or high levels of recidivism, comprehensive cross-sectoral approaches are most likely to minimise the risk of relapse and recidivism.

Homelessness is a common consequence of untreated severe mental illness. Severe mental illness is often accompanied by personal disorganisation and episodes of acute care, resulting in loss of rental accommodation, or leaving the family home due to conflict arising from behaviour associated with the mental illness. Unstable housing arrangements also contribute to deterioration of mental health. Appropriate clinically supported short-term and long-stay accommodation options for people with severe or ongoing disability caused by mental illness should be developed, enabling early

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intervention at points of crisis and instability and preventing avoidable homelessness. In addition, multi-faceted coordinated accommodation programs that encompass a range of public and private housing options may further enhance consumer outcomes.

2.7 Carers

The crucial role of carers in prevention, early intervention, treatment and recovery will be acknowledged and respected and provided with appropriate support to enable them to fulfil their role.

Many people with mental health problems and mental illness receive care and support from carers who can be spouses, parents, other relatives or friends. Children and young people are often placed in this role. Carers play a crucial and often unacknowledged role in enabling people with mental health problems and mental illness to live and participate meaningfully in the community. Some carers also act as advocates, working with people with mental health problems and mental illness, their families and friends to achieve recovery goals, to influence policy and practice, and to bring about positive societal change.

Carers require acknowledgement and respect for the role they play. To perform their role effectively, carers must be able to access relevant information and services, whenever necessary. Carers also need to be able to access information regarding the treatment, on-going care and rehabilitation of the person for whom they are caring. This requires:

- balancing the rights of carers with the rights of people with mental health problems and mental illness
- clear definitions of responsibilities and entitlements
- articulated lines of communication and legalised agreements regarding disclosure
- information sharing.

Like people with mental health problems and mental illness, carers have an integral role to play in service planning, delivery and evaluation. Carers require education and training to undertake these activities and need to be able to access workers trained in the appropriate use of their expertise. Services must increase workers' responsiveness to carers, and improve communication between these groups.

Being a carer can result in significant emotional, social and economic burden. Carers have their own needs, and are known to be at risk of experiencing depression, anxiety and stress. Carers' needs must be recognised and their health and well-being

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safeguarded. This should occur through access to information, resources and support programs, and, where necessary, to crisis assistance and respite care services.

The importance of extended family and community systems for Aboriginal and Torres Strait Islander peoples has implications for the way in which the role of carer is viewed. The needs of Aboriginal and Torres Strait Islander carers have traditionally not been well represented by carer organisations, and alternative ways of understanding and meeting these needs may be necessary.

2.8 Workforce

The supply and distribution of appropriately-trained workers in the mental health sector and other relevant sectors will be adequate to meet the needs of people with mental health problems and mental illness.

Mental health should be a career of choice. Mental health services require a workforce that is enthusiastic and well supported. The workplace should be one where the environmental and organisational culture promotes a positive and inclusive culture. There should be access to high quality education and training opportunities to enable the development of a flexible and competency based workforce. There should be greater effort to promote the benefits of working in this sector.

Workforce issues have been recognised as a challenge since the inception of the original *National Mental Health Policy*. Despite continued effort and expansion, the recruitment and retention of clinical and non-clinical workers to mental health services remains an area of concern. The supply and distribution of professionals in the relevant service sectors underpins the effectiveness of the broad approach in addressing the mental health of Australians. These professionals need to be adequately trained to provide high quality services.

There should be sufficient numbers of providers to meet community needs across public, private and non-government sectors. This includes psychiatrists, general practitioners, psychologists, mental health nurses, social workers, occupational therapists and Aboriginal and Torres Strait Islander mental health workers, as well as consumer and carer consultants, and recovery and peer support workers.

Recruitment and retention of professionals depends on there being opportunities to work in safe environments with adequate amenity, systemic supports, and also on there being satisfactory incentives and rewards (e.g. satisfactory levels of remuneration, appropriate

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career development opportunities, prospects for promotion) to ensure job satisfaction. Ongoing efforts are needed to address the maldistribution of these professionals, which typically manifests itself in insufficient numbers in rural and remote areas and in areas of low socio-economic status. Consideration should be given to the mix of skills within and across professional groups, and how best to match expertise with the needs of individuals seeking care. Flexible models of workforce development and new definitions of workforce competency should be developed and implemented.

Funding arrangements for services, models of care, population distributions as well as training opportunities, all need to be considered when addressing the problems of distribution of mental health professionals.

Consistent, appropriate training of the mental health workforce throughout Australia is a necessary component to address issues of supply and distribution. Suitable undergraduate, postgraduate and other education and training opportunities should be available to attract and retain sufficient numbers of qualified workers. Continuing education options should also be provided. Such training should equip the existing and future mental health workforce to provide high quality care that promotes prevention, early intervention and recovery, and is sensitive to cultural and linguistic diversity and the rights of the individual. Clearly, some curricula should be discipline-specific, whereas other training content might be generalised across disciplines. Aboriginal and Torres Strait Islander mental health workers and peer support workers are emerging as new components of the workforce, and should be supported in this context to reach their full potential. Adequate staffing of services to meet the needs of people with mental health problems and mental illness, regardless of where they live, remains a challenge.

Similar principles apply outside the mental health sector. There have been recent efforts to increase the skills of general practitioners, and the knowledge and awareness of mental health issues in other professional areas such as teachers, paramedics and police. These staff should receive appropriate training which equips them with a basic understanding of mental health problems and mental illness, and ensures that they have the skills necessary to meet the needs of people with mental health problems and mental illness as they apply in their sector. Such training should also provide them with information about the interface between their particular sector and the specialist mental health sector, and prepare them for coordinating care and support across sectors. These staff should also have access to the specialist mental health sector for referral, support and advice, when necessary.

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2.9 *Quality and outcomes*

Across all sectors, services provided to people with mental health problems and mental illness should be monitored and evaluated to ensure that they are of high quality and achieving positive outcomes.

People with mental health problems and mental illness should receive high quality mental health and social services. Clearly-articulated quality frameworks that ensure that the appropriate information is available and that this information is used to guide decision-making about service development and delivery should be in place across all sectors. These quality frameworks should set out comprehensive processes for gathering and feeding back information to continuously improve service performance, including articulating lines of responsibility and accountability.

Mental health and other services should be geared to achieving positive outcomes for individuals and their families. These outcomes might be defined in different ways, and could include reductions in symptomatology and improvements in quality of life, as well as positive perceptions of care. In order to achieve these outcomes, services will need to meet agreed standards, and ensure that their staff have the knowledge and skills to deliver evidence-based best practice. In addition, they should consult people with mental health problems and mental illness and their carers as to what constitutes a high quality service and promotes recovery.

Continued efforts to improve the monitoring of service quality must be encouraged. The importance of listening and responding to the consumer and carer experience to inform service development should be recognised. Quality assurance programs, benchmarking activities and independent accreditation initiatives should be fostered, both locally and nationally to improve accountability. Professional bodies and individual providers should have a role in developing and implementing these efforts, as should people with mental health problems and mental illness and their carers.

In the mental health sector, explicit measures should be developed to assess service quality and track progress against desired outcomes. The development and implementation of National Standards for Services, and National Practice Standards for the workforce support quality improvement, and should apply across all mental health services. In other sectors, too, the extent to which quality services are being provided to people with mental health problems and mental illness should be examined critically. Higher level outcomes should also be assessed, both as they relate to the delivery of

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high quality services, as well as to the aim of achieving outcomes such as employment and general health equity.

Supplementary outcome measures need to be developed and implemented to capture issues for particular groups, such as the broader view of social and emotional well-being held by Aboriginal and Torres Strait Islander peoples. Additional indicators of quality may also need to be developed to reflect specific issues such as the cultural respectfulness of services.

2.10 Building and using the evidence base

<p>Rigorous research and evaluation efforts generate new knowledge about mental health problems and mental illness that can reduce the impact of these conditions.</p>

Achieving optimal individual outcomes for people with mental health problems and mental illness depends on a strong evidence base. However, scientific knowledge about mental health and mental illness has traditionally lagged behind that of other areas of health. Greater understanding of the incidence and prevalence of mental health problems and mental illness is required, as is improved understanding of the varying courses of specific conditions. More information is also needed about the risk and protective factors for mental health problems and mental illness, and the causal pathways by which these factors might operate. Evaluative evidence on the effectiveness and cost-effectiveness of different interventions across all mental health services is a priority, particularly given the expanded emphasis on innovative, inter-sectoral models of care.

Gathering evidence of this type requires that greater priority be given to innovative mental health research in a range of fields, including the biomedical, psychological and social sciences, program evaluation and health economics. At present, there is limited evidence as to how best to tailor assessment and treatment for specific populations, including Aboriginal and Torres Strait Islander peoples and people from culturally diverse backgrounds.

Research should focus on enhancing the capacity of the mental health sector to address gaps and improve service delivery through synthesis, dissemination and utilisation of new knowledge. Existing evidence should be assembled, and gaps in the evidence should receive particular research and evaluation attention. A variety of stakeholders, including people with mental illness and their carers, should be involved in research and evaluation activities.

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There should be ongoing dialogue between researchers, decision-makers, service providers and other stakeholders to ensure that research is designed, conducted and disseminated in a manner that will have maximum impact on mental health policy and service development and implementation. As knowledge builds and a cohesive evidence base develops, information should be disseminated in a manner that is most likely to influence individual outcomes for people with mental health problems and mental illness. The management, design and governance of services should be directed to reinforce uptake of evidence-based service provision.

3 Glossary

Acute services/treatment: 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 treatment effort is focused upon symptom reduction with a reasonable expectation of substantial improvement.

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.

Carer consultants: People who have experience of caring for a person with a mental illness. They are employed by public mental health services, and have a good knowledge of the mental health system and the issues that are faced by families and other carers. Carer consultants provide emotional support, information and referral advice for families and carers. They also work with mental health staff in developing service responsiveness to the needs of carers and families.

Community controlled services: Aboriginal Community Controlled Health Services are primary health care services initiated, operated and controlled by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it (through a locally elected Board of Management). Services form a network, but each is autonomous and independent both of one another and of government.

Community mental health teams: Teams which may include: social workers, community psychiatric nurses, consumer and carer consultants, peer support workers, occupational therapists, psychologists and psychiatrists and Aboriginal mental health workers. Community mental health teams provide a range of services in the community including: individual treatment programs; family interventions; short and long term support and psycho-education.

Consumer consultants: Consumers who are employed to advise on and facilitate service responsiveness to people with a mental health problem or mental illness and the inclusion of their perspectives in all aspects of planning, delivery and evaluation of mental health and other relevant services.

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Criminal justice system: Explicit rules (laws) created by political authorities and designated officials such as police, lawyers and judges to make, interpret and enforce rules, and the provision for punishment for those who offend and commit acts against the rules and society at large.

Cultural competence: A set of behaviours, attitudes and a culture within a system that respects and takes into account the person's cultural background, cultural beliefs, and their values and incorporates it into the way healthcare is delivered to that individual.

Cultural respect and safety: Cultural respect and safety is the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples and other cultural groups.

Day programs: Programs providing individual or group centre-based activities on a whole or part-day basis. They include but are not limited to: assessment, assertive life skills training, activities programs, diversional therapy and pre-vocational training.

Disability: The effects of mental illness which severely impair functioning in different aspects of a person's life such as the ability to live independently, maintain friendships, maintain employment and to participate meaningfully in the community.

Diversion: A process which diverts mentally ill offenders away from the criminal justice system to the health and social care sectors. Diversion can occur at any stage of the criminal justice process: before arrest, after proceedings have been initiated, in place of prosecution, or when a case is being considered by the courts.

Emotional resilience: A feature of personality which contributes to mental health and well-being. In situations of significant adversity, emotional resilience enables a person to pursue their goals, to solve problems and to quickly regain emotional equilibrium. It also enables a person to cope more confidently and effectively in day-to-day life and to handle stress better than those who are less emotionally resilient.

Forensic mental health services: Services providing assistance to people who experience mental illness and are in contact with the adult criminal and juvenile justice systems.

Incidence: The proportion of individuals in a particular population who have a newly developed mental illness during a specific time period.

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Key performance indicators: Achievable, measurable targets, used for goals and monitoring of performance.

Meaningful participation: The capacity of a person to engage in personal, educational, employment, social, political and other activities within their community in such a way that they are able to fully realise their potential and to feel socially valued and personally validated.

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

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* (DSM) or the *International classification of diseases* (ICD).

Non-government mental health sector: Private, not-for-profit, community-managed organisations that provide community support services for people affected by mental health problems and mental illness. Non-government organisations may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness and carers or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, prevocational training, residential services and respite care.

Peer support: Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis.

Population health framework: An understanding that the factors which impact on the mental health of individuals and populations 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 well-being. Interventions span the spectrum from prevention to recovery and relapse prevention across the lifespan.

Prevalence: The proportion of individuals in a particular population who have a mental illness during a specific period of time.

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Primary care services: Community based services which often constitute the first point of contact for people experiencing a mental health problem or a mental illness and their families. The primary care sector includes general practitioners, emergency departments and community health centres.

Private sector specialist mental health services: The range of mental health care and services provided by psychiatrists, mental health nurses and allied mental health professionals in private practice. Private mental health services also include inpatient and day-only services provided by private hospitals, for which private health insurance funds pay benefits, and some services provided in general hospital settings

Public sector specialist mental health services: The range of specialist mental health services provided by government locally, regionally and state-wide. Services include child and adolescent mental health services, adult mental health services and aged persons' mental health services and specialist state-wide services (e.g. forensic services).

Psychiatric disability support services: Services provided by the non-government sector including: physical health care, assertive outreach, advocacy services, peer support services, consumer-operated services, and programs addressing areas such as living skills, vocational training, accommodation support and respite care.

Quality assurance: Activities designed to evaluate, monitor and improve the quality of mental health services. Activities include monitoring of performance indicators, clinical audit including medical record audit, peer review, customer surveys, observational studies, quality reviews and quality improvement projects.

Recovery: A personal process of changing one's attitudes, values, feelings, goals, skills and /or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources.

Respite care: Services for carers enabling them to 'take time out' from the role of direct carer. Respite may occur in the home and outside the home. Services include centre-based respite, recreational respite, cottage-style residential respite and one-on-one respite.

Social inclusion: Contemporary concepts of disadvantage often refer to social exclusion. Social *inclusion* refers to policies which result in the reversal of circumstances

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or habits which lead to social exclusion. Indicators of social inclusion are that all Australians are able to secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and have their voices heard.

Social and emotional well-being: An holistic Aboriginal definition of health that includes: mental health; emotional, psychological and spiritual well-being; and issues impacting specifically on well-being in Aboriginal and Torres Strait Islander communities such as grief, suicide and self-harm, loss and trauma.

Supported accommodation: Decent, safe, and affordable community-based housing combined with non-clinical and clinical supports and services which enable people with mental health problems and mental illness to live independently in the community. This also applies to people who may need 24 hour clinical support in a residential (long-stay inpatient) setting rather than an institutional setting.

Whole-of-government, whole-of-community : Public service agencies working across portfolio boundaries and in partnership with, non-government organisations, private service agencies and individuals, and with the community at large to achieve a shared goal and an integrated response to particular mental health issues. Approaches can be formal and informal. They can focus on policy development, program management and service delivery.